

Case Number:	CM15-0163930		
Date Assigned:	09/01/2015	Date of Injury:	03/11/2015
Decision Date:	09/30/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/20/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

This 48 year old female sustained an industrial injury to the right wrist and arm on 1-29-15. Previous treatment included physical therapy (nine sessions) and medications. Electrodiagnostic studies of the right upper extremity (8-12-15) showed moderate compression of the right median nerve at the carpal tunnel. In an initial evaluation dated 6-29-15, the injured worker complained of right shoulder and right arm pain with right arm swelling and instability of the shoulder with clicking, popping and grinding and right wrist and hand pain associated with numbness, tingling, swelling, loss of grip strength and loss of sensation. The injured worker rated her pain 7 to 9 out of 10 on the visual analog scale. Physical exam was remarkable for right elbow with decreased range of motion, positive Mills' and Tinel's test and 4 out of 5 muscle strength with pain on supination and pronation and right wrist with positive Phalen's, decreased sensation in the ulnar nerve distribution, intact range of motion and 5 out of 5 motor strength. Current diagnoses included right elbow sprain and strain, right lateral epicondylitis, rule out tear, right cubital tunnel syndrome, right carpal tunnel syndrome and right wrist sprain and strain. The treatment plan included electromyography and nerve conduction velocity test of bilateral upper extremities, magnetic resonance imaging right elbow, a hand consultation and continuing Aleve.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right elbow: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (updated 06/23/2015) - Online Version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic), MRI's.

Decision rationale: ACOEM states, 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 correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. For most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There are a few exceptions to the rule to avoid special studies absent red flags in the first month. These exceptions include: Plain-film radiography to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis. Electromyography (EMG) study if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. Nerve conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. For patients with limitations of activity after 4 weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: When surgery is being considered for a specific anatomic defect. To further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. ACOEM further recommends MRI for suspected ulnar collateral ligament tears and recommends against MRI for suspected epicondylgia. ODG writes regarding elbow MRI, "Recommended as indicated below. Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Epicondylitis (lateral - 'tennis elbow' or medial - in pitchers, golfers, and tennis players) is a common clinical diagnosis, and MRI is usually not necessary. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear. Indications for imaging - Magnetic resonance imaging (MRI): Chronic elbow pain, suspect intra-articular osteocartilaginous body; plain films non-diagnostic; Chronic elbow pain, suspect occult injury; e.g., osteochondral injury; plain films - non-diagnostic; Chronic elbow pain, suspect unstable osteochondral injury; plain

films non-diagnostic; Chronic elbow pain, suspect nerve entrapment or mass; plain films non-diagnostic; Chronic elbow pain, suspect chronic epicondylitis; plain films non-diagnostic- Chronic elbow pain, suspect collateral ligament tear; plain films non-diagnostic; Chronic elbow pain, suspect biceps tendon tear and/or bursitis; plain films non-diagnostic; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." The medical documentation provided indicate decreased grip strength, generalized swelling, decreased sensation and increased pain. This patient has failed conservative therapy. The treating physician indicates concern for a tear. As such, the request for MRI of the right elbow is medically necessary.