

<b>Case Number:</b>	CM13-0029471		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	07/23/2011
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	08/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### 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 General Surgery and is licensed to practice in Texas. 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:

The injured worker is a 41-year-old male who reported an injury due to a twisting motion while bending forward with a subsequent fall on 07/23/2011. On 02/05/2014, his diagnoses included urinary frequency with nocturia, probable neurogenic bladder, urinary incontinence with enuresis, incomplete bladder emptying, erectile dysfunction, decreased libido, orthopedic injuries, psychiatric illness