

Case Number:	CM13-0039551		
Date Assigned:	12/20/2013	Date of Injury:	01/10/2012
Decision Date:	02/14/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Fellowship training in Cardiovascular Disease and is licensed to practice in Texas. 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 physician 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 33-year-old male who reported a work related injury on 01/10/2012, as a result of a strain to the lumbar spine. The patient presents for treatment of lumbar sprain/strain and bilateral inguinal hernias. The clinical note dated 10/02/2013 reports the patient was seen under the care of [REDACTED]. The provider documented the patient was referred for gastrointestinal symptoms. The provider documented the patient reports of complaints of change of appetite, complaints of nausea, and complaints of heartburn on a daily basis with reflux and regurgitation towards the throat area. The provider documented the patient's symptomatology is not controlled with proton pump inhibitors, as omeprazole is ineffective. The clinical notes document the patient utilizes the following medication regimen: tramadol 50 mg 1 tab by mouth 4 times daily, cyclobenzaprine 7.5 mg 1 tab 3 times daily, naproxen 500 mg 1 tab by mouth twice daily, omeprazole 20 mg delayed release 1 cap by mouth daily, zolpidem 10 mg 1 tab by mouth at bedtime, hydrocodone 5/500 1 tab by mouth 3 times daily. The provider documented the patient presents with abdominal pain, change in bowel habits, nausea with vomiting, and rectal bleeding. The provider recommended the patient undergo an upper endoscopy and colonoscopy with a gastroenterologist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective Upper Endoscopy and Colonoscopy with Gastroenterologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sharma, Virender K. "Role of Endoscopy in GERD." Gastroenterology Clinics of North America 43.1 (2014): 39-46. Morgan, Jenna, et al. "Transparent cap colonoscopy versus standard colonoscopy for investigation of gastrointestinal tract conditions." Cochrane Database

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. The clinical documentation submitted for review reports the patient presents with multiple gastrointestinal complaints to include nausea, vomiting, diarrhea, and constipation. The provider documents the patient utilizes omeprazole 1 tab by mouth daily for his GERD complaints. However, documentation of the patient utilizing maximum potential treatments for his gastrointestinal complaints was not evidenced in the clinical notes reviewed. Furthermore, the provider documented the patient reported blood in his stool; however, guaiac sampling of stool was not evidenced in the clinical notes reviewed. A journal article entitled Role of Endoscopy in GERD indicates "endoscopy is recommended for the evaluation of medically refractory or atypical GERD, patients with alarm symptoms of dysphagia, anemia or weight loss for diagnosis in surveillance of Barrett's esophagus and patients with chronic GERD and for application of such therapies as esophageal dilation or ablation." The clinical notes failed to document the patient has exhausted lower levels of treatment for his gastrointestinal symptomatology. In addition, the clinical notes failed to evidence the duration of the patient's gastrointestinal complaints. Furthermore, given the lack of documentation of guaiac of the patient's stool, the requested colonoscopy is not supported. As the journal article entitled "Transparent Cap Colonoscopy Versus Standard Colonoscopy for Investigation of Gastrointestinal Tract Conditions" indicates "colonoscopy is considered the gold standard investigation for screening and diagnosis of colorectal cancer. It is also becoming increasingly desirable for assessment, management, diagnosis, and follow-up of other rectal diseases, such as inflammatory bowel diseases and acute diverticulitis." However, given all the above, the request for prospective upper endoscopy and colonoscopy with gastroenterologist is not medically necessary or appropriate.