Case Number:	CM15-0111934		
Date Assigned:	06/18/2015	**Date of Injury:**	11/09/2013
Decision Date:	07/20/2015	**UR Denial Date:**	05/14/2015
Priority:	Standard	**Application Received:**	06/10/2015

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: California, Indiana, New York
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 36 year old female who sustained an industrial injury on 11/09/2013. The injured worker was diagnosed with right lateral and medial epicondylitis and contracture of joint of hand. The injured worker is status post right elbow extensor slide with lateral epicondylectomy on November 25, 2014. Treatment to date has included diagnostic testing, surgery, steroid injections, physical therapy (24 sessions post operatively), tennis elbow brace and medications. According to the primary treating physician's progress report on May 4, 2015, the injured worker continues to experience elbow pain with radiation to the forearm associated with weakness and soreness in the right shoulder. The injured worker also reports right hand pain with weakness, numbness and tingling to the fingers. Examination demonstrated tenderness to the medial and lateral elbow region. A nodule was felt on palpation on the forearm. There was full range of motion, good capillary refill and no evidence of instability of the elbow. Provocative testing demonstrated positive resistive wrist flexion with tenderness at the medial and posterior aspects of the elbow, positive resistive wrist extension with tenderness laterally and borderline elbow flexion test with paresthesias to the ulnar nerve distribution within one minute. There was negative ulnar Tinel's sign. Current medications are listed as Vicodin, Tramadol, Anaprox DS, Terocin Patch and Omeprazole. Treatment plan consists of follow-up acupuncture therapy and the current request for MRI Arthrogram right elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Arthro Right Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow (Acute & Chronic), magnetic resonance imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): Table 4. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow section, MRI, arthrogram.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI arthrogram right elbow is not medically necessary. MR imaging may provide important diagnostic information for evaluating the adult elbow including collateral ligament injury, epicondylitis, injury to the biceps and triceps tendon, abnormality of ulnar, radial or median nerve, and for masses about the elbow joint. Indications for imaging are enumerated in the official disability guidelines. They include, but are not limited to, chronic elbow pain suspect intra-articular osteocartilaginous body with non-diagnostic plain films, osteochondral injury, suspect unstable osteochondral injury, suspect nerve entrapment, suspect chronic epicondylitis, suspect collateral ligament tear, etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the injured worker's working diagnoses are lateral epicondylitis, status post extensive slide right; laceration finger, tendon involvement, small finger status post repair; medial epicondylitis right; and contracture of joint of hand small finger. The date of injury is November 9, 2013. Subjectively, according to a May 14, 2015 progress note, the injured worker has right elbow pain and right hand pain status post elbow surgery. The injured worker received activity modification, medications, injections, 24 postoperative physical therapy sessions. There were x-rays performed in an MRI of the elbow. Objectively, there is a star overlying the lateral elbow. There is tenderness over the medial elbow region and lateral elbow region. There is tenderness over the forearm. An MRI of the right elbow was performed July 28, 2014. There was no acute tendinous or ligament abnormality identified. There was no evidence of epicondylitis. Electrodiagnostic studies were normal. Plain radiographs performed April 6, 2015 did not show any significant abnormality. The treating provider is requesting an MRI arthrogram of the right elbow. Utilization review states there was a peer-to-peer conference with the office. The discussion included chronic elbow pain with a prior MRI with ongoing symptoms. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There are no new significant symptoms and/or objective findings suggestive of significant pathology. There is no evidence of progressive deterioration involving the affected elbow. Consequently, absent clinical documentation of progressive deterioration involving the right elbow, an MRI performed July 28, 2014 with no significant abnormalities and no significant new symptoms and or objective findings, MRI arthrogram right elbow is not medically necessary.