

<b>Case Number:</b>	CM13-0069909		
<b>Date Assigned:</b>	12/26/2013	<b>Date of Injury:</b>	04/26/2012
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Expedited	<b>Application Received:</b>	12/24/2013

### 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 Physical Medicine and Rehabilitation 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:

This 41 year-old female sustained an injury to the upper extremities on 4/26/12 while employed by [REDACTED]. Report dated 11/5/13 from [REDACTED], orthopedic QME noted the patient worked in the [REDACTED] performing repetitive computer motions consistent with her ongoing pain complaints in the neck, elbows, wrists, shoulders, hands, and fingers with stiffness and weakness in the left wrist and numbness in her elbow. She was taken off work on 5/23/12 and has seen a chiropractor, psychiatrist, had physical therapy, acupuncture sessions, and medications. Assessment included ongoing non-radicular cervical spine strain; Mild impingement of shoulders without weakness; Ongoing tendonitis of bilateral elbows and Ongoing bilateral tender wrists with mild evidence of carpal tunnel syndrome; however, waiting for EMG/NCV test already performed for further assessment. There is an ultrasound report dated 3/28/13 performed in [REDACTED] office with impression of Right common extensor tendon origin (edema, micro tear and fibrosis); right normal biceps tendon, triceps tendon, normal cubital tunnel region; Normal left elbow. Per report dated 10/10/13 from [REDACTED], the EMG/NCV dated 5/18/12 was within normal limits with negative carpal tunnel syndrome, negative cubital tunnel syndrome and cervical spine radiculopathy. Treatment was for therapy, home exercise program and brace. Report of 11/21/13 from [REDACTED] noted continued right elbow pain rated at 7-8/10 on medications with any type of activities and persistent bilateral thumb pain. Diagnoses include deQuervain's right medial; Cubital tunnel syndrome; Lateral epicondylitis; and Carpal tunnel syndrome with request for ultrasound guided cortisone injection to bilateral elbow which was non-certified on 12/4/13 by [REDACTED].

### IMR ISSUES, DECISIONS AND RATIONALES

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

**URGENT ultrasound cortisone injection to bilateral elbows:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 594. Decision based on Non-MTUS Citation ODG Elbow, Injections

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

**Decision rationale:** The Physician Reviewer's decision rationale: This injured worker sustained a cumulative trauma injury to her upper extremities on 4/26/12 while working as a [REDACTED] Personnel. She continued to treat for chronic neck and upper extremity pain complaints with associated stiffness and numbness. Electrodiagnostics show no evidence for cervical radiculopathy, polyneuropathy, or entrapment syndromes of the carpal tunnel or cubital tunnel. Conservative treatment has included physical therapy and acupuncture sessions along with medications; however, no specific quantity or efficacy outcome has been documented. The patient remains off work since May of 2012 without any functional improvement. Current request is for ultrasound guided cortisone injection of both elbows; however, an ultrasound report on 3/28/13 has impression of normal left elbow and right normal biceps/triceps tendons, normal cubital tunnel region and right common extensor tendon origin with edema, micro tear and fibrosis. Orthopedic QME report has diagnoses to include ongoing tendinitis of the elbow without recommendation for corticosteroid injections for clinical findings of tender epicondyle with normal range and intact neurological exam. ACOEM Treatment Guidelines, Updated Chapter 10 for Elbow Complaints in regards to corticosteroid injections has no recommendation to require ultrasound guided injection of the elbow commonly done upon clinical exam. Although studies indicate the injections produce short-term pain relief; however, in the long term, they are less effective in providing pain relief and benefit than is physical therapy and has higher recurrence rates. In addition, glucocorticoid injections have some risks of tendon fraying and even rupture which may not be appropriate for this patient with assessed micro tear and fibrosis on ultrasound. Submitted reports have not adequately demonstrated the indication or necessity to support for this request. The urgent ultrasound-guided cortisone injections to bilateral elbows are not medically necessary and appropriate.