Case Number:	CM14-0023025		
Date Assigned:	05/14/2014	**Date of Injury:**	11/15/2010
Decision Date:	07/10/2014	**UR Denial Date:**	01/28/2014
Priority:	Standard	**Application Received:**	02/24/2014

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 Internal Medicine and is licensed to practice in Virginia and District of Columbia. 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 is a 30 year old patient who sustained injury on Nov 15 2010 after he slipped on a pipe and twisted both ankles. He developed bloating and diarrhea. He then was diagnosed as to rule out celiac disease. The patient's case was reviewed by [redacted] on June 7 2013. He noted that the patient complaints of diarrhea and body aches in Jan 18 2006 . He was then diagnosed with gastroenteritis and had ultrasound showing fatty liver. He also had ongoing symptoms on Jan 24 2006 and was given Imodium with good effect. In Sept 15 2006 she was found to have upper abd pain which was better with Pepcid and diarrhea which improved with Metamucil. He was diagnosed with IBS(Irritable Bowel Syndrome) and treated with Pepcid. He had ongoing abdominal pain and was diagnosed with appendicitis in Aug 15 2008 for which he had an appendectomy. He was diagnosed with GERD in Sept 15 2008. It was noted that the patient had a long history of lactose intolerance and IBS. He had right ankle surgery on Feb 2012. [redacted] saw the patient on Oct 21 2013 for bloating and diarrhea. He suspected that the patient had celiac disorder. He recommended EGD and duodenal biopsy for diagnosis. He also diagnosed the patient with GERD and recommended an EGD with sedation or, monitored anesthesia care or MAC, for further evaluation of this as well. He also recommended stool studies

IMR ISSUES, DECISIONS AND RATIONALES

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

UPPER ENDOSCOPY WITH ANESTHESIA SUPPORT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 1. Rubio-Tapia A, Hill ID, Kelly CP, Calderwood AH, Murray JA. ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease. Am J Gastroenterol. May 2013;108(5):656-76. [Medline].2.Douglas D. ACG Issues Celiac Disease Guidelines. Medscape. May 3 20133.http://emedicine.medscape.com/article/171805-workup4.http://digestive.niddk.nih.gov/ddiseases/pubs/celiac/#diagnosishttp://gi.org/guideline/diagnosis-and-managemen-of-gastroesophageal-reflux-disease/.

Decision rationale: There were no guidelines to address this specific condition in ACOEM or MTUS or ODG. Alternate sources were sought and are included above. The patient had a longstanding history of diarrhea and bloating. Celiac disease was suspected and there are laboratory tests which are used to assess the patient to establish the diagnose. These include:-Patients should be tested prior to being placed on a gluten-free diet-Antibody testing, especially immunoglobulin A anti-tissue transglutaminase antibody (IgA TTG), is the best first test, although biopsies are needed for confirmation; in children younger than 2 years, the IgA TTG test should be combined with testing for IgG-deamidated gliadin peptides-Patients diagnosed with celiac sprue disease should be examined for deficiencies, including low bone density-Patients already on a gluten-free diet without prior testing need to be evaluated to assess the likelihood that celiac sprue is present; genetic testing and a gluten challenge are most helpful-Patients in whom celiac sprue is highly likely despite absence of prior testing should be treated as though they have the disease-Although most patients get better on a gluten-free diet, a systematic evaluation is needed for those who do not.The patient was also diagnosed with GERD but, despite different interventions, he was having perstent symptoms. To establish the diagnosis:Per the American college of gastroenterology, . Upper endoscopy is not required in the presence of typical GERD symptoms. Endoscopy is recommended in the presence of alarm symptoms(such as dysphagia) and for screening of patients at high risk for complications. Repeat endoscopy is not indicated in patients without Barrett's esophagus in the absence of new symptoms. (Strong recommendation, moderate level of evidence)Mandatory studies include upper GI endoscopy and manometry. Endoscopy can help confirm the diagnosis of reflux by demonstrating complications of reflux (esophagitis, strictures, Barrett esophagus) and can help in evaluating the anatomy (eg, hiatal hernia, masses, strictures). Manometry helps surgical planning by determining the lower esophageal sphincter (LES) pressure and identifying any esophageal motility disorders. Esophageal amplitudes and propagation of esophageal swallows are also evaluated.The patient had an EGD with sedation which was not medically indicated at this time.