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| <b>Case Number:</b>   | CM14-0097186 |                              |            |
| <b>Date Assigned:</b> | 07/28/2014   | <b>Date of Injury:</b>       | 02/28/2013 |
| <b>Decision Date:</b> | 01/26/2015   | <b>UR Denial Date:</b>       | 06/04/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/25/2014 |

### 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 Practice, 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 35-year old laborer reported multiple injuries dated 2/28/13 after he jumped off the 5th step of ladder which was twisting, landing on his feet and then striking his left knee on concrete. Initial treatment included medications and chiropractic manipulation. On about 5/20/13 the patient was admitted to the hospital for a suspected stroke. His discharge diagnosis was Bell's palsy. Subsequent treatment has included medications and acupuncture. He was referred to an internist (internal medicine specialist) for complaints of abdominal pain, acid reflux, alternating diarrhea and constipation attributed to his medications, as well as for a weight gain of 100 pounds. Current diagnoses include cervical spine disc syndrome, bilateral shoulder rotator cuff syndrome, lumbar spine disc syndrome, bilateral knee sprain, bilateral knee lateral meniscal tear, bilateral knee medial meniscal tear, Bell's palsy, and migraine headaches. The patient was seen for the first time by the internist on 5/7/14. In addition to the complaints listed above as reasons for the referral, the internist documented complaints of constant headache, mouth breathing, snoring, frequent awakening at night, sexual dysfunction, memory impairment, depression, stress and anxiety. Virtually nothing is documented regarding the patient's symptoms except for these diagnoses. The symptoms that lead to a diagnosis of reflux disease are not documented. There is no description of the nature, timing or duration of his abdominal pain. There is no description of the frequency, nature or timing of his diarrhea or constipation. Physical exam findings include extreme obesity (BMI 44.2), and periumbilical tenderness without mass. Findings are otherwise documented as normal, include exams of the spine and extremities. Listed diagnoses include abdominal pain, acid reflux/rule out anatomical alteration; constipation/diarrhea, rule out irritable bowel syndrome; and sleep disorder, rule out obstructive sleep apnea. Three additional diagnoses, "orthopedic diagnosis", "psychiatric diagnosis" and umbilical hernia are "deferred to appropriate specialists". Treatment plan included requests for EKG, "labs", urine drug screen,

abdominal ultrasound, referral to GI specialist, a sleep study, medications including Prilosec, ranitidine, and Gaviscon as well as probiotics and Sentra (a medical food), which was dispensed. The patient has not worked since 5/20/13 and is at total disability status per his primary treater, who is an orthopedist. A request for authorization (RFA) for labs/GI profile was submitted on 5/7/14, and was non-certified in UR on 6/4/14. The basis for non-certification was lack of documentation of medical necessity of the GI profile labs, and of lack specification as to which tests are being requested. MTUS, ODG and Harrison's Principles of Internal Medicine, 18th edition are all cited without specific references.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **GI (Gastrointestinal) Profile Labs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine, 18th Edition, 2011

**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](http://www.uptodate.com)), Diagnostic approach to abdominal pain in adults; Clinical manifestations and diagnosis of gastroesophageal reflux in adults; Clinical manifestations and diagnosis of irritable bowel syndrome in adults

**Decision rationale:** There is no standard definition of a "GI profile," so it is impossible to guess what it might contain. Profiles are usually panel of blood tests, and do not include other types of testing. According to the Up-to-date abdominal pain reference, the clinician should first determine if the patient's abdominal pain is acute or chronic. Assuming it is chronic, the initial work-up should focus on differentiating benign functional illness (irritable bowel syndrome) from organic pathology. History should determine the overall time course of the illness, should differentiate pain that is constant from pain that is intermittent, and should describe the patient's bowel habits. Physical exam should be complete, and should include a rectal exam with testing for occult blood. Appropriate laboratory tests should be ordered based on the history and exam findings, and may include complete blood count, electrolytes, BUN and creatinine, calcium, aminotransferases, alkaline phosphatase and bilirubin, lipase, ferritin and anti-tissue transglutaminase. Per the Up-to-date gastroesophageal reflux citation, a diagnosis of gastroesophageal reflux disease (GERD) is usually based on clinical symptoms alone. A subset of patients require diagnostic testing, including those with significant or progressive dysphagia, symptoms suggestive of esophageal obstruction, patients who do not respond to twice daily proton pump inhibitors, and patients with epigastric pain and nausea with suspected biliary tract disease. Appropriate testing may include upper GI endoscopy with biopsy, biliary tract ultrasonography, ambulatory pH monitoring, esophageal manometry, and double contrast barium swallow. According to the Up-to-date Irritable bowel syndrome (IBS) reference above, appropriate testing for diarrhea-predominant IBS includes stool cultures if giardia exposure is suspected, serum testing for Celiac disease, 24-hour stool collection if osmotic or secretory

diarrhea is suspected, and colonoscopy or flexible sigmoidoscopy and biopsy. Testing for constipation-predominant IBS includes a plain abdominal film of the abdomen and flexible sigmoidoscopy or colonoscopy if a structural lesion is suspected. Screening tests for mixed IBS should be based on the patient's clinical history. The clinical documentation in this case does not support the performance of any laboratory testing at all, and certainly not an undefined "GI profile". There is no documentation of a careful history and physical, with careful consideration of the most probable diagnoses. A weight gain of 100 pounds should suggest that the patient is unlikely to have serious organic GI disease. If the most likely diagnoses are IBS and GERD, initial laboratory testing is not indicated, though endoscopy and imaging studies may be. If the patient truly has chronic abdominal pain with a concern for other causes besides IBS and GERD, a plethora of laboratory tests may be indicated depending on the patient's history and specific findings. Many of these tests would probably not be included in a GI profile. Based on the clinical documentation provided for my review and on the evidence-based citations above, a GI profile is not medically necessary in this case. It is not medically necessary because the provider had not done a complete physical exam, which led to careful decisions about appropriate testing. There were tests ordered, as well as blood testing may not be indicated at all in this case; and because if blood testing is indicated, appropriate tests may not be included in a GI profile panel test.