

<b>Case Number:</b>	CM14-0204589		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	11/13/2013
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 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:

The injured worker (IW) is a 29-year-old man with a date of injury of November 13, 2013. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are cervical radiculopathy; lumbar disc protrusion; lumbar spinal stenosis; right hip sprain/strain; and right knee chondromalacia patella. A review of the medical records including an October 2014 progress note, a September 2014 progress note, and an August 2014 progress note contain no subjective gastrointestinal complaints, objective gastrointestinal findings or diagnoses related to a gastrointestinal etiology. Pursuant to the Primary Treating Physician's Progress Note (PR-2) dated September 8, 2014, the IW complains of constant neck pain rated 6-7/10. The pain radiates to the right upper extremity with numbness and tingling. He also has constant low back pain radiating to the left lower extremity. Documentation indicates the IW denies side effects or G.I. symptoms with the use of oral medications. Current medications were not documented in the medical record. The IW is 4 weeks status post the second lumbar epidural steroid injection performed August 8, 2014 and reports continued benefit from the injection. An objective physical finding reveals tenderness in the cervical and lumbar spine. Straight leg raise test is positive on the right. The treating physician is recommending continuation of home exercises, and reports that authorization is pending for the IW to undergo an evaluation with an internist, due to G.I. symptom. There is no documentation in the medical record regarding any G.I. symptoms. The current request is for an upper G.I. endoscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Upper Gastrointestinal Endoscopy: 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 Official Disability Guidelines (ODG); Pain Section, Office Visits. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, Consultations Page 127.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, an upper G.I. endoscopy is not medically necessary. Consultations are appropriate if they aid in the diagnosis or treatment. The need for an office visit with a healthcare provider is individualized based upon review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. In this case, the injured worker's working diagnoses are cervical radiculopathy; lumbar disc protrusion; right hip sprain/strain; and right knee Chondromalacia patella. A review of the medical records including an October 2014 progress note, a September 2014 progress note, and in August 2014 progress note contain no subjective gastrointestinal complaints, objective gastrointestinal findings or diagnoses related to a gastrointestinal etiology. The treatment plan states authorization is pending for patient to undergo an evaluation with an internist due to G.I. symptoms. There is no documentation in the medical record regarding any G.I. symptoms. Consequently, there is no indication for an internal medicine consultation, there is no clinical indication for a gastroenterology consultation and there is no clinical indication for an upper G.I. endoscopy absent clinical information and/or clinical rationale indicating why an upper G.I. endoscopy is appropriate. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, upper G.I. endoscopy is not medically necessary.