MAXIMUS Federal Services

Case Number:	CM15-0137537		
Date Assigned:	07/27/2015	Date of Injury:	09/17/2010
Decision Date:	08/24/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 56-year-old female, who sustained an industrial injury on September 17, 2010. She reported a slip and fall incident during which she landed flat on her back, striking her left elbow, shoulder and head on the floor. Treatment to date has included lumbar fusion, MRI of the lumbar spine, physical therapy, left ulnar nerve transposition, NSAIDS, cognitive behavioral therapy and medications. Currently the injured worker complains of abdominal pain, nausea, constipation, acid reflux and sleep disorder. On physical examination, the injured worker had tenderness to palpation over the right upper quadrant of the abdomen. The evaluating physician noted that her objective findings were consistent with the subjective findings and felt that the injured worker suffered from possible gastroplasty and irritable bowel syndrome related to the use of narcotics for pain relief. The treatment plan includes stool H- pylori antigen test, electrocardiogram, gastrointestinal profile, iron panel, ICG, Nexium, Amitiza, Phenergan, abdominal ultrasound and body composition study. The injured worker was advised to avoid NSAIDS and follow a low-fat diet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Body Composition Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation https://www.premera.com/medicalpolicies/cmi_009711.htm.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://journals.lww.com/co-clinicalnutrition/Abstract/2009/01000/Body_composition_analysis_techniques_in_the_aged.3.aspx.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, body composition study is not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. Measurement of body composition provides information of importance to health and function. Techniques used for assessment should be those unaffected by age-related changes in body composition, or those that have been adapted or validated in this age group. Particular roles of these techniques in the elderly include screening or surveillance of those at risk of malnutrition, and monitoring a range of chronic illnesses that are prevalent in older individuals. In this case, the injured worker's working diagnosis according to the internal medicine provider is abdominal pain; GERD; constipation and sleep disorder. Date of injury is September 17, 2010. Request for authorization is dated June 26, 2015. A progress note dated June 11, 2015 shows the workers 56 years old and weighs 140 pounds. Subjective complaints include abdominal pain, nausea, constipation, gastroesophageal reflux and sleep disorder. The documentation includes stress and anxiety. Objectively, shows right upper quadrant tenderness. The discussion includes gastrointestinal symptoms, sleep disorder and irritable bowel syndrome. The treatment plan includes ordering labs. There is no clinical discussion, clinical indication or rationale for ordering a body composition study. The utilization review indicates this was a repeat test. Consequently, absent clinical documentation with the clinical discussion, indication and clinical rationale for body composition study, body composition study is not medically necessary.

GI Profile (TSH, AML, LIPS, CMPR, CBC): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McPherson & Pincus: Henry's Clinical Diagnosis and Management by Laboratory Methods, 21st ed.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and physical assessments Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, G.I. profile (TSH, AML, LIPS, CMPR, and CBC) are not medically necessary. Thorough history taking is

always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the injured worker's working diagnosis according to the internal medicine provider is abdominal pain; GERD; constipation and sleep disorder. Date of injury is September 17, 2010. Request for authorization is dated June 26, 2015. A progress note dated June 11, 2015 shows the workers 56 years old and weighs 140 pounds. Subjective complaints include abdominal pain, nausea, constipation, gastroesophageal reflux and sleep disorder. The documentation includes stress and anxiety. Objectively, shows right upper quadrant tenderness. The discussion includes gastrointestinal symptoms, sleep disorder and irritable bowel syndrome. The treatment plan includes ordering labs. The injured worker reportedly has a history of Graves' disease (hyperthyroidism) and H. pylori. There is no documentation of prior laboratory work in the medical record. There is no documentation establishing causation of the hyperthyroidism to the industrial injury. Consequently, absent clinical documentation establishing causation of hyperthyroidism (Graves' disease) to the industrial injury, prior laboratory work from prior lab testing and the clinical rationale for ordering a comprehensive G.I. profile, G.I. profile (TSH, AML, LIPS, CMPR, and CBC) are not medically necessary.

ICG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and physical assessments Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, ICG is not medically necessary. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and community is not simply for screening purposes. In this case, the injured worker's working diagnosis according to the internal medicine provider is abdominal pain; GERD; constipation and sleep disorder. Date of injury is September 17, 2010. Request for authorization is dated June 26, 2015. A progress note dated June 11, 2015 shows the workers 56 years old and weighs 140 pounds. Subjective complaints include abdominal pain, nausea, constipation, gastroesophageal reflux and sleep disorder. The documentation includes stress and anxiety. Objectively, shows right upper quadrant tenderness. The discussion includes gastrointestinal symptoms, sleep disorder and irritable bowel syndrome. The treatment plan includes ordering labs. The request for authorization contains in order for an ICG. There is no definition in the medical record for ICG. There is no clinical discussion, rationale or indication for an ICG. Consequently, absent clinical documentation with the definition for ICG, a CPT code for ICG and a clinical indication and rationale for an ICG, ICG is not medically necessary.