

Case Number:	CM14-0198261		
Date Assigned:	12/08/2014	Date of Injury:	03/31/2009
Decision Date:	01/29/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/25/2014

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 Physical Medicine Rehab, has a subspecialty in Interventional spine 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 53 year old male with an injury date on 3/31/09. The patient complains of right lower quadrant pain which patient notes with the bowel movement since the lumbar fusion surgery per 10/16/14 report. The patient notes a significant amount of flatulence, and fairly regular bowel movements but at the time is constipated and takes Miralex per 10/16/14 report. The patient has had a remote CT abdomen since 2011 per 10/16/14 report. Based on the 10/16/14 progress report provided by the treating physician, the diagnosis is abdominal pain, RLQ onset 10/15/14. A physical exam on 10/16/14 showed "L-spine has poor range of motion, abdomen has mild RLQ tenderness to deep palpation." The patient's treatment history includes medications, L-spine L2-L5 fusion, abdomen ultrasound notable only for renal cyst. The treating physician is requesting abdominal and pelvic CT with IV and PO contrast. The utilization review determination being challenged is dated 10/30/14. The requesting physician provided treatment reports from 4/2/14 to 10/16/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Abdominal and pelvic CT with IV and PO contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis, CT

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis: CT Scan.

Decision rationale: This patient presents with right lower quadrant abdominal pain. The treater has asked for abdominal and pelvic CT with IV and PO contrast on 10/16/14 "to assess further work up pending review of results [of abdominal CT]." Regarding pelvic CT, ODG states recommended as indicated below. Computed tomography (CT) reveals more subchondral fractures in osteonecrosis of the femoral head than unenhanced radiography or MR imaging. (Stevens, 2003) CT provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic window evaluation. Instrument scatter-reduction software provides better resolution when metallic artifact is of concern. (Colorado, 2001) (Kalteis, 2006) (Wild, 2002) (Verhaegen, 1999) Based on a few, very small studies, CT may not be accurate enough for an occult hip fracture, but it is rapidly obtained and may be reasonable to use in some situations, such as high-energy trauma. Computed tomography is readily accessible in the ED and is a chief method of evaluating the multiply injured trauma patient. Addition of the third dimension with CT can often define a fracture when it is not seen on X-ray study. However, there is scarce evidence to support the use of CT for occult hip fracture evaluation. The few studies available are small and statistically insignificant. A more extensive review beyond isolated findings and case reports is needed to ascertain the specific role of CT in hip evaluation." In this case, the patient has abdominal pain. A prior abdominal ultrasound showed renal cyst. The treater is requesting an abdominal/pelvic CT to assess for a further workup. As quoted above regarding CT of pelvis, the patient has not had a traumatic injury, and there is no indication of sacral insufficiency fractures, suspected osteoid osteoma, subchondral fracture, or a failure of a closed reduction as per ODG guidelines. There are no abdominal exam findings of any significant to consider CT scan of the abdomen either. The requested abdominal and pelvic CT with IV and PO contrast is not medically necessary.