

Case Number:	CM13-0027693		
Date Assigned:	12/11/2013	Date of Injury:	01/21/2011
Decision Date:	06/19/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 37 year old female with a date of work injury 1/21/11. The diagnoses include right shoulder impingement. Bilateral knee chondromalacia patella, bilateral knee mild degenerative joint disease, right wrist tenosynovitis, involuntary tremors. There are requests for the medical necessity of x-ray of the right shoulder and x-ray of the right elbow. There is an 11/26/13 office visit document that states that the patient reports dorsal sided wrist pain as well as right lateral epicondylar pain. She reports she had cortisone injection x2 for the right lateral epicondyle and physical therapy but it did not provide her relief. The pain in the right wrist comes and goes. Pain radiates into the shoulder and neck. She wakes up in pain. She has pain lifting anything heavy. Her elbow aches all the time. There is loss of grip strength and weakness in the right arm. Physical exam reveals no ganglion cyst dorsal wrist. The patient had negative scapholunate interval tenderness, negative Watson's test, negative lunotriquetral interval tenderness, and a negative ulnar fovea sign. Distal radial ulnar joint stable in neutral, pronated and supinated position. There is mild dorsal wrist tenderness. A negative Tinel's, direct compression Phalen's right median nerve and a negative Finkelstein's test. Right lateral epicondyle is tender to palpation. There is mild radial tunnel tenderness. Resisted finger extension test negative. Resisted wrist extension test positive. The point of tenderness is at the right lateral epicondyle. Resisted forearm supination test negative. The grip test shows strength on the right 60/45/40 pounds, on the left 60/65/65 pounds. X-ray of the right thumb AP, oblique, lateral and Robert's view x-rays were ordered and reviewed November 26, 2013 and reveal no fracture, no dislocation. No arthropathy at the intercarpal, carp metacarpal, interphalangeal and metatarsophalangeal joint spaces in the field of view for the right thumb. AP and lateral view x-ray of the right elbow on November 26, 2013 were ordered and the review reveals no fracture,

no dislocations, and no arthropathy at the ulnohumeral, radial capitellar, proximal radial joint. There were no calcifications of the right lateral epicondyle. The patient was diagnosed with right lateral epicondylitis and possible right dorsal wrist capsulitis versus occult ganglion cyst. A 7/11/13 document states that the patient has right shoulder, right elbow, right wrist, and bilateral knee pain. On exam the patient has antalgic gait, AC joint pain with cross arm testing. There is positive subacromial bursitis. There is positive impingement 4+/5 strength. The right elbow has limited range of motion, tenderness. The patient's right hand and wrist; tenderness, and grip strength is a 4+/5. The left knee has a limited range of motion and positive painful patellofemoral crepitus with motion, tenderness and 4+/5 strength the treatment plan includes bilateral Knee brace wrap-around Hinged Knee Brace, a Right Knee Orthovisc Injections series of 3 injections once a wk for 3 weeks, A Referral to hand specialist, X -ray of the right shoulder, right elbow, and right wrist, Bilateral knees, and a MRI of the right shoulder and right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

X RAY OF THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: An X ray of the right shoulder is not medically necessary per the ACOEM MTUS guidelines. The guidelines states that the primary criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The documentation does not indicate acute trauma, plan for surgery, red flag or neurovascular dysfunction. The x-ray of the right shoulder is not medically necessary.

X-RAY OF THE RIGHT ELBOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 573-606.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33.

Decision rationale: An X-ray of the right elbow is not medically necessary per the ACOEM MTUS guidelines. The guidelines states that imaging is not needed unless the imaging study results will substantially change the treatment plan, or there is an emergence of a red flag, failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the

patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. The documentation does not indicate a new injury, red flag, suspicion of infection, significant neurovascular compromise or plan for surgery. The request for x-ray of right elbow is not medically necessary.