

<b>Case Number:</b>	CM13-0017123		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	10/07/2009
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	07/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2013

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 54 year old male who reported an industrial injury on 10/7/2009, almost 5 years ago, attributed to the performance of his custom job tasks. The patient complained of persist lower back pain with radiation to the lower extremities. The patient reported difficulty making it to the restroom on some occasions since his surgical intervention. The patient characterized his low back pain is constant. The patient reports trouble with directions and ejaculation to low back pain. It was noted that electrodiagnostic studies performed on 3/19/2013 demonstrated L5-S1 radiculopathy bilaterally subsequent to the surgical intervention of June 2012. Patient was reported to have depressed mood and affect. The objective findings on examination included diminished ankle reflexes; gait was moderately antalgic using a quad cane; 2-3 inch midline surgical scar that was well healed; tenderness to palpation to the paralumbar muscles; diminished lumbar spine range of motion. The diagnosis was failed low back syndrome with myelitic and residual chronic painting gait dysfunction; status post L4-L5 fusion during June 2010; secondary depression secondary insomnia due to chronic pain is still incontinence with sexual dysfunction reported as difficulty with ejaculation as well as erection rule out cauda equina syndrome; MRI positive arachnoiditis 2/10/2012. Pain management requested authorization of an urology consultation was requested because of reported sexual dysfunction and to rule out cauda equina syndrome or other causes that may be contributing to difficulties and for G.I. consultation due to stool incontinence to address sphincter dysfunction any other gastrointestinal condition may be causing incontinence.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **UROLOGICAL CONSULTATION: 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 Non-MTUS: ACOEM, 2nd Edition, (2004) chapter 7 page 127;.

**Decision rationale:** The requesting physician does not provide any objective evidence that the assessed issues related to erectile dysfunction or sexual dysfunction is an effect of the industrial injury or the provided surgical intervention with fusion. There was no demonstrated spinal cord injury, parasympathetic injury or sympathetic nerve injury to support the occurrence of ED on an industrial basis. There is no documented nerve impingement radiculopathy as the diagnosis is chronic low back pain s/p fusion L4-L5. The patient does not meet the criteria for erectile dysfunction as a diagnosis in relation to a lumbar spine injury. There is no established diagnosis of ED or urinary incontinence as a result of the industrial injury and there is no rationale supported by objective evidence to support the medical necessity of a Urology consultation. The consultation is screening for pathology without a provided nexus to the industrial injury. There is no demonstrated medical necessity for a Urologist for the treatment of ED or urinary incontinence as there is no specificity of the diagnosis and no rationale provided in the treatment plan. The subjective findings are not supported with objective findings on examination. The request was to rule out cauda equina syndrome over two years after the last surgical intervention. The issues surrounding the reported sexual dysfunction are not related to the MRI findings of Lumbar spine DDD with no evidence of a nerve impingement neuropathy on MRI. The patient is not demonstrated to have nerve damage at S1-S4 in relation to the industrial injury. The request for a Urologist evaluation is not demonstrated to be medically necessary for the cited diagnoses or the objective findings documented. There is no nexus of a sexual dysfunction to the cited mechanism of injury. There is no provided objective evidence that the occurrence of what is reported as sexual dysfunction is directly or temporally related to the industrial injury. There are no objective findings on examination and no subjective evidence provided by [REDACTED] that supports the medical necessity of a Urological consultation for the effects of the industrial injury. There are no objective findings consistent with a Urological issue and there is no medical necessity for a urological consultation for the occurrence of what is stated to be ED or a perceived sexual dysfunction. There is no evidence that the patient has an injury to the lumbar spine that has resulted in Erectile Dysfunction. There are no documented sacral spine lesions to support the reported causation of ED or urinary incontinence. It is not clear what type of sexual dysfunction is being treated or considered an effect of the cited industrial injury. There is no EMG/NCS documented S1 radiculopathy and the diagnosis of loss of libido or erectile dysfunction has no demonstrated nexus to the industrial injury. There is no demonstrated cauda equinus syndrome or any demonstrated neurological abnormalities to the sacral nerves S1 through S4. There is no objective medically based evidence provided to support the diagnosis of "sexual dysfunction or ED" or for the treatment of erectile dysfunction. The patient is not documented to have continued Urological complications and the treating provider is requesting a Urological opinion. There is no objective evidence that the GU system is affected

by the industrial injury and there are no documented objective findings consistent with a compression neuropathy that would affect the bladder or Innervation of the GU system. There is no demonstrated medical necessity for a urology consultation and no evidence of ED or sexual dysfunction. The request is not medically necessary and appropriate.

**GASTROINTESTINAL CONSULTATION:** 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 (ACOEM), 2ndEdition, (2004) chapter 7 page 127;.

**Decision rationale:** There is no rationale to support the medical necessity of a GI consultation based on the objective findings documented by the requesting physician. The objective findings on examination documented no abdominal examination positive findings and there was no documented GI or abdominal related diagnoses. There was no rectal examination to demonstrate diminished sphincter tone. The request for GI consultation to evaluate for rectal incontinence was made without performing a rectal examination to provide objective evidence of incontinence. There was no documented stool incontinence as the patient did not report incontinence but rather urgency. The medical necessity of the requested GI consultation is not demonstrated to be medically necessary for the effects of the industrial injury. There is no evidence of stool incontinence over two years after the last surgical intervention. The request was a screening consultation for anything GI that would cause incontinence which was not actually reported by the patient. There is no documented objective evidence that the currently reported "gastroenterology problems" is related to the performed surgical procedure or the effects of the industrial injury. The requested GI consultation was requested routinely without any objective findings on examination to support medical necessity. There are no objective findings on examination to support the request for GI consultation. The request for a GI consultation is not supported with a rationale or objective evidence to support medical necessity. The reported GI issues are not supported with a rationale and objective evidence with a nexus to the cited mechanism of injury. The request for authorization for a GI consultation on an industrial basis as requested by is directed to the underlying medical issues of the patient and is not supported with the rationale for medical necessity in relation to industrial injury and there is no demonstrated etiology of the stated abdominal symptoms on an industrial basis. The requested GI consultation is a screening evaluation to evaluate for GI issues that might lead to incontinence. There is no demonstrated sphincter dysfunction and no demonstrated rectal examination demonstrating poor sphincter tone. The request is not medically necessary and appropriate.