

<b>Case Number:</b>	CM14-0046960		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/17/2001
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Arizona. 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 injured worker is a 60-year-old man with a work-related injury dated 1/17/01 resulting in chronic low back pain. The diagnoses include lumbar post laminectomy syndrome, lumbar strain and chronic pain syndrome. The patient had an agreed medical exam (AME) by internal medicine on 10/4/13. He complained of constipation and symptoms of gastroesophageal reflux disease (GERD), resulting from chronic treatment with opioid medications and non-steroidal anti-inflammatory drugs (NSAIDs). The exam showed a benign abdomen with slight tenderness in the epigastrium and right quadrant. Laboratory studies showed positive helicobacter pylori antibodies indicating active infection. The recommended future medical care included treatment of his gastritis and GERD including treatment of H. pylori. On 10/10/13 and 11/12/13, the injured worker was evaluated by the primary treating physician, he complained of rectal bleeding during both encounters. The treatment included use of stool softeners and a gastroenterology consultation for rectal bleeding. The gastrointestinal (GI) consult was done on 1/21/14. The provider noted a benign abdomen. The family history was negative for any related cancers. The diagnosis included GERD, irritable bowel syndrome with chronic constipation and GI bleeding. The recommendation was for a colonoscopy and an upper endoscopy. Under consideration is the upper and lower endoscopy done by the GI provider in response to the history of GI bleeding with a change of bowel habits in this 60-year-old man.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Upper Endoscopy:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Consultation Page(s): 1. Decision based on Non-MTUS Citation ACOEM Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 7, Consultation, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), TWC, Pain Procedure Summary, and on the Non-MTUS [www.UptoDate.com](http://www.UptoDate.com). Etiology of lower GI bleed in adults and Approach to acute lower gastrointestinal bleeding in adults.

**Decision rationale:** The Official Disability Guidelines indicate that evaluation and management (E&M) outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines, such as opiates, or medicines such as certain antibiotics, require close monitoring. As the patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, a 60-year-old man had symptoms of change in bowel habits with recurrent bright red bleeding from the rectum. It is reasonable to consider both upper and lower gastrointestinal (GI) etiologies of pain. After excluding an upper GI source of bleeding (upper endoscopy), a colonoscopy is the initial examination of choice for the diagnosis and treatment of acute lower GI bleeding. It was medically necessary for the consultant to proceed with both upper and lower endoscopy in this patient who is older than 50-years-old, with bleeding from the rectum and risk factors for peptic ulcer disease. Office visits are recommended as determined to be medically necessary.

**Lower Endoscopy:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Consultation Page(s): 1. Decision based on Non-MTUS Citation ACOEM Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 7, Consultation, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC, Pain Procedure Summary, and on the Non-MTUS [www.UptoDate.com](http://www.UptoDate.com). Etiology of lower GI bleed in adults and Approach to acute lower gastrointestinal bleeding in adults.

**Decision rationale:** The Official Disability Guidelines indicate that evaluation and management (E&M) outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The

determination is also based on what medications the patient is taking, since some medicines, such as opiates, or medicines such as certain antibiotics, require close monitoring. As the patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, a 60-year-old man had symptoms of change in bowel habits with recurrent bright red bleeding from the rectum. It is reasonable to consider both upper and lower gastrointestinal (GI) etiologies of pain. After excluding an upper GI source of bleeding (upper endoscopy), a colonoscopy is the initial examination of choice for the diagnosis and treatment of acute lower GI bleeding. It was medically necessary for the consultant to proceed with both upper and lower endoscopy in this patient who is older than 50-years-old, with bleeding from the rectum and risk factors for peptic ulcer disease. Office visits are recommended as determined to be medically necessary.