

Case Number:	CM13-0060717		
Date Assigned:	12/30/2013	Date of Injury:	03/07/2008
Decision Date:	10/01/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/03/2013

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 Family Practice, 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:

This 43-year old realtor has multiple physical and psychiatric diagnoses deemed to be the result of an assault on 3/7/08, during which she was sexually molested, beaten, stabbed and left for dead. Current diagnoses include: status post cervical fusion with persistent radiculopathy; status post L shoulder arthroscopy with recurrent pain; status post multiple surgeries on L hand with stiffness; L carpal tunnel syndrome, insomnia; lumbar discogenic back pain; abdominal pain; post-traumatic-stress disorder. A 9/13/13 progress note by one of her primary providers, an orthopedist, states that "even though the medicines help her out, she is not having abdominal pain". There is no other documentation in regards to her abdominal symptoms. The documented physical exam included only the neck and L shoulder. His plan was to appeal facet injections of the neck, perform epidural steroid injections of the neck, perform an L subacromial steroid injection (which he did the same day), and refer to an internist in regards to abdominal pain. An internist evaluated the patient on 10/23/13. The patient's complaints included burning epigastric pain of the abdomen, which had been present for about 6 weeks. She had symptoms of reflux of acid in her throat. She had some difficulty with swallowing both solids and liquids, and had to chew her food very well in order to be able to swallow. She had some nausea, but no vomiting. She had been on multiple medications which include Soma, Lorazepam, tramadol, Effexor and ibuprofen. She was under chronic stress and was having trouble sleeping. Physical exam of the abdomen revealed normal bowel sounds, mild epigastric tenderness, no guarding, rebound or organomegaly. Rectal exam was not performed. Diagnoses included: abdominal pain, rule out irritable bowel syndrome; GERD, secondary to non-steroidal anti-inflammatory drug use/stress; dysphagia, rule out causation secondary to cervical spine fusion, deferred to GI. Recommendations included: complete blood counts, comprehensive metabolic panel, lipase, H. pylori stool antigen, TSH; abdominal ultrasound and upper GI series. The patient was advised to

avoid all NSAIDs and was instructed in a GERD diet. She was given a prescription for twice daily ranitidine and for Gaviscon as needed. A request for authorization was made on 11/8/13. It is not included in the available records, but according to the UR review of 11/26/13 it included requests for cervical epidural steroid injections, upper GI series and abdominal ultrasound. All three requests were non-certified in UR on 11/26/13. The UR note states that GI consult and lab work had been authorized, but not yet performed. An application for IMR of the non-certification of the abdominal ultrasound was generated on 12/3/13. Note that the record contains lab results which should have been available to the requesting physician by 10/23/13, and which showed that the patient was anemic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Abdominal Ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:UptoDate, an online evidence-based review service for clinicians (www.uptodate.com), Diagnostic approach to abdominal pain in adults.

Decision rationale: Per the up-to-date reference above, abdominal pain that persists for less than a few days is classified as acute. Pain that has remained unchanged for months to years can be safely classified as chronic. Pain that does not clearly fit either category should be classified as sub-acute. Sub-acute epigastric pain falls into the category of dyspepsia. Patients with dyspepsia should be divided into those who can safely undergo a therapeutic trial or watchful waiting; and those with alarm features that require further evaluation. Alarm features include: age over 50, weight loss, persistent vomiting, dysphagia, anemia, hematemesis, palpable abdominal mass, family history of upper GI carcinoma, previously identified pathology requiring reassessment, or history of gastric surgery for pathology that could recur. Patients with dyspepsia who have alarm symptoms should generally be investigated with gastroscopy, which is preferable for the evaluation of reflux esophagitis, peptic ulcer disease, and for gastric and esophageal cancer because of its potential for obtaining biopsies. The clinical findings in this case are consistent with sub-acute epigastric pain, or dyspepsia. An internal medicine consultation was obtained, and an evaluation performed which inexplicably did not include a rectal exam. Appropriate lab work was performed, and a referral to a gastroenterologist requested. Usually, when a specialty referral is requested, it is customary to defer ordering further testing to the specialist. In this case, the referring internist ordered testing himself, which included abdominal ultrasound. Abdominal ultrasound is clearly not the test of choice in this situation, since the patient has at least one of the alarm features listed above (dysphagia). If the internist had checked results of the laboratory testing he ordered, which is also customary prior to ordering imaging studies, he would have known that the patient also has anemia, which is another alarm feature. The medically appropriate test in this case should have been gastroscopy. Taking into account the evidence-based guideline cited above and the clinical findings in this case, an abdominal

ultrasound is not medically indicated. An abdominal ultrasound is not medically necessary because it is not the appropriate test given the presence of one of the alarm features described above, and because the requesting physician did not check the laboratory results which could (and ultimately did) suggest that other testing should be performed. Therefore, this request is not medically necessary.