

Case Number:	CM14-0174785		
Date Assigned:	10/28/2014	Date of Injury:	09/01/2005
Decision Date:	12/04/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/22/2014

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 New York. 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 worker was reported to have sustained an injury while on the job at a construction site on or about 1 September 2005. He was reported to have tripped on a wire falling and landing on his right (R) knee. He completed that day's work and subsequently was evaluated and placed on modified work until going off work entirely on or about 2 December 2005. He has not returned to work. During a comprehensive review by psychiatry (8 November 2008) it was noted that the member had previously sustained an industrially related back injury with another company. This occurred in approximately 1998 and was eventually settled for \$50,000. His additional stressors at that time were reported to include financial issues, ongoing complaints from a head injury after being thrown out of a nightclub and struck by a security guard, being accused of child abuse and assigned mandatory classes for several months and a history of alcohol abuse. The alcohol use was reported to have been dramatically reduced after the injury in 2005. At the time of that interview he was under psychological care and was reportedly taking Klonopin, Sertraline, Omeprazole, Ranitidine and Tramadol. A review of the available records fails to refer to specific gastrointestinal complaints. This included the above comprehensive review of his depression that only referred tangentially to gastrointestinal upset and a comprehensive re-review by an orthopedist on 25 November 2012. Subsequent to the R knee injury issues were detailed with regard to his back, eventually resulting in a laminectomy, discectomy and posterior fusion at L3-4-5 and surgical repair to debride the R knee with repair of the lateral meniscus. A consultation with an Internist was accomplished 4 September 2014, organized by the primary treating physician (PTP). The chief complaint was listed as gastropathy. The review of his complaint reports accomplishment of an endoscopy for abdominal pain and acid reflux and shortly after a diagnosis of stomach ulcers (endoscopy report unavailable) from 2011. The injured worker reported that he continued to experience abdominal pain (location, frequency and intensity not

documented), acid reflux, nausea, constipation and bright red rectal bleeding (frequency, volume, association with bowel movements not documented). He was reported to be taking Tramadol, Omeprazole and Gabapentin at that visit. The physical examination notes a soft abdomen with normal bowel sounds. No TTP is noted. No rectal examination is reported and no result for fecal occult blood testing reported. The summary indicates the belief that the injured worker sustained these problems as a result of his injuries and the stress involved and medications used for pain relief. The diagnoses generated include Gastropathy (abdominal pain, reflux, gastric ulcer) and Irritable Bowel (constipation and rectal bleeding). The specific issues for review resulting from this consultation are a request for Probitotics 60, Gaviscon 1 bottle, Barium Enema, UGI Series and an Abdominal Ultrasound.

IMR ISSUES, DECISIONS AND RATIONALES

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

Probitotics #60: Upheld

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

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: www.nature.com/nrgastro vol 11, Hill C, et al, 508-514 (2014) and Cochrane Collaboration of Systematic Reviews

Decision rationale: As noted in the UR, the MTUS, ODG and ACOEM guidelines do not touch on this subject. An available review of the evidence to support the use of probiotics states "Probitotics" is broad and only now is a consensus developing as to the appropriate use of the term. A recent expert panel in Nature Reviews had laid out clear guidelines. Currently, any statement beyond "contains probiotics" cannot be supported for the most part. The Cochrane Collaboration of evidence based, systematic reviews reports that "probitotics" can reduce the incidence of antibiotic related C. difficile infections and may modify the impact and severity of traveler's diarrhea. There is no evidence to support the management of rectal bleeding, irritable bowel or upper gastrointestinal (GI) symptoms. This injured worker has not sustained any of the related issues above. The history and examination does not support the diagnosis of irritable bowel. Taken together, there is no support for the utility of "probitotics" in this situation.

Barium Enema: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hiki, N., Kaminishi, M., Yasuda, K., Uedo, N., Honjo, H., Matsubashi, N., & Suzuki, M. (2011). Anitperistaltic effect and safety of L-menthol sprayed on the gastric muscosa for upper GI endoscopy: a phase III, multicenter, randomized, double-blind, placebo-controlled study. *Gastrpomtestonal endoscopy*, 73(5), 932-941.

