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| Case Number: | CM14-0111297 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 09/18/1995 |
| Decision Date: | 10/16/2014 | UR Denial Date: | 07/07/2014 |
| Priority: | Standard | Application Received: | 07/16/2014 |

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 Family 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:

This 44-year old woman has a date of injury of 9/18/95, the mechanism of which is not described in the available records. She has had three low back surgeries, none of which have successfully treated her ongoing severe back pain. She is not working now, and apparently has not worked since her injury. The available records contain only two progress notes from the primary treater's office, both signed by a PA. Both document ongoing back pain and limited back range of motion. The note dated 1/22/14 states that the patient has no vomiting, diarrhea or constipation, then states that the patient is to continue Amitza for constipation. The note dated 4/21/14 documents that the patient is having "GI discomfort". Neither note includes documentation of any other GI complaints, or of an abdominal or rectal exam. The medications documented at both visits include Norco, Flexeril, Amitza, Valium and Nexium. Per an internal medicine re-evaluation report dated 4/29/14, the patient continues to experience severe heartburn which radiates to the left upper quadrant and occasionally into the back. She has noted food lodging in the middle of her chest 3-4 times per week. She has no problems swallowing liquids. Other symptoms include chest pain and severe constipation with the need to digitally remove bowel contents via her vagina. She has apparently recently developed kidney stones, although the associated symptoms are not described. Current medications are listed as Lyrica, Nexium, TUMS, Norco, Flexeril, Valium and Amitza. A urea breath test was negative. Her abdominal exam is notable for diffuse tenderness especially in the epigastric area and the left upper quadrant. There is also right upper quadrant tenderness and an equivocal Murphy's sign. There is no sign of ascites, mass, or organ enlargement. Rectal exam is normal. Diagnoses included "gastroesophageal reflux disease with probable gastritis secondary to administrations of medications for industrially related conditions"; and "severe constipation with features of irritable bowel syndrome periodically secondary to medications prescribed for job-related

orthopedic injuries". The plan included referral to a gastroenterologist for completion of upper gastrointestinal endoscopy, and colonoscopy (to be deferred pending evaluation by a proctologist). The patient is to continue omeprazole (which she was not documented as taking), continue Amitiza and add Kristalose to her medications for constipation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Upper Gastrointestinal Endoscopy: Overturned

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

<http://www.guideline.gov/syntheses/synthesis.aspx?id=48060&search=upper+gastrointestinal+endoscopy> Diagnosis and Treatment of Gastroesophageal Reflux Disease (GERD) National Guideline Clearinghouse (NGC). Guidelines synthesis: Diagnosis and treatment of gastroesophageal reflux disease (GERD). In: National Guideline Clearinghouse (NGC) (Website) Rockville (MD) : Agency for Healthcare Research and Quality (AHRQ); 2008 May(revised 2014 June

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; Overview of dysphagia in adults

Decision rationale: Per the UptoDate reference on abdominal pain 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 subacute. Subacute 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. Per the reference on dysphagia, dysphagia that is associated with chronic heartburn may be due to complications of gastroesophageal reflux disease, such as erosive esophagitis, peptic stricture and adenocarcinoma of the esophagus. The clinical records in this case, while not complete, would indicate that this patient has subacute abdominal pain which falls into the category of dyspepsia. She has one alarm feature, which is dysphagia (difficulty with swallowing). The appropriate evaluation in this situation would be upper GI endoscopy. It should be noted that the presumed industrial basis for her symptoms (medications administered for her industrial injury) is not clearly established in the available records. The patient is not currently taking medications that would cause reflux, nor is there documentation of past medications that would have caused ongoing reflux. However,

causation is a separate issue, and it remains clear that upper GI endoscopy is medically necessary in this case due to the concerning nature of the patient's symptoms.