

Case Number:	CM15-0183530		
Date Assigned:	09/24/2015	Date of Injury:	11/12/1996
Decision Date:	11/02/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/18/2015

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, Florida, 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 55 year old female, who sustained an industrial injury on 11-12-96. The injured worker was diagnosed as having left elbow pain, status post left cubital tunnel decompression for cubital tunnel syndrome, status post left tennis elbow release for chronic lateral epicondylitis, left medial epicondylitis, and left triceps insertional pain. Treatment to date has included left carpal tunnel release in 2008, left lateral epicondylar repair in 2009, left cubital tunnel release in November 2013, left submuscular ulnar nerve transposition on 3-18-15, left elbow injections, physical therapy, a home exercise program, and medication. Physical examination findings on 8-20-15 included tenderness over the radial tunnel and the lateral epicondyle. Pain was noted with resisted wrist extension, middle finger extension, and forearm supination. Full active and passive elbow range of motion was noted. Currently, the injured worker complains of left arm pain. The treating physician requested authorization for a MRI of the left elbow without intraarticular contrast. On 9-2-15 the request was non-certified; the utilization review physician noted "the documentation provided does not indicate that the patient has had failure to progress in a rehabilitation program or that there is evidence of significant tissue indult or neurological dysfunction that has been shown to be correctable by invasive treatment."

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging), Left Elbow, without intra articular contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, MRI.

Decision rationale: This claimant was injured in 1996 with left elbow pain, post left cubital tunnel decompression, and post left tennis elbow release. There is full active and passive ROM of the left elbow on exam. Regarding Elbow MRI, the ODG notes: 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. With a normal active and passive range of motion exam, it is difficult to suggest there could be internal orthopedic derangement to drive the need for MRI. The request is not medically necessary.