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: Up to Date: Approach to minimal bright red bleeding per rectum in adults, RM Penner and SR Majumdar. Literature review current through: Oct 2014

Decision rationale: As noted in the UR, the MTUS, ODG and ACOEM guidelines do not touch on this subject. Generally, bright red rectal bleeding represents distal gastrointestinal (GI) problems. In and of itself in this circumstance would generally represent bleeding from hemorrhoids. In the absence of details such as whether the blood is mixed with stool, any pain with defecation, family history for cancer or congenital vascular anomalies, it would be impossible to assess the source with the existing documentation. As presented, there is nothing on the abdominal examination which could point to any specific distal bowel issues such as Inflammatory or Infectious bowel disease. The recommendations in general in the case of Bright Red Bleeding Per Rectum (BRBPR) is for the use of sigmoidoscopy or more generally colonoscopy rather than Ba Enema. Barium enema has no role in the initial evaluation of minimal BRBPR as it is insensitive to small neoplasms, cannot identify acutely bleeding lesions, and does not evaluate the distal colon and rectum well. The requested investigation does not meet the standard for medical necessity.

Upper Gastrointestinal (GI) Series: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Poh, C.H., Gasiorowska, A., Navarro-Rodrigues, T., Willis, M.R., Hargadon, D., Noetck, N.,... & Fass, R. (2010). Upper GI tract findings in patients with heartburn in whom proton pump inhibitor treatment failed versus those not receiving antireflux treatment. *Gastrointestinal endoscopy*, 71(1), 28-34.

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: Furth EE, Rubesin SE, Levine MS: Pathologic primer on gastritis: an illustrated sum and substance. *Radiology* 1995; 197:693-698, Up to Date: Diagnostic approach to abdominal pain in adults, RM Penner and SR Majumdar. Literature review current through: Oct 2014

Decision rationale: As noted in the UR, the MTUS, ODG and ACOEM guidelines do not touch on this subject. The radiologic evaluation and diagnosis of gastritis remains problematic, because the pathologic classification is based on etiologic (e.g., proof of H pylori infection) and histologic criteria that have no imaging correlation. In general, the radiologic signs on an upper gastrointestinal (UGI) study that suggest the diagnosis of gastritis have been nonspecific and often conflicting; these include (1) fold thickening; (2) loss of rugal folds; (3) contour and caliber changes; (4) antral alterations, such as narrowing; and (5) nodulation or erosions. The "Gold Standard" remains direct visualization with endoscopy and biopsy of lesions and for determination of the presence or absence of H. pylori. The documented examination failed to demonstrate any symptoms or signs consistent with reflux, gastritis or gastric ulcer. Of note there was no history of melena and bright red rectal bleeding is a sign of distal tract disease and not proximal. An allusion to the possible role of non-steroidal anti-inflammatory drugs (NSAID's) could not be supported as there was no historical evidence for their use. There is nothing to support medical necessity for this test.

Abdominal Ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/ency/article/003777.htm>

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: Up to Date: Diagnostic approach to abdominal pain in adults, RM Penner and SR Majumdar. Literature review current through: Oct 2014

Decision rationale: As noted in the UR, the MTUS, ODG and ACOEM guidelines do not touch on this subject. Generally the utility of the abdominal ultrasound is in assisting with confirmation of a working diagnosis and helping guide further evaluations or consultations. The working diagnoses of Gastropathy, Reflux, Irritable Bowel, constipation or rectal bleeding are not assisted by this technique. It certainly is useful for identifying pancreatitis, cholecystitis, hepato-splenomegaly, abdominal aortic aneurysm, hydronephrosis, urinary retention, ovarian cysts and uterine anomalies. None of these potential diagnoses have any of the characteristics presented by the injured worker. Therefore, the request does not meet the standard for medical necessity.

Gaviscon 1 bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

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: FDA Approved Manufacturers Information Insert / Epocrates.com

Decision rationale: As noted in the UR, the MTUS, ODG and ACOEM guidelines do not touch on this subject. Per the FDA approved manufacturers information, Gaviscon is a combination product. It combines a foaming agent together with a traditional antacid. The theory behind its use was that it would float on the stomach contents and in the event of reflux into the esophagus would help to neutralize gastric acid. This patient has been maintained on either H2 Blockers (Ranitidine) or Proton Pump Inhibitors (Omeprazole) and would be expected to have adequately suppressed acid production. Therefore, the Gaviscon would add nothing to the injured workers symptomatic control of gastroesophageal reflux disease (GERD), if that were the source of his abdominal pain. Therefore, selection of this product does not meet the standard for medical necessity.