

Case Number:	CM15-0170428		
Date Assigned:	09/11/2015	Date of Injury:	07/21/2010
Decision Date:	10/20/2015	UR Denial Date:	08/22/2015
Priority:	Standard	Application Received:	08/29/2015

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

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 37 year old female, who sustained an industrial injury on July 21, 2010. She reported bilateral shoulder pain and neck pain. The injured worker was diagnosed as having cervicothoracic strain, arthrosis and discopathy with neural encroachment, left shoulder impingement syndrome with possible partial thickness rotator cuff tear, left medial and lateral epicondylitis of the elbow, right shoulder impingement syndrome, probable complex regional pain syndrome, proctalgia fugax, and psychiatric diagnosis. Treatment to date has included diagnostic studies, shoulder injection (minimally beneficial), physical therapy, conservative care and medications. It was noted her status was permanent and stationary. Currently, the injured worker continues to report bilateral shoulder pain and abdominal pain with significant abdominal symptoms. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on February 24, 2015, revealed continued pain as noted. It was noted she had significant abdominal symptoms and recently finished a round of antibiotics without a change in the symptoms or pain. It was noted by the physician she would need further abdominal evaluation by an internist. Upper gastrointestinal with small bowel follow through with air contrast was performed on April 3, 2015, and revealed normal findings. Evaluation on July 6, 2015, revealed continued pain as noted. It was noted the answer regarding a gastrointestinal consultation had not been answered. Pain management evaluation on July 13, 2015, revealed continued left neck and upper back pain extending into the left upper extremity rated at 9 on a 1-10 scale with 10 being the worst. No abdominal assessment was included in the exam. Evaluation on July 17, 2015, revealed post

heavy NSAID use with associated reduced appetite, nausea, bloating, belching, gurgling, flatulence, erucations, early satiety, sharp, crampy, burning umbilical pain radiating to the right flank, worsened with the need to defecate. It was noted stool samples were positive for H. pylori in July 2014, and was noted to be treated with a combination antibiotic therapy. The RFA included a request for possible colonoscopy and was non-certified on the utilization review (UR) on August 21, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible Colonoscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ASGE Standards of Practice Committee, Early DS, Practice Parameters Committee of the American College of Gastroenterology, Guidelines for the Management of Dyspepsia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Society of Gastrointestinal Endoscopy, Appropriate use of GI Endoscopy, Volume 75, No. 6: 2012, page 1129.

Decision rationale: Both ODG and MTUS are silent on the subject of Colonoscopies. Based on the American society of gastrointestinal endoscopy, a Colonoscopy is generally indicated in the following circumstances: A. Evaluation of an abnormality on barium enema or other imaging study that is likely to be clinically significant, such as a filling defect and stricture. B. Evaluation of unexplained GI bleeding: 1. Hematochezia. 2. Melena after an upper GI source has been excluded. 3. Presence of fecal occult blood. C. Unexplained iron deficiency anemia. D. Screening and surveillance for colonic neoplasia: 1. Screening of asymptomatic, average-risk patients for colonic neoplasia. 2. Examination to evaluate the entire colon for synchronous cancer or neoplastic polyps in a patient with treatable cancer or neoplastic polyp. 3. Colonoscopy to remove synchronous neoplastic lesions at or around the time of curative resection of cancer followed by colonoscopy at 1 year and, if normal, then 3 years, and, if normal, then 5 years thereafter to detect metachronous cancer. 4. Surveillance of patients with neoplastic polyps. 5. Surveillance of patients with a significant family history of colorectal neoplasia. E. For dysplasia and cancer surveillance in select patients with long-standing ulcerative or Crohn's colitis. For evaluation of patients with chronic inflammatory bowel disease of the colon, if more precise diagnosis or determination of the extent of activity of disease will influence management. F. Clinically significant diarrhea of unexplained origin. G. Intraoperative identification of a lesion not apparent at surgery (e.g., polypectomy site, location of a bleeding site). H. Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia and polypectomy site. I. Intraoperative evaluation of anastomotic reconstructions typical of surgery to treat diseases of the colon and rectum (e.g., evaluation for anastomotic leak and patency, bleeding, pouch formation). J. As an adjunct to minimally invasive surgery for the treatment of diseases of the colon and rectum. K. Management or evaluation of operative complications (e.g., dilation of anastomotic strictures). L. Foreign body removal. M. Excision or ablation of lesions. N. Decompression of acute megacolon or sigmoid volvulus. O. Balloon dilation of stenotic lesions

(e.g., anastomotic strictures). P. Palliative treatment of stenosing or bleeding neoplasms (e.g., laser, electrocoagulation, stenting). Q. Marking a neoplasm for localization. Based on the evidence in this case, the patient is complaining of upper gastrointestinal issues and her symptoms correspond to this as well. There are no clear indications for a colonoscopy, as the patient does not have diarrhea, melena or bright red blood per rectum. Therefore, based on the evidence in this case, the request for a Colonoscopy is not medically necessary.