

Case Number:	CM15-0133123		
Date Assigned:	07/21/2015	Date of Injury:	10/12/1998
Decision Date:	08/25/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/09/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 59-year-old female who sustained a work related injury October 12, 1998. Past history included cervical spine fusion 1995, bilateral carpal tunnel release, and lateral epicondylar repair of the left elbow 2002, right shoulder surgery 2007, hypertension, depression and anxiety. A physician's progress notes dated April 20, 2015, finds the injured worker struggling with depression, panic attacks, and a high level of anxiety. She is taking Wellbutrin XL, Valium and Restoril. He discontinued the Restoril and started her on Trazodone at night with re-evaluation in a month. Mental status examination revealed; appearance is good; no evidence of agitation or psychomotor retardation; quite anxious; oriented to person, time, place, and situation; memory grossly intact to immediate recall, recent and remote events. The most recent primary treating physician's progress report dated March 17, 2015, finds the injured worker with complaints of left medial elbow pain. Physical examination of the left elbow revealed tenderness on palpation, limited range of motion and negative Tinel sign. This did not respond to immobilization in a cast but rather the pain is worse. Status post left elbow steroid injection was successful for approximately 4 days. She reports the pain is at least 70% better. She also complains of left shoulder difficulties with external rotation and an area on the medial aspect of the left shoulder blade and first noted the pain when the forearm cast was removed. She has completed 12 sessions of physical therapy for the left medial epicondylitis and still has exquisite point tenderness over the left medial epicondyle, especially with resisted wrist flexion. The left elbow revealed pain with pronation against resistance as well as resisted wrist and finger flexion. Impression is documented as medial epicondylitis, left elbow. At issue, is the request for authorization for a left elbow MRI with intra articular contrast (arthrogram). The medication list includes Wellbutrin, Celebrex, Valium and Ibuprofen. The patient had received treatment inform of immobilization of left elbow for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left elbow MRI with intra articular contrast (arthrogram): 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): 601 and 602.

Decision rationale: Request Left elbow MRI with intra articular contrast (arthrogram): Per the ACOEM guidelines, "Criteria for ordering imaging studies are: The imaging study results will substantially change the treatment plan, Emergence of a red flag, Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctable by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctable lesion is confirmed." Past history included cervical spine fusion 1995, bilateral carpal tunnel release, and lateral epicondylar repair of the left elbow 2002, right shoulder surgery 2007, hypertension, depression and anxiety. The most recent primary treating physician's progress report dated March 17, 2015, finds the injured worker with complaints of left medial elbow pain. Physical examination of the left elbow revealed tenderness on palpation, limited range of motion. This did not respond to immobilization in a cast but rather the pain is worse. The left elbow steroid injection was successful for approximately 4 days. She has completed 12 sessions of physical therapy for the left medial epicondylitis and still has exquisite point tenderness over the left medial epicondyle, especially with resisted wrist flexion. The patient had received treatment in the form of immobilization of the left elbow for this injury. The left elbow revealed pain with pronation against resistance as well as resisted wrist and finger flexion. Impression is documented as medial epicondylitis, left elbow. Therefore the patient had significant objective findings and further medical management would be benefited by a Left elbow MRI. However, a detailed rationale for the use of intra-articular contrast along with the MRI request was not specified in the records provided. Per the cited guidelines, "Several studies" have "failed to identify additional advantages of MR arthrography over conventional MR imaging of the elbow." Also a recent left elbow X-ray report is not specified in the records provided. The request of a Left elbow MRI with intra articular contrast (arthrogram), as requested, is not medically necessary or fully established in this patient, given the records provided.