

<b>Case Number:</b>	CM15-0225623		
<b>Date Assigned:</b>	11/24/2015	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2015

### 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 55 year old male, who sustained an industrial-work injury on 8-20- 12. The injured worker was diagnosed as having knee injury with internal derangement of right knee and meniscal tear, lumbar disc disease, radiculopathy, GERD (gastro-esophageal reflux disease), hypertension, IBS (irritable bowel syndrome). Treatment to date has included medication: Dexilant, Tramadol, Gabapentin, Menthol, Camphor, Capsaicin, Alba-Derm cream; psychological management, and diagnostics. Currently, the injured worker complains of reflux and abdominal distention following use of anti-inflammatories for knee injury. Initial complaints included left lumbar, right lumbar, bilateral sacroiliac, buttock and leg to foot pain. There was anxiety, stress, and insomnia. Per the primary physician's progress report (PR-2) on 5-18-15, exam noted abnormal posture, appropriate mood and affect, increased lumbar lordosis, use of a lumbar back support, decreased range of motion in right knee and positive orthopedic tests on the right. Current plan of care includes continuation of medication and diet changes. The Request for Authorization requested service to include Colonoscopy, Endoscopy and Pre-op clearance. The Utilization Review on 10-23-15 denied the request for Colonoscopy, Endoscopy and Pre-op clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Colonoscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.ncbi.nlm.nih.gov/pubmed/8069470](http://www.ncbi.nlm.nih.gov/pubmed/8069470).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/1819350-overview>.

**Decision rationale:** Pursuant to Medscape, colonoscopy is not medically necessary. Recommendations vary among the leading organizations in this field, namely the American Cancer Society (ACS), the World Health Organization (WHO), the US Preventive Services Task Force (USPSTF), and the American College of Physicians (ACP). It is generally recommended, however, that average-risk adults should begin colorectal cancer screening at age 50 years, utilizing one of several options for screening, among which is colonoscopy, every 10 years. 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 diagnoses are gastroesophageal reflux and irritable bowel syndrome. Date of injury is August 20, 2012. Request for authorization is October 14, 2015. There is no documentation by the requesting provider in the medical record. Consequently, there is no clinical indication or rationale for an upper G.I. endoscopy and a lower G.I. endoscopy. According to utilization review, medical records from the treating/requesting provider were available for review dated October 7, 2015 - October 14, 2015. According to an October 7, 2015 progress note (by the utilization reviewer), the injured worker took non-steroidal anti-inflammatory medications and developed gastroesophageal reflux disease and irritable bowel syndrome. Additional documentation by the utilization reviewer indicates the injured worker was seen in consultation by a gastroenterologist August 24, 2015. The gastroenterologist recommended conservative treatment and did not recommend an upper or lower endoscopy. Upper and lower G.I. endoscopy were not recommended and, consequently, a preoperative clearance for these procedures was not clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation by the requesting/treating provider, and G.I. documentation indicating conservative management is indicated and upper and lower G.I. endoscopies are not recommended, colonoscopy is not medically necessary.

## **Endoscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [Medscape.com](http://www.medscape.com).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/8069470>.

**Decision rationale:** According to gastrointestinal endoscopy clinics of North America, endoscopy is not medically necessary. Upper endoscopy is currently one of the most frequently performed procedures. The most common indications for diagnostic EGD include dyspepsia unresponsive to medical therapy or associated with systemic signs, dysphagia or odynophagia, persistent gastroesophageal reflux symptoms, occult gastrointestinal bleeding, and surveillance for malignancy. These guidelines, however, are largely based on consensus opinion, and few controlled trials have evaluated the effect of endoscopy on patient outcome, medical expenditures, and management. It appears that the benefits of therapeutic upper endoscopy for such conditions as acute gastrointestinal bleeding, foreign-body removal, and stricture dilatation are more well defined. Future studies should be directed at the most cost-effective and beneficial management strategies for many of these common conditions. 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 diagnoses are gastroesophageal reflux and irritable bowel syndrome. Date of injury is August 20, 2012. Request for authorization is October 14, 2015. There is no documentation by the requesting provider in the medical record. Consequently, there is no clinical indication or rationale for an upper G.I. endoscopy and a lower G.I. endoscopy. According to utilization review, medical records from the treating/requesting provider were available for review dated October 7, 2015 - October 14, 2015. According to an October 7, 2015 progress note (by the utilization reviewer), the injured worker took non-steroidal anti-inflammatory medications and developed gastroesophageal reflux disease and irritable bowel syndrome. Additional documentation by the utilization reviewer indicates the injured worker was seen in consultation by a gastroenterologist August 24, 2015. The gastroenterologist recommended conservative treatment and did not recommend an upper or lower endoscopy. Upper and lower G.I. endoscopy were not recommended and, consequently, a preoperative clearance for these procedures was not clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation by the requesting/treating provider, and G.I. documentation indicating conservative management is indicated and upper and lower G.I. endoscopies are not recommended, endoscopy is not medically necessary.

**Pre-op clearance:** 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 <http://www.aafp.org/afp/2013/0315/p414.html>.

**Decision rationale:** Pursuant to the Official Disability Guidelines and American Family Physician, preoperative clearance is not medically necessary. Preoperative testing (e.g., chest

radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, the injured worker's working diagnoses are gastroesophageal reflux and irritable bowel syndrome. Date of injury is August 20, 2012. Request for authorization is October 14, 2015. There is no documentation by the requesting provider in the medical record. Consequently, there is no clinical indication or rationale for an upper G.I. endoscopy and a lower G.I. endoscopy. According to utilization review, medical records from the treating/requesting provider were available for review dated October 7, 2015 - October 14, 2015. According to an October 7, 2015 progress note (by the utilization reviewer), the injured worker took non-steroidal anti-inflammatory medications and developed gastroesophageal reflux disease and irritable bowel syndrome. Additional documentation by the utilization reviewer indicates the injured worker was seen in consultation by a gastroenterologist August 24, 2015. The gastroenterologist recommended conservative treatment and did not recommend an upper or lower endoscopy. Upper and lower G.I. endoscopy were not recommended and, consequently, a preoperative clearance for these procedures was not clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation by the requesting/treating provider, and G.I. documentation indicating conservative management is indicated and upper and lower G.I. endoscopies are not recommended, endoscopy and colonoscopy are not medically necessary. As a result, if endoscopy and colonoscopy are not medically necessary, preoperative clearance is not medically necessary.