

Case Number:	CM14-0173051		
Date Assigned:	10/23/2014	Date of Injury:	06/23/2010
Decision Date:	12/31/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/20/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Minnesota. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59 year old female was injured 6/23/10 after slip and fall in which she landed on her right buttock and fell on right side. Since that time the injured worker has had chronic neck and lower back pain, residual left shoulder pain (status post surgical intervention exact surgery not documented) and her main complaint as of 5/5/14 was persistent pain and swelling of the medial aspect of the right elbow with decreased range of motion and weakness. There is a history of paresthesias and numbness in the ulnar forearm extending from the cubital tunnel to the 4th and 5th fingers. No associated intrinsic atrophy in the hand was documented. In addition, she had increased pain, numbness and weakness in the right wrist and first, second and third digits of the right hand. These symptoms interfere with her ability to lift, push and pull objects, as well as with repetitive hand motion. On physical exam, spasm and tenderness were noted in the paravertebral musculature of the cervical and lumbar spine with decreased range of motion. Positive Neer and Hawkins impingement signs were noted in the right shoulder. There was tenderness over the medial epicondyle of the right elbow with edema and a positive Tinel's sign over the ulnar nerve at the cubital tunnel. Positive Phalen and reverse Phalen signs were noted in the right wrist with decreased grip strength. Her medications include Celexa, Neurontin, Prilosec and Relafen which provide some pain relief and ability to maintain function. Diagnoses include cervical and lumbosacral radiculopathy, right shoulder impingement, wrist and elbow bursitis and ankle sprain/strain. Results of electromyography and nerve conduction studies done on 8/14/13 indicated left chronic L5 radiculopathy. A request for right elbow MRI without intra-articular contrast was submitted on 5/19/14 and a second request 6/5/14 along with a request for electrodiagnostic testing of the upper extremities was submitted. Documentation of conservative management (6/23/14) includes self stretching and range of motion exercise and medication. No formal physical therapy for the elbow is documented. The records do not include a radiology

report pertaining to X-rays of the right elbow. There is documentation (1/28/14) that the injured worker has had cortisone injections to the left shoulder with temporary relief, had rotator cuff repair (11/16/12), had physical therapy post-operatively and found some relief with water aerobics (2013). Evaluation by orthopedics in May 2013 declared the injured worker permanent and stationary. On 9/8/14 following a denial of an MRI request for the right elbow the injured worker received steroid injection to the lateral epicondyle of the right elbow without complications and is to be re-evaluated in 6-8 weeks. This was the first time lateral epicondylar pain was documented. The previous notes referred to the medial epicondyle and the cubital tunnel as the site of pain and swelling. The injured worker remains temporarily totally disabled and has not worked since 1/11. Latest documented request for MRI of the right elbow was 9/27/14; however, the result of the lateral epicondylar injection of corticosteroids is not known. On 10/9/14, per Utilization Review, right elbow MRI without intra-articular contrast was non-certified based on lack of documentation of conservative care such as cortisone injection and plain x-ray findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right elbow MRI without Intra-articular contrast: Upheld

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 Chapter: Indications for Imaging - Magnetic resonance imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 11,18, 20, 22, 23, 25, 26, 27, 33, 34, 35.

Decision rationale: The California MTUS guidelines recommend MRIs of the elbow if there is emergence of a red flag or if the results of the MRI are likely to change the treatment. Based upon the information provided, the injured worker has a chronic cubital tunnel syndrome. She also has lateral epicondylagia per the last progress note. The ulnar paresthesias may also be due to C8, T1 radiculopathy. The electrodiagnostic studies will differentiate between the two. The corticosteroid injection of the lateral epicondyle should help with the lateral epicondylagia. Physical therapy may also be needed per guidelines including iontophoresis, ultrasound, instruction in home exercise, and bands or braces. For cubital tunnel syndrome, the guidelines recommend elbow padding, avoidance of leaning on the ulnar nerve, avoidance of prolonged hyperflexion such as an extension splint at night, and use of NSAIDs. The documentation does not suggest elbow instability. However, in light of the history of chronic pain x-rays will be necessary to look for degenerative changes. Based upon the guidelines, the request for an elbow MRI scan is not medically necessary at this time.