

Case Number:	CM14-0103035		
Date Assigned:	07/30/2014	Date of Injury:	02/08/2008
Decision Date:	09/09/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/03/2014

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 & 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 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 injured worker is a 54-year-old female who reported an injury on 02/08/2008. The mechanism of injury was not provided. Her diagnoses were noted to be myalgia/myositis, brachial plexus lesion, and chronic pain syndrome. The injured worker was noted to participate in a functional restoration program and physical therapy. It was noted that the injured worker had an EMG, MRI, and a cervical X-Ray, and an X-Ray to evaluate right elbow. The injured worker was noted to have cervical spine fusion. The injured worker had a clinical evaluation on 05/20/2014. Her subjective complaints were dryness in her throat. However, she denied tingling or numbness in her arms. The pertinent objective physical examination findings were noted to be sensory examination intact to light touch; no focal tenderness of the spine. Spinal range of motion was somewhat restricted to the right. Rotation to the left was full. Gait was normal. The treatment plan was for a completion of physical therapy and a follow up X-Ray of the cervical spine. The provider's rationale for the request was not submitted with the documentation provided for review. A request for authorization form was not provided within the documents submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right medial and lateral elbow injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Elbow Chapter Injections (corticosteroid).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 26.

Decision rationale: The request for right medial and lateral elbow injection is non-certified. The California MTUS American College of Occupational and Environmental Medicine Guidelines state corticosteroid injections are recommended if a noninvasive treatment strategy fails to improve a condition over a period of at least 3 to 4 weeks for subacute chronic lateral epicondylgia. The documentation submitted for review failed to indicate a diagnosis of epicondylgia. In addition, documentation failed to indicate failure of conservative treatment. In addition, the provider's request failed to indicate what type of injection is being requested. Therefore, the request for right medial and lateral elbow injection is not medically necessary.