



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: February 26, 2010

IRO Case #:

Description of the services in dispute:

This is a request for a right epicondylar release for this patient.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Plastic Surgery. This reviewer is a fellow of the American College of Surgeons. This reviewer is a member of the American Medical Association, the American Society of Maxillofacial Surgeons and the American Society of Plastic Reconstructive Surgeons. This reviewer has been in active practice since 1999.

Review Outcome

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

Medical necessity is not established for a right epicondylar release.

Information provided to the IRO for review

Confirmation of Receipt of a Request for a Review by an independent Review Organization (IRO), 01/26/10 (5 pages)

Request form, Request for a review by an Independent Review Organization, 01/21/10 (3 pages)

Clinic note from, MD, 12/29/09 (1 page)

MD PA, Electrodiagnostic study, 12/22/09 (3 pages)

, MRI report, 12/18/09 (1 page)

Clinic note from, MD, 12/08/09 (1 page)

Clinic note from, MD, 10/26/09 (1 page)

Clinic note from, MD, 10/15/09 (1 page)

Clinic note from, MD, 10/05/09 (1 page)

Records Received from The State:

, Instruction for Outpatient Surgery, 01/13/10 (1 page)

Mutual, letter of denial from, 01/11/10 (2 pages)

MES Solutions, Peer Review Report, 01/07/10 (2 pages)

Mutual, Reconsideration letter from, 01/06/10 (2 pages)

Mutual, letter of denial from, 12/31/09 (2 pages)

Clinic note from, MD, 12/29/09 (1 page)

MD PA, Electrodiagnostic study, 12/22/09 (3 pages), MRI report, 12/18/09 (1 page) MES Solutions, Peer Review Report, 12/15/09 (2 pages) Clinic note from, MD, 12/08/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 12/07/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 12/02/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/30/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/24/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/23/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/18/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/16/09 (1 page)  
Hand and Microsurgery Therapy, Therapy Daily note, 11/09/09 (1 page)  
Objective Findings form, undated (1 page)  
Hand and Microsurgery Therapy, ROM/Strength Evaluation, 10/27/09 (1 page)  
Hand and Microsurgery Therapy, Initial Evaluation, 10/27/09 (1 page)  
Clinic note from, MD, 10/26/09 (1 page)  
Clinic note from, MD, 10/15/09 (1 page) Clinic note from, MD, 10/05/09 (1 page) MedClinic, encounter notes, 09/24/09 (2 pages)  
Texas Workers' Compensation Work Status Report, 08/26/09 (1 page)  
MedClinic, encounter notes, 09/02/09 (2 pages)  
MedClinic, encounter notes, 08/26/09 (1 page)  
Hand and Microsurgery, Authorization request, 12/29/09 (1 page)  
Health Care Provider Summary screen print, printed 01/26/10 (1 page)  
Health Care Provider Detail, printed 01/26/10 (1 page)  
Prior review, FYI, 12/30/09 (4 pages)

#### Patient clinical history [summary]

The patient is an administrative assistant that has had pain in the lateral aspect of her right arm and elbow with radiating pain to her hand since xx/xx/xx. She describes the onset of symptoms after lifting and her job requires repetitive use of her right arm. She has been treated for diabetes and hypertension. Since the injury the patient has been evaluated by an orthopaedic upper extremity specialist. She has been treated with direct injection, splinting, light duty and physical therapy. EMG studies show no indication of nerve entrapment and the MRI shows chronic lateral epicondylitis.

#### Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Lateral epicondylitis (tennis elbow) is an overuse injury involving the extensor muscles that originate on the lateral epicondylar region of the distal humerus. It is more properly termed a tendinosis that specifically involves the origin of the extensor carpi radialis brevis muscle. Such elbow pain with the MRI supported diagnosis of lateral epicondylitis can be extremely difficult to

treat, more difficult in patients with comorbid diabetes. Approximately 90–95% of patients with lateral epicondylitis (tennis elbow) respond to conservative measures and do not require surgical intervention. Patients whose condition is unresponsive to 6 months of conservative therapy (including corticosteroid injections) are candidates for surgery. Nonsurgical treatment is the mainstay of care for patients with lateral epicondylitis (tennis elbow).

The goal of initial treatment is cessation of the offending activity. Rest, use of a counterforce brace, and nonsteroidal anti-inflammatory drugs (NSAIDs) often provide relief of symptoms. Often, wrist splinting is necessary.

Jafarian et al compared 3 common types of orthoses for their effect on grip strength in patients with lateral epicondylitis. In a randomized, controlled study of 52 patients, maximum and pain-free grip strength were assessed with the patient wearing an elbow strap orthosis, an elbow sleeve orthosis, a wrist splint, or a placebo orthosis. Use of the elbow strap and sleeve orthoses resulted in an immediate and equivalent increase in pain-free grip strength; consequently, the researchers suggest that either of these types of orthosis may be used. The wrist splint provided no immediate improvement in either pain-free or maximum grip strength.

Both corticosteroid and autologous blood injections have been shown to be effective. Corticosteroid injections at the lateral epicondyle have been shown to significantly decrease pain scores in the early post-injection period. Autologous blood injections for lateral epicondylitis were described in 2003 and showed encouraging pain relief in two thirds of patients treated.

Low-level laser therapy appears to provide short-term pain relief and improvement in disability, even in cases resistant to other nonsurgical therapy. A systematic review noted, however, that success with laser therapy has been limited to studies that used direct irradiation of the tendon insertion and wavelengths of 904 nm (and possibly 632 nm), for a total dose of 0.5 to 7.2 joules.

When the patient is free of pain through a full range of motion, begin strengthening therapy in a very slow and progressive way. When the patient regains strength and nears resumption of activity, place the emphasis on preventing future irritation (eg, correct technique or address equipment concerns in athletes who participate in racquet sports, modify jobs or activities in patients who are not athletes).

The use of extracorporeal shockwave therapy raised initial excitement. However, 2 prospective, randomized, blinded trials showed no benefit of this intervention over placebo.

Medical necessity is not established for a right epicondylar release. The patient has a clear diagnosis of chronic lateral epicondylitis—this is confirmed by MRI examination. Her current treatment reflects thorough care by a skilled upper extremity specialist. However, ODG guidelines (726.32) that are well supported by current literature do not support surgical epicondylar release until six months of

conservative therapy. The only documented physical therapy for patient begins in 11/09, there was a question of compliance and no extended documentation of preferred range of motion/strengthening exercises noted. The documentation does not clearly support six months of conservative therapy.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG guidelines, (726.32)

Van Rijn RM, Huisstede BM, Koes BW, Burdorf A. Associations between work-related factors and specific disorders at the elbow: a systematic literature review. *Rheumatology* (Oxford). May 2009;48(5):528-36. [Medline].

Stahl S, Kaufman T. The efficacy of an injection of steroids for medial epicondylitis. A prospective study of sixty elbows. *J Bone Joint Surg Am*. Nov 1997;79(11):1648-52. [Medline].

Krischek O, Hopf C, Nafe B, Rompe JD. Shock-wave therapy for tennis and golfer's elbow--1 year follow-up. *Arch Orthop Trauma Surg*. 1999;119(1-2):62-6. [Medline].

Gabel GT, Morrey BF. Operative treatment of medial epicondylitis. Influence of concomitant ulnar neuropathy at the elbow. *J Bone Joint Surg Am*. Jul 1995;77(7):1065-9. [Medline]. [Full Text]

Baker CL Jr, Jones GL. Arthroscopy of the elbow. *Am J Sports Med*. Mar-Apr 1999;27(2):251-64. [Medline].

Canale TS. Medial epicondylitis. In: Canale TS, ed. *Campbell's Operative Orthopaedics*. 10th ed. St Louis, Mo: Mosby, Inc; 2003:2365-6.

Dee R, Hurst LC, Gruber MA, Kottmeier SA, eds. *The elbow joint. Principles of Orthopaedic Practice*. 2nd ed. New York, NY: McGraw-Hill; 1997:1111.

Kurvers H, Verhaar J. The results of operative treatment of medial epicondylitis. *J Bone Joint Surg Am*. Sep 1995;77(9):1374-1386.

Saliman JD, Beaulieu CF, McAdams TR. Ligament and tendon injury to the elbow: clinical, surgical, and imaging features. *Top Magn R*