

Case Number:	CM13-0039338		
Date Assigned:	01/03/2014	Date of Injury:	04/13/2010
Decision Date:	05/21/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	10/04/2013

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 Internal Medicine, and is licensed to practice in California. 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:

The patient is a 42 year old male who was injured on 04/13/2010 while he was lifting a tub that weighs approximately 300 pounds when he felt a sharp pain in his left groin. He sustained injury to his neck, lower back as well as his elbow. He carries a diagnosis of hypertension, GERD, chronic pain, headache, cervical radiculopathy and left sided inguinal hernia. Prior treatment history has included L5-S1 transforaminal lumbar interbody fusion on 09/29/2011. He underwent a course of postoperative physiotherapy and on 01/15/2013 he underwent removal of hardware. Final Determination Letter for IMR Case Number CM13-0039338 3 He has received trigger point injections into the cervical and lumbar spine. Medications included: Norco 300 mg twice per day, Naprosyn 550 mg once per day, omeprazole 20 mg once per day. A note by General Surgeon, [REDACTED], dated 05/13/2013, documented objective findings on examination of the abdomen revealing the abdomen is soft with a tender left side ventral/inguinal hernia measuring 9 x 5 cm in size which is palpable. There is no hernia on the right side. A general surgical consultation report dated 08/22/2013, which was written by a physician assistant, documented the patient with complaints of intermittent left groin pain. The pain is minimal with lifting. No hernia was appreciated on exam. A CT abdomen was requested to rule out left inguinal hernia.

IMR ISSUES, DECISIONS AND RATIONALES

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

ABDOMINAL CT SCAN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment in Workers' Comp, 11th edition, Hernia

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) HERNIA, HERNIA REPAIR

Decision rationale: The patient had been complaining of intermittent left groin pain and in a note dated 5/13/13, a general surgeon noted the patient to have a 9x5cm left inguinal hernia on exam. A subsequent note written by a physician assistant on 8/22/13, states that there is no hernia visualized on exam, and this is what prompted the order for CT abdomen. Per the ODG, CT and ultrasound are not necessary in every case of abdominal hernias. Clinically obvious hernias do not require ultrasound, but surgeons might order ultrasound to confirm or exclude questionable hernias. If imaging is required, ultrasound is the initial modality of choice for diagnosing abdominal and groin hernias, not CT abdomen. Thus, the request for CT abdomen is not medically necessary and appropriate.