Case Number:	CM15-0108471		
Date Assigned:	06/15/2015	**Date of Injury:**	04/24/2014
Decision Date:	07/16/2015	**UR Denial Date:**	05/19/2015
Priority:	Standard	**Application Received:**	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 57-year-old male who sustained a work related injury April 24, 2014. While driving a semi-truck, his tire blew and he hit another truck, went through a concrete embankment to railroad tracks, where the truck caught on fire. He injured his left ribs and complained of lumbar spine pain. Past history included diabetes. Positive results for MRI's of the cervical and lumbar spines, dated January 21, 2015 (reports are present in the medical record). According to a primary treating physician's progress report, dated May 7, 2015, the injured worker presented feeling unchanged from previous visit. He reports, still having constant neck pain, stiffness, headaches and dizziness, and left elbow tenderness with fluid in the left elbow. There is low back pain present radiating to the left leg, the left knee is numb, and the right ankle is numb. He reports ringing sounds in both ears. Physical examination revealed; left elbow bursa swelling and tenderness with painful range of motion. The low back reveals tenderness to palpation of the paravertebral muscles and cervical spine and lumbar spine revealed muscle guarding and decreased range of motion. Some of the handwritten notes are difficult to decipher. Diagnoses are cervical spine stain; cervical spondylosis; elbow bursitis. Treatment plan included pain management consultation, neurology consultation, and physical therapy treatment for the cervical spine. At issue, is the request for authorization for aspiration and injection of left olecranon bursa with ultrasound guidance for needle placement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aspiration and injection of left olecranon bursa: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 565.

Decision rationale: Per MTUS guidelines, olecranon bursitis is a condition associated with a generally painless effusion of the olecranon bursa, frequently caused by either overt or seemingly insignificant trauma over the olecranon. In a minority of cases, it may become infected, at which point pain and tenderness predominate. Quality studies are not available on the following treatment options for olecranon bursitis, and as such, there is no evidence of benefits. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, the following treatment options are recommended: 1) Soft padding of the elbow which appears successful for most cases; 2) Modifying activities to avoid direct pressure over the olecranon and allowing time to reabsorb the fluid. Glucocorticoid injection into an uninfected bursa is not recommended for initial management as it may introduce an infection and necessitate surgery; however, it is sometimes used for bursitis that is resistant to other treatment. Therefore, injection of a glucocorticosteroid 3 or more weeks later is neither recommended nor not recommended. In this case, there is no indication that the injured workers bursa is infected or that more conservation, non-invasive modalities have been attempted. The request for aspiration and injection of left olecranon bursa is not medically necessary.

Ultrasound guidance for needle placement: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 565.

Decision rationale: Per MTUS guidelines, olecranon bursitis is a condition associated with a generally painless effusion of the olecranon bursa, frequently caused by either overt or seemingly insignificant trauma over the olecranon. In a minority of cases, it may become infected, at which point pain and tenderness predominate. Quality studies are not available on the following treatment options for olecranon bursitis, and as such, there is no evidence of benefits. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, the following treatment options are recommended: 1) Soft padding of the elbow which appears successful for most cases; 2) Modifying activities to avoid direct pressure over the olecranon and allowing time to reabsorb the fluid. Glucocorticoid injection into an uninfected bursa is not recommended for initial management as it may introduce an infection and necessitate surgery; however, it is sometimes used for bursitis that is resistant to other treatment. Therefore, injection of a glucocorticosteroid 3 or more weeks later is neither recommended nor not recommended. In this case, there is no indication that the injured workers bursa is infected or that more conservation, non-invasive modalities have been attempted. As the request for aspiration and injection of left olecranon bursa is not medically necessary, the request for ultrasound guidance for needle placement is not medically necessary.