

Case Number:	CM15-0025122		
Date Assigned:	02/17/2015	Date of Injury:	11/28/2014
Decision Date:	03/31/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/10/2015

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 46 year old male who sustained a work related injury November 28, 2014. Past medical history includes hyperlipidemia and gastroesophageal reflex disease (GERD). He was trying to unstrap his harness (buckle located on upper back) with his left hand when a sharp pain on his lateral left elbow was felt as he applied greater force than usual to the buckle. Diagnosis was documented as sprain elbow/forearm not otherwise specified. According to a physician's notes dated January 5, 2015, the injured worker presented for one month evaluation. The pain is described as mild and only felt when extending elbow, supinating/pronating and gripping and decreases with rest. Current medications included Naproxen, Prilosec, Simvastatin and Bupropion HCL. Physical examination of the left elbow reveals lateral epicondyle tenderness and pain with resisted wrist extension and flexion and left wrist exam within normal limits. Diagnosis documented as lateral epicondylitis. Treatment plan included apply cold pack to area, dispensed medications and continue with sessions of physical therapy authorized. Patient has received 8 PT visits for this injury with improvement. Per the doctor's note dated 2/9/15 patient had complaints of pain in left arm at 2-3/10 that was decreasing with PT visits and rest. Physical examination of the left elbow revealed tenderness on palpation and limited range of motion, 5/5 strength and negative all special tests. Any surgery or procedures related to this injury were not specified in the records provided. Any diagnostic imaging report was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided Kenalog injection to the left elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Steroid injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): Page 594. Decision based on Non-MTUS Citation Elbow (updated 02/27/15) Injections (corticosteroid)

Decision rationale: Request: Ultrasound guided Kenalog injection to the left elbow As per cited guideline "injections (e.g., 1 mL triamcinolone [10 mg/mL] with a 25 or 27 gauge needle) are recommended for short term benefit to reduce the overall magnitude of pain in select cases. In most cases, physicians should carry out conservative measures (i.e., NSAIDs, orthotics, other non-interventional measures) for 4-6 weeks before considering injections...Quality studies are available on glucocorticoid injections and there is evidence of short-term benefits, but not long-term benefits." Per the ODG guidelines cited below, corticosteroid injection is "not recommended as a routine intervention for epicondylitis, based on recent research. In the past a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. (Boisauvert, 2004) The significant short-term benefits of corticosteroid injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. (Bisset, 2006) While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued non-operative management. Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit. (Assendelft, 1996) (Bowen, 2001) (Reveille, 1997) (AHRQ, 2002) (Newcomer, 2001) (Smidt, 2002) (Stahl, 1997) (Crowther, 2002) (Smidt, 2005)" The cited guidelines do not recommend steroid injection for the epicondylitis as first line therapy. Patient has received 8 PT visits for this injury with improvement. Previous conservative therapy notes are not specified in the records provided. In addition it is noted in the records that the patient's pain was relieved with medications and rest Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Ultrasound guided Kenalog injection to the left elbow is not fully established in this patient.