

Case Number:	CM15-0013907		
Date Assigned:	02/04/2015	Date of Injury:	08/28/2013
Decision Date:	03/25/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/23/2015

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 45 year old male, who sustained an industrial injury on 8/28/13. He has reported elbow injury. The diagnoses have included pain in joint involving upper arm and tennis elbow. Treatment to date has included post op left lateral epicondylar release, medications and physical therapy. Currently, the injured worker complains of elbow remainizng painful and blanching of the ulnar digits when it is cold. Physical exam dated 12/18/14 revealed tenderness over the lateral epicondyle and slight swelling, otherwise normal elbow exam. On 1/8/15 Utilization Review non-certified (MRI) magnetic resonance imaging of left elbow, noting the injured worker is about 5 months post-surgical release of left lateral epicondylitis and no complaints of persistent pain. AOEM and ODG guidelines were cited. On 1/15/15, the injured worker submitted an application for IMR for review of (MRI) magnetic resonance imaging of left elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Left Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43, 45. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 4-16,22-25,42-44z.

Decision rationale: Per ACOEM guidelines, regarding Lateral Epicondylalgia (Lateral Epicondylitis) Lateral epicondylalgia (lateral epicondylitis) causes soreness, or pain on the outside (lateral) side of the upper arm near the elbow. There may be a partial tear of the tendon fibers, which connect muscle to bone, at or near their point of origin on the outside of the elbow. Initial Care Comfort is often a patient's primary concern. In employment settings, where milder cases are more frequently seen, nonprescription analgesics may provide sufficient pain relief for most patients with acute and subacute elbow symptoms. Patients in clinical settings may be more severe and may require prescription analgesics as first line treatments. If the treatment response is inadequate, such that symptoms and activity limitations continue, prescribed pharmaceuticals, orthotics, or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences should guide the health care professional's choice of recommendations. Table 3 summarizes options for lateral epicondylalgia. Conservative care often consists of activity modification using epicondylalgia supports (tennis elbow bands), and NSAIDs with standard precautions on potential side effects. Medications Acetaminophen: There is no evidence evaluating the effects of acetaminophen in treating epicondylalgia. However, acetaminophen may provide enough mild analgesic relief to allow the patient to exercise or function at a higher level. Quality studies are not available on acetaminophen, and there is not evidence of its treatment benefits. However, it is low cost, has few side effects, and is not invasive. Thus, while there is insufficient evidence, acetaminophen is recommended [Insufficient Evidence (I), Recommended]. Oral NSAIDs: One intermediate-quality study (patients with symptoms of 10 or less days) was reviewed that randomized flurbiprofen vs. piroxicam 28 and found that "flurbiprofen was significantly superior to piroxicam with regard to relief of pain at day 28, pain on active movement at days 14 and 28, pain on passive movement at days 7, 14 and 28 and pain, as measured by a visual analogue scale, at day 14." Two low-quality studies evaluated diflunisal and naproxen. The first found no significant differences between the groups (patients with symptoms for at least 6 or 7 days prior to evaluation) and therefore, concluded that diflunisal and naproxen are "equivalent in providing relief of pain and tenderness due to tennis elbow."²⁹ The second study (patients' duration of symptoms not indicated) concluded that diflunisal and naproxen significantly reduce pain." However, diflunisal provided more effective pain relief in the group studied.³⁰ Lastly, one high-quality study (43.3% of patients had symptoms for less than 6 weeks and 44.1% had symptoms for more than 6 months) evaluated diclofenac (150 mg) versus placebo, with the results indicating that a statistically and clinically significant reduction of pain was associated with Ndiclofenac, but no clinically significant difference in grip strength or functional improvement could be detected between the 2 groups. ³¹ The authors concluded that it is difficult to recommend the use of diclofenac in the treatment of lateral epicondylalgia at the dosage used in this study. In conclusion, there is some evidence that NSAIDs result in improvements. There also is some weak, preliminary evidence suggesting that all NSAIDs may not be equally efficacious for lateralepicondylalgia. Evidence suggests that piroxicam is inferior to other NSAIDs for the treatment of lateral epicondylalgia, and thus should not be either the first- or second-line treatment. Quality studies are available on NSAIDs including acute (less than 1 month), subacute (1-3 months), and chronic (more than 3 months) lateral epicondylalgia patients and there is evidence of its benefits. Effects are dose dependent

and caution should be used with higher doses primarily due to gastrointestinal side effects. Overall, these options are low cost, have few side effects, and are not invasive. Thus, NSAIDs are recommended as a treatment option [Evidence (B), Moderately Recommended]. 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, eg preoperative plain film radiography when incision and drainage of an infected olecranon is indicated-to further evaluate potentially serious pathology, such as possible tumor, when the examination suggests the diagnosis. As per guidelines, this diagnostic study would not be indicated at this time.