

Case Number:	CM14-0210401		
Date Assigned:	12/23/2014	Date of Injury:	07/16/2007
Decision Date:	03/24/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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 68 year old male, who sustained an industrial injury on July 16, 2007. He has reported a back injury. The diagnoses have included achalasia, paraesophageal hernia. Treatment to date has included lumbar back surgery, laparoscopic myotomy and partial fundoplication with repair of a paraesophageal hiatal hernia, radiological imaging, and medications. Currently, the Injured Worker complains of early feeling of fullness after eating, coughing, aspiration, and dysphagia. The records indicate x-rays of the esophagus on October 23, 2014, reveal no evidence of achalasia. Physical findings indicate a negative straight leg raise test. On December 2, 2014, Utilization Review non-certified esophagogastroduodenoscopy with biopsy, based on non-MTUS guidelines. On December 9, 2014, the injured worker submitted an application for IMR for review of esophagogastroduodenoscopy with biopsy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EGD with biopsy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.asge.org/assets/0/71542/71544/28549c5c-8b0e-4050-a588-11791c75ceb2.pdf>

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and American Society for Gastrointestinal Endoscopy, an esophagogastroscope (EGD) with biopsy 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 not simply for screening purposes. In this case, the injured worker's working diagnoses are achalasia and paraesophageal hernia. The last progress note in the medical record is dated February 6, 2014. The request for authorization is dated November 21, 2014 (proximally nine months later). There is no supporting documentation with the request for authorization. An office note dated February 6, 2014 indicates the injured worker presented for follow-up one-year post laparoscopic myotomy and partial fundoplication hiatal hernia. The injured worker had an unusual combination of achalasia with a paraesophageal hernia. The injured worker was doing well, although the injured worker notes difficulty with liquids and regurgitation of saliva type material periodically. Upper endoscopy reveals an intact partial fundoplication with a trivial recurrent hiatal hernia. Barium swallow reveals a small recurrent hernia with the delay in the esophagus and active peristalsis. Periodic radiology reports from esophagram dated October 23, 2014 reveals no evidence of achalasia. There is greater than 95% of the ingested contrast that reached the stomach before the one-minute interval. Regarding the EGD with biopsy, the injured worker is status post laparoscopic myotomy and partial fundoplication with repair of paraesophageal hiatal hernia. The injured worker was noted to have an unusual combination of achalasia and paraesophageal hernia. However, there is no documentation in the medical record setting forth the current clinical condition of the injured worker. As noted above, the most recent progress note is dated February 6, 2014 and the request for authorization is November 21, 2014. There is no clinical indication or clinical rationale to support the EGD. Consequently, absent clinical documentation to support an EGD with biopsy, and EGD with biopsy is not medically necessary.