

<b>Case Number:</b>	CM13-0040144		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	08/19/2010
<b>Decision Date:</b>	02/24/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in California. 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 physician 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 58-year-old male who reported an injury on 08/19/2010. The patient's initial course of therapy is unclear; however, it is noted that he has had an unknown duration of physical therapy and Kenalog injections to the right upper arm with no long term relief. The patient underwent a right shoulder arthroscopy on 02/29/2010, as well as a revision with EUA/MUA on 12/23/2011. An EMG/NCV performed on 04/18/2012 revealed left ulnar motor nerve decreased conduction velocity; all other values were within normal limits. The patient is known to have received MRIs to the right hand, wrist, and shoulder, as well as cervical spine. Cervical spine MRI results included a large disc extrusion at C5-6 resulting in severe right neural foraminal stenosis and mild C6 neural edema, a small left disc protrusion at C6-7 with mild canal stenosis, and right C4-5, left C5-6, and right C6-7 mild to moderate neural foraminal stenosis. He was also noted to have borderline bilateral facet hypertrophy at C4-5 and C5-6. A current medication list was not provided in the medical records, and the patient's current diagnoses include complex regional pain syndrome with sympathetically maintained pain to the right upper extremity, and right hand pain with palmar fibrosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI w/o contrast for right elbow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Elbow Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

**Decision rationale:** The California MTUS/ACOEM Guidelines state that most patients presenting with elbow problems do not require special studies unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. In this case, for patients whose symptoms have been consistent and persisted for these 4 weeks or more, it may be appropriate for imaging studies if surgery is being considered for a specific anatomic defect or to further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. In the most recent clinical note dated 11/14/2013, the patient was noted to have tenderness to the medial epicondyle and painful resisted wrist flexion. The medical records submitted for review did not discuss any possible invasive treatment to correct the patient's discomfort, nor was there discussion of a potentially serious pathology at the origin of his pain. As such, the guideline recommendations have not been met and the request for MRI of the right elbow is non-certified.