

Case Number:	CM15-0164704		
Date Assigned:	09/02/2015	Date of Injury:	03/24/2015
Decision Date:	10/06/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/21/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 45-year-old female, who sustained an industrial injury on 3-24-15. Initial complaint was of her lower back. The injured worker was diagnosed as having lumbosacral spine sprain-strain; sprain-strain thoracic spine; bursitis of the hip-greater trochanter bilateral; impingement syndrome right; bilateral carpal tunnel syndrome; bilateral cubital tunnel syndrome; bilateral pronator tunnel; cervical sprain-strain. Treatment to date has included physical therapy; urine drug screening; medications. Diagnostics studies included MRI lumbar spine (7-30-15). Currently, the PR-2 notes dated 7-23-15 indicated the injured worker complains of left shoulder pain due to her industrial injury. She is being seen on this day to review diagnostic testing results. She has received medications, injections and physical therapy. She reports her pain as sharp, stabbing, throbbing, dull and aching. Her pain is constant and severity is described as moderate to severe with profound limitations. She also complains of right gluteal and left lower extremity pain and this condition is not improving. The provider lists her medications as metformin, flexeril and Ultracet. The provider includes a physical examination. He also notes cervical spine x-rays that reveal normal lordosis and no acute fracture or instability. The lumbar spine x-rays demonstrate mild spondylosis. The requested EMG-NCV of the upper extremities has been authorized and scheduled on 8-24-15. The provider is requesting authorization of MRI of the right elbow; MRI of the left elbow and MRI of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (Magnetic Resonance Imaging) of the right elbow: 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): 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 records do not indicate any of the red flags that are indicative of an emergency. An EMG for bilateral elbows is pending which should abrogate the need for an MRI for diagnosis of cubital tunnel, impingement, etc. The treatment notes do not indicate any other extenuating circumstances to warrant deviation from the guidelines. As such, the request for Magnetic Resonance Imaging (MRI) of the right elbow is deemed not medically necessary.

MRI (Magnetic Resonance Imaging) of the left elbow: 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): 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 records do not indicate any of the red flags that are indicative of an emergency. An EMG for bilateral elbows is pending which should abrogate the need for an MRI for diagnosis of cubital tunnel, impingement, etc. The treatment notes do not indicate any other extenuating circumstances to warrant deviation from the guidelines. As such, the request for Magnetic Resonance Imaging (MRI) of the left elbow is deemed not medically necessary.

MRI (Magnetic Resonance Imaging) of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

Decision rationale: ACOEM states "Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery and Clarification of the anatomy prior to an invasive procedure". ODG states, "Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging". Indications for imaging MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit, Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present, Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present, Chronic neck pain, radiographs show bone or disc margin destruction, Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal", Known cervical spine trauma: equivocal or positive plain films with neurological deficit, Upper back/thoracic spine trauma with neurological deficit. The treating physician has not provided evidence of red flags to meet the criteria above. As such the request for MRI of the cervical spine is deemed not medically necessary.

