

Case Number:	CM15-0099636		
Date Assigned:	06/02/2015	Date of Injury:	07/09/2012
Decision Date:	07/21/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/22/2015

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: Arizona, Texas
 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 was a 59 year old female, who sustained an industrial injury, July 9, 2012. The injured worker previously received the following treatments colonoscopy, Ativan for anxiety, Ibuprofen, Pantoprazole, Tylenol ES, gastroenterologist, small bowel biopsy on January 19, 2015 results were consistent with Barrett's Esophagus, colonoscopy on January 19, 2015 was negative, home exercise program and psychiatry services. The injured worker was diagnosed with cervical spine pain with disc bulge at C5-C6 with left sided C6 radiculopathy, cervicalgia, lumbar spine pain, anxiety, depression, esophageal reflux, flatulence, eructation and gas pain, abdominal pain generalized, dysphagia, early satiety, irritable bowel syndrome and Barrett's esophagus. According to progress note of March 13, 2015, the injured workers chief complaint was heartburn and abdominal bloating. The injured worker was well nourished and well developed. The physical exam noted the abdomen to have normal bowel sounds, no bruits, no masses and no tenderness. The treatment plan included a request for a small bowel CT scan with dye enterography (abdomen and pelvis).

IMR ISSUES, DECISIONS AND RATIONALES

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

CT small bowel with dye enterography (abdomen and pelvis): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate.com. Diagnostic approach to abdominal pain in adults.

Decision rationale: The MTUS is silent regarding the use of CT Enterography in the diagnostic approach to chronic abdominal pain. According to UptoDate.com, The following laboratory measurements should be performed in most patients with chronic abdominal pain: Complete blood count with differential, Electrolytes, BUN, creatinine, and glucose, Calcium, Aminotransferases, alkaline phosphatase, and bilirubin, Lipase, Ferritin, and Anti-tissue transglutaminase. A complete blood count can reveal anemia or an elevated white blood cell count, and it will occasionally demonstrate elevated platelet counts that may be associated with iron deficiency or inflammation [45]. A low ferritin suggests iron deficiency, which should raise the suspicion of celiac disease or inflammatory bowel disease. The above studies should be normal in patients with functional abdominal pain. Abdominal pain is not a common presentation of hyper- or hypothyroidism, but when additional symptoms suggest abnormalities of thyroid function, a thyroid stimulating hormone (TSH) should be measured. Patients with puzzling chronic abdominal pain should have a measurement of antibodies associated with celiac disease (see "Diagnosis of celiac disease in adults", section on 'Summary and recommendations'), since this is a treatable etiology of abdominal pain that may present at any age [46]. C-reactive protein and ESR are sensitive but nonspecific markers that may suggest the presence of occult organic disease and that have some utility in ruling out organic causes of chronic abdominal pain and diarrhea [47]. At the conclusion of the initial workup, young patients with no evidence of organic disease can be treated symptomatically. The use of further invasive testing should be directed at ruling in or out specific diseases and not as a general screen. In this case the patient has undergone an extensive work-up for chronic abdominal pain. The work-up has included colonoscopy, upper endoscopy with biopsies, imaging, lab studies. The diagnosis have included Barrets esophagus, GERD and IBS. The biopsies during endoscopy were negative for celiac disease or IBD. The documentation doesn't support the medical necessity for CT Enterography.