

Case Number:	CM13-0063857		
Date Assigned:	04/30/2014	Date of Injury:	09/06/2011
Decision Date:	06/12/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	12/04/2013

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 Occupational Medicine 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 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 an employee of [REDACTED] and has submitted a claim for left arm, shoulder, and upper back pain associated with an industrial injury date of September 6, 2011. Treatment to date has included medications, physical therapy, chiropractic treatment, acupuncture, and 1 left medial epicondylar steroid injection and 1 lateral epicondylar steroid injection (date of service is unknown) with improvement of symptoms. Medical records from 2013 were reviewed, which showed that the patient complained of constant mild to moderate pain in her left arm, shoulder, and upper back, which benefited from physical therapy (a decrease in pain score from 6/10 to 3-4/10). The patient reported that her arm was more functional and that she was taking less medication. On physical examination of the shoulder, there was no limitation of range of motion and provocative tests were negative but tenderness was noted in the periscapular muscles, rhomboids, and trapezius. Trigger points were also palpable. Examination of the elbow showed tenderness over the lateral epicondyle with no limitation of range of motion. There was decreased strength of the abductor pollicis brevis muscle. Sensation was intact. Utilization review from November 7, 2013 denied the request for Left Lateral Epicondylar Injection because corticosteroid injections do not provide any long-term clinically significant improvement in the outcome of epicondylitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT LATERAL EPICONDYLAR INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, LATERAL EPICONDYLAGIA (LATERAL EPICONDYLITIS), 590-600

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-40.

Decision rationale: According to pages 33-40 of the ACOEM Practice Guidelines, there is good evidence that glucocorticoid injections reduce lateral epicondylar pain. There is evidence of short-term benefits but not long-term benefits. If a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended. Furthermore, guidelines state that subsequent injections should be supported by either objective improvement or utilization of a different technique or location for the injection. In this case, a lateral epicondylar injection was recommended for flare ups in her elbow; however, the patient's subjective complaints and physical exam findings did not support findings of such flare ups. Moreover, although the medical records indicated improvement of symptoms following previous lateral epicondylar injection, the records also documented functional improvement with physical therapy, which is a non-invasive treatment strategy. In addition, guidelines state that if symptom relief is obtained, then a proven graduated exercise program should be considered to maintain and enhance that improvement. There is no clear indication for a repeat lateral epicondylar injection; therefore, the request for left lateral epicondylar injection is not medically necessary.