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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** February 16, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI of the left elbow and EMG/NCS of the left upper extremity (73221, 95864, 95904, 95903 and 95900).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D., Board Certified in Orthopedic Surgery.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld                      (Agree)  
 Overturned                      (Disagree)  
 Partially Overturned              (Agree in part/Disagree in part)

The requested services, MRI of the left elbow and EMG/NCS of the left upper extremity (73221, 95864, 95904, 95903 and 95900) are not medically necessary for treatment of the patient's elbow pain.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 1/25/XX.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO).

3. Notice of Assignment of Independent Review Organization dated 2/6/XX.
4. Medical records from MD dated 12/3/XX.
5. Letter from MD dated 1/14/XX.
6. Denial documentation.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained a work injury to his left elbow on XX/XX/XX. By report, the patient is status post ulnar nerve transposition and olecranon bursectomy in 20XX. In November 20XX, he presented to his provider with complaints of swelling and pain after bumping the left elbow. An x-ray performed in December 20XX was indicative of medial epicondylitis and olecranon bursitis. On examination, there was tenderness in the medial epicondyle and tenderness swelling of the olecranon. A positive Tinel's sign was noted at the cubital tunnel. The patient's provider recommended surgical intervention, specifically, medial epicondylectomy, resection of bursa and ulnar in-situ decompression. A letter from the provider dated 1/14/XX recommended that the patient undergo MRI of the left elbow and EMG/NCS of the left upper extremity (73221, 95864, 95904, 95903 and 95900). The provider states that these services are medically indicated because the surgery will be taking place in the area of the ulnar nerve which will require mobilization to adequately remove the aforementioned spurs.

The Carrier indicates that the requested services are not medically necessary. The Carrier states that there is no documentation of any injections or physical therapy. Additionally, the Carrier indicates there is evidence to suggest cubital tunnel syndrome with Tinel at the cubital tunnel, but there is no evidence of abnormal ulnar nerve functioning neurologically in assessing atrophy, motor strength, or sensibility testing.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Upon review of the American College of Occupational & Environmental Medicine (ACOEM) guidelines, the Official Disability Guidelines (ODG), and American Academy of Orthopedic Surgeon (AAOS) guidelines, as well as the submitted clinical information provided, I find the requested services, MRI of the left elbow and EMG/NCS of the left upper extremity, are not medically necessary for this patient. The clinical information provided does not include documentation of conservative treatment measures other than the patient taking Naproxen. Recent attempts with conventional modalities are indicated prior to pursuing the requested diagnostic services. Specifically, the ACOEM guidelines suggest MRI for suspected tears of the ulnar collateral ligament and EMG/NCV testing for only those patients who have failed conservative treatment measures. This patient's symptoms at the time of her December 2010 evaluation do not warrant MRI of the left elbow or EMG/NCV studies of the left arm. There is a lack of signs and symptoms suggestive of abnormal nerve function to support the proposed studies in this case.

Accordingly, I have determined the requested MRI of the left elbow and EMG/NCS of the left upper extremity are not medically necessary for this patient.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

**AMERICAN ACADEMY OF ORTHOPEDIC SURGERY (AAOS)**