MEDICAL CONTESTED CASE HEARING NO. 15024

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determined that Claimant is not entitled to a left elbow lateral epicondylar debridement common extensor repair.

STATEMENT OF THE CASE

On February 12, 2015, Katie Kidd, a Division hearing officer, held a contested case hearing to decide the following disputed issues:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that Claimant is not entitled a left elbow lateral epicondylar debridement common extensor repair?

PARTIES PRESENT

Claimant appeared and was represented by MJ, attorney.

Respondent/Carrier appeared and was represented by TW, attorney.

Petitioner did not attend the hearing other than during his testimony.

DISCUSSION

The medical records indicate that Claimant sustained an injury to his left elbow on (Date of Injury). Claimant first sustained an electrical shock while disconnecting and reconnecting chill water condensing pump motors. Claimant further injured his left elbow when moving chill pumps and heavy water pipes. Claimant began treating with JZ, D.O., on June 6, 2013. Dr. Z provided a cortisone injection, started Claimant on stretching exercises, and provided an elbow strap. Claimant was also advised to take anti-inflammatory medications for pain and was given light duty restrictions.

Claimant saw Dr. Z again on July 9, 2013, and was noted to be "doing very well with conventional treatment." Dr. Z recommended continued stretching exercises and provided a new lateral epicondylitis strap. Claimant was released to return to work without restrictions. On November 15, 2013, Claimant was evaluated by Dr. Z who noted that Claimant had recurrent pain "related to lifting activity he engaged in at work." Claimant was advised to continue stretching exercises, ibuprofen for pain, continued use of brace at work, and Ambien for sleep.

Dr. Z administered another cortisone injection. Claimant was allowed to return to work without restrictions.

Claimant was evaluated by Dr. Z on January 14, 2014, and noted to have recurrent pain, and had not improved from his last injection. Dr. Z restricted Claimant from working and recommended a left lateral epicondyle percutaneous microtenotomy. The operative procedure was performed by Dr. Z on January 27, 2014.

Claimant was followed-up by Dr. Z on February 6, 2014, and was noted to be doing well without "numbness or tingling distally." Claimant denied taking any pain medications at that time. Dr. Z advised Claimant to stay off work for the next month and not to lift more than five pounds for the next few weeks.

Dr. Z examined Claimant again on March 6, 2014, and noted that Claimant's left elbow lateral epicondyle is "recurrent after lifting activity." Dr. Z prescribed physical therapy and restricted Claimant from working. After follow-up on March 9, 2014, Dr. Z noted that Claimant's symptoms were aggravated with activity. Claimant advised that he was attending physical therapy, requested pain cream, and declined an injection. Claimant was provided pain cream, recommended to continue physical therapy, and advised to return in two weeks if there was no improvement. Claimant remained in an off duty status.

On May 9, 2014, Claimant returned to Dr. Z and reported increased symptoms including numbness and tingling in fingers, inability to rotate a steering wheel, or to roll down his car window. An MRI was recommended. Claimant remained in an off duty status.

Claimant had an MRI on May 13, 2014, and the results suggested lateral epicondylitis and possible partial tear. Claimant returned to Dr. Z on June 17, 2014, to discuss the diagnostic findings. Claimant was noted to have "exhausted all minimally invasive and conservative treatment. Dr. Z recommended a left elbow lateral epicondylar debridement with common extensor repair. Claimant remained in an off duty status.

Dr. Z submitted requests for a left elbow lateral epicondylar debridement common extensor repair and preauthorization was denied on June 23, 2014 by RAL, D.O., board certified orthopedic surgeon, and on August 8, 2014 by WCB, M.D., orthopedic surgeon. (See CR-D and CR-E) The IRO noted the first denial was because "no information was submitted confirming full course of conservative treatment." The IRO noted the second denial was because "insufficient information was submitted confirming clinical status indicating appropriateness of the proposed procedure." (See CR-F, p. 3) The IRO also concluded that the request for the treatment does not meet the requirements of the *Official Disability Guidelines* (ODG).

Evidence Based Medicine (EBM)

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

In reference to surgery for epicondylitis, the ODG provides:

> Recommended for chronic lateral epicondylitis as indicated below, after 12 months of failed conservative treatment. Conservative measures work over 95% of the time, but when they fail, surgical management may be indicated. Almost all patients respond to conservative measures and do not require surgical intervention. Treatment involves rest, ice, stretching, strengthening, and lower intensity to allow for maladaptive change. Any activity that hurts on extending or pronating the wrist should be avoided. With healing, strengthening exercises are recommended. Patients who are recalcitrant to after 12 months of conservative therapy (including injections) may be candidates for surgery. There currently are no published controlled trials of surgery for lateral elbow pain. Without a control, it is impossible to draw

conclusions about the value of surgery. Generally, surgical intervention may be considered when other treatment fails, but over 95% of patients with tennis elbow can be treated without surgery. (Buchbinder-Cochrane, 2002) (California, 1997) (Piligian, 2000) (Foley, 1993) (AHRQ, 2002) (Theis, 2004) (Jerosch, 2005) (Balk, 2005) (Sennoune, 2005) (Szabo, 2006) Disappointing results of surgery were found in litigants with epicondylitis. (Kay, 2003) (Balk, 2005) Surgery is not very common for this condition. In workers' compensation, surgery is performed in only about 5% cases. (WLDI, 2007) For the minority of people with lateral epicondylitis who do not respond to nonoperative treatment, surgical intervention is an option. The surgical techniques for treating lateral epicondylitis can be grouped into three main categories: open, percutaneous, and arthroscopic. Although there are advantages and disadvantages to each procedure, no technique appears superior by any measure. Therefore, until more randomized, controlled trials are done, it is reasonable to defer to individual surgeons regarding experience and ease of procedure. (Lo, 2007) For possibly recommended initial conservative epicondylitis treatments, see Acupuncture; Autologous blood injection; Exercise; Injections (corticosteroid); Iontophoresis; Laser treatment (LLLT); Manipulation; NSAIDs; Physical therapy; Platelet-rich plasma (PRP); Prolotherapy; Stretching; Tennis elbow band; Topical NSAIDs; Ultrasound, therapeutic; Viscosupplementation.

Recent research: Most patients improve with nonoperative measures, such as activity modification, physical therapy, and injections. A small percentage of patients will require surgical release of the extensor carpi radialis brevis tendon. Common methods of release may be performed via percutaneous, arthroscopic, or open approaches. (Tosti, 2013) Symptom resolution occurs in over 70% to 80% of patients within the first year. A watch-and-wait approach can be an appropriate treatment option, and physical therapy has been shown to be an effective first-line therapy. For patients with symptoms refractory to conservative management, surgical intervention has shown to be a successful treatment modality. (Behrens, 2012) There is fair-quality evidence for elbow arthroscopy in the treatment of lateral epicondylitis. (Yeoh, 2012)

Criteria for Lateral Epicondylar Release for Chronic Lateral Epicondylalgia:

- Limit to severe entrapment neuropathies, over 95% recover with conservative treatment
- 12 months of compliance with non-operative management:
- Failure to improve with NSAIDs, elbow bands/straps, activity modification, and PT exercise programs to increase range of motion and strength of the musculature around the elbow.
- Long-term failure with at least one type of injection, ideally with documented short-term relief from the injection.
- Any of the three main surgical approaches are acceptable (open, percutaneous and arthroscopic).

At the hearing, Dr. Z testified outlining the treatment that he provided to Claimant. Dr. Z noted that Claimant failed conservative treatment and opined that the requested treatment was medically necessary.

SAD, M.D., Carrier's peer review doctor, also testified. Dr. D observed that it has been more than a year since Claimant's injury. However, Claimant had surgery for the injury in (Date of Injury). By May 2014, it was evident that Claimant had recurrent epicondylitis. Dr. D noted that the ODG does not distinguish between primary and recurrent epicondylitis and opined that the one-year period for conservative treatment began again in May 2014 when the epicondylitis re-manifested. Dr. D agreed that Claimant has failed conservative care, but that pursuant to the ODG, the requested treatment is indicated neither at this time, nor at the time the pre-authorization request was made. Dr. D observed in testimony and in his report of November 10, 2014, that

> Most patients improve with nonoperative measures such as activity modification, physical therapy, and injections. A small percentage of patients will require surgical release…..Symptom resolution occurs in over 70% to 80% of patients within the first year. A watch-and-wait approach can be an appropriate treatment option, and physical therapy has been shown to be an effective first-line therapy. (See CR-G, p. 5, citing ODG)

Claimant did not meet the evidentiary standard required to overcome the IRO decision and the preponderance of the evidence is not contrary to the IRO's determination that the Claimant is not entitled at this time to a left elbow lateral epicondylar debridement common extensor repair.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), Employer provided workers' compensation insurance with Service Lloyds Insurance Company, Carrier/Respondent.

   D. On (Date of Injury), Claimant sustained a compensable injury to include at least a lesions to the left ulnar and radial nerves, lateral epicondylitis of the left elbow, and sprain/strain of the left elbow

   E. The Independent Review Organization determined Claimant/Petitioner should not have the requested treatment of elbow lateral epicondylar debridement common extensor repair on September 10, 2014.

F. Petitioner filed his appeal of the decision of the IRO on September 25, 2014.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. A left elbow lateral epicondylar debridement common extensor repair is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that a left elbow lateral epicondylar debridement common extensor repair is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a left elbow lateral epicondylar debridement common extensor repair.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **SERVICE LLOYDS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

JOSEPH KELLY-GRAY, PRESIDENT
6907 CAPITOL OF TEXAS HIGHWAY NORTH
AUSTIN, TEXAS 78755

Signed this 12th day of February, 2015.

Katie Kidd
Hearing Officer