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DATE OF REVIEW:
06/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right tennis elbow release and drilling osteochondritis desiccans and lesion of capitellum.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.
The requested right tennis elbow release and drilling osteochondritis desiccans and lesion of capitellum is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
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PATIENT CLINICAL HISTORY [SUMMARY]:
The injured individual had a wrist injury and wrist pain from his date of injury of xx-xxxx as reported to numerous providers. He had no trauma. He reported different mechanisms of injury: a repetitive injury; stated he was lifting a case; stated he was loading a box onto a truck. The injured individual had physical therapy (PT). X-ray was negative. Electromyogram (EMG) was negative. The MRI of 04/2009, almost a year later showed degenerative changes and tendinopathy per the radiologist report but the orthopaedic surgeon feels the injured individual has osteochondritis desiccans and right epicondylitis. He has requested to do surgery for both of these diagnoses.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The injured individual had a wrist injury and wrist pain from his date of injury of xx-xxxx as reported to numerous providers; not an elbow injury. He had no trauma. He reported different mechanisms of injury: a repetitive injury; stated he was lifting a case; stated he was loading a box onto a truck. The injured individual had PT. X-ray was negative. EMG was negative. MRI of 04/2009, almost a year later showed degenerative changes and tendinopathy per the radiologist report but the orthopaedic surgeon feels the injured individual has osteochondritis desiccans and right epicondylitis. He has requested surgery for both of these diagnoses. This was denied due to lack of compensability per the mechanism of injury reported and the fact that the injured individual claimed a wrist injury initially. The use of surgery for epicondylitis is considered investigational/experimental (I/EO per Official

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Disability Guideline. The use of surgery for a radial head fracture is indicated only for certain types of fracture; this injured individual has no evidence of those types of fractures. MRI and x-ray showed no osteochondritis. For all these reasons the proposed surgery is not warranted.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guideline (ODG) for epicondylitis surgery: Under study. 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 six months of conservative therapy (including corticosteroid 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)

ODG for radial head fracture: Recommended for level III and IV fractures. Under study for level II, and not recommended for level I. Radial head fractures are common elbow fractures. The Mason classification is used to describe the fracture. For nondisplaced fractures (level I), a sling may be all that is necessary, and symptomatic treatment and splinting followed by early range of motion also appear to produce uniformly good results. A systematic review compared the results of conservative treatment with different surgical strategies for radial head fractures. For Mason type II fractures, residual pain was present in 42% of the conservatively treated patients compared to 32% of the surgically treated patients. Good/excellent results for Broberg score were 52 and 88%, respectively. For Mason type III and IV fractures, no conservatively treated patients were described. (Thompson, 1988) (Bano, 2006) (Struijs, 2007) Radial head fractures are common injuries, occurring in about 20 percent of all acute elbow injuries, usually caused by a fall breaking the smaller bone (radius) in the forearm. (AAOS, 2001)