

Case Number:	CM15-0033540		
Date Assigned:	02/27/2015	Date of Injury:	11/19/2008
Decision Date:	04/10/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/23/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 71 year old male, who sustained an industrial injury on 11/19/08. He has reported long standing abdominal pain after being assaulted. The diagnoses have included chronic abdominal pain, history of prostate cancer, perforated ulcer disease and status post small bowel obstruction secondary to obstruction. Per the doctor's note dated 1/13/15, he had complains of persistent epigastric pain, worse in the morning with no relieving or exacerbating factors that he can attribute to, taking Nexium twice daily without improvement. He had dysphagia occasionally when eating solids/sandwiches, not liquids. He also reported constipation. Physical examination of the abdomen revealed surgical scars and mild tenderness to palpation in mid epigastric area, soft and non-tender with no rebound or guarding. The current medications list includes Alprazolam, Citalopram, Clonazepam, Dicyclomine, Esomeprazole, Hydrocodone-Acetaminophen, Levothyroxine, Prochlorperazine, Ranitidine, Miralax, Valcyclovir and Trazodone. He has had an upper gastrointestinal series since last visit dated 12/19/14 which revealed esophageal reflux, esophageal dysmotility and two duodenal diverticula. He has had esophagogastroduodenoscopy on 9/4/2014 which revealed esophagitis, mild gastritis and duodenitis and hiatus hernia. Treatment to date has included medications and diagnostics. Treatment plan was for Esophagogastroduodenoscopy EDG, Esophageal manometry and Ph study on medications to see if related to acid reflux. On Utilization Review non-certified a request for esophageal manometry, noting the (MTUS) Medical Treatment Utilization Schedule Guidelines American College of Gastroenterology- Medical Specialty Society was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Esophageal manometry: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Gastroenterology-Medical Specialty Society.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pulmonary (updated 07/29/14) 4. Chronic cough, secondary to GERD: B. Definitive Evaluation and Other Medical Treatment Guidelines PubMedTIAGA technical review on the clinical use of esophageal manometry. AUPandolfino JE, Kahrilas PJ, American Gastroenterological Association SO Gastroenterology. 2005;128(1):209. AD Northwestern University, Chicago, Illinois, USA. PMID.

Decision rationale: Request Esophageal manometry: Esophageal manometry is most useful in evaluating patients with dysphagia, noncardiac chest pain, and prior to antireflux surgery. Patient has already had upper gastrointestinal series since the last visit dated 12/19/14 which revealed esophageal reflux, esophageal dysmotility and two duodenal diverticula; esophagogastroduodenoscopy on 9/4/2014 which revealed esophagitis, mild gastritis and duodenitis and hiatus hernia. Rationale for the additional test- Esophageal manometry is not specified in the records provided. Evidence of a plan for reflux surgery is not specified in the records provided. The medical necessity of Esophageal Manometry is not fully established for this patient; therefore, this request is not medically necessary.