

<b>Case Number:</b>	CM14-0215872		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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

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 female patient, who sustained an industrial injury on 08/04/2011. A primary treating office visit dated 10/16/2014 reported the patient with subjective findings of requesting medications and increased lumbar spine symptoms. Objective findings showed lumbar spine with limited range of motion and she is diagnosed with discogenic disease low back L4-5 dermatome, closed head trauma, cervical spine strain/sprain and rule out discogenic disease. A QME medical evaluation dated 11/10/2014 described present complaints as intermittent neck pain that increases with movement and rated an 8 out of ten in intensity without medications and with administration of medication the pain is noted decreased to 5 out of 10. The patient also has complaint of low back pain, headaches, jaw pain, parasthesias to bilateral lower extremities, left shoulder pain and depression. She is currently prescribed Tylenol with Codeine and Omeprazole. She is diagnosed with Temporomandibular disorder, myofascial pain, missing teeth and parafunctional habit, bruxism. On 11/13/2014 Utilization Review non-certified the request for a gastroenterology consultation, noting the CA MTUS, Chronic Pain medical guidelines, referral was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GI consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page(s) 92, 127

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment Page(s): 21, 22, 24, 33, 92.

**Decision rationale:** The MTUS/ACOEM Guidelines comment on the use of referrals and the evaluation of organ-specific symptoms. In general, there should be an assessment for red flag symptoms that are associated with potentially dangerous conditions (Page 21). There should be evidence of a focused history and physical examination that is relevant to the symptoms provided by the patient (Page 22). This should include a review of the chief complaint which provides information on the nature of the symptom, its onset, character and location. A review of symptoms pertinent to the organ system involved in the complaint should be performed (Page 24). A focused physical examination is to be expected as part of the assessment (Page 33). Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. The goal of such an evaluation is, in fact, functional recovery and return to work. In this case there is insufficient information provided in the medical records as to the specific nature of this patient's gastrointestinal symptoms. There is insufficient content on the nature of the symptoms, e.g. its character, onset and location. There is also insufficient information as to whether there are any red flags that would suggest a potentially serious underlying condition. Further, there is insufficient documentation that a physical examination of the abdomen has been completed as part of the assessment of the patient's gastrointestinal symptoms. Finally, there is no rationale provided as to the clinical question posed for the gastrointestinal consultation or outcome measures that will allow an assessment of the effectiveness of this intervention. For these reasons, a GI consultation is not considered as medically necessary.