

Case Number:	CM15-0056852		
Date Assigned:	04/01/2015	Date of Injury:	04/01/2013
Decision Date:	05/06/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/25/2015

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: District of Columbia, Virginia
 Certification(s)/Specialty: Internal 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 51 year old male, who sustained an industrial injury on 4/1/2013. The current diagnoses are left olecranon and triceps tendonitis, right carpal tunnel syndrome, cervical strain with degenerative disc disease, rule out cervical radiculopathy, left shoulder subacromial impingement syndrome, and status post right carpal tunnel release (1/26/2015). According to the progress report dated 2/2/2015, the injured worker complains of right wrist pain (9/10) with spasm and tingling. Additionally, she reports neck pain (8/10), bilateral arm pain (9/10) with numbness in the right arm, left elbow pain (7/10), and occasional left hand/wrist pain (7/10). The current medications are Hydrocodone/APAP. Treatment to date has included medication management and MRI of the left elbow. The plan of care includes post-operative occupational therapy sessions, follow-up, Hydrocodone/APAP, and MRI of the cervical spine, left shoulder, left elbow, hands and wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): ACOEM 42-43.

Decision rationale: ACOEM guidelines indicate the following regarding criteria for ordering imaging studies of the elbow: Emergence of a red flag. Physiological evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. For most patients presenting with true elbow problems, special studies are not needed unless a four week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There are a few exceptions: Plain film radiography to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis. EMG and NCV study if cervical radiculopathy is suspected as a cause of lateral arm pain. NCV study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination and denervation atrophy is likely. For patients with limitations of activity after four weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning. Imaging findings should be correlated with physical findings. In general, an imaging study may be appropriate for consideration for a patient whose limitations due to consistent symptoms have persisted for one month or more, as in the following cases: When surgery is being considered for a specific anatomic defect, e.g. preoperative plain film radiography when incision and drainage of an infected olecranon is indicated. Per review of the clinical documentation provided, the patient had evidence of neurologic findings in her right upper extremity. She had undergone a left sided carpal tunnel release surgery prior to having pain in both arms. Per cited guidelines, there is no clear indication for an MRI of the left elbow. This patient did not have neurological signs or symptoms, nor were other treatment modalities tried. It would not be medically indicated for this patient. To further evaluate potentially serious pathology, such as possible tumor, when the examination suggests the diagnosis. The request is not medically necessary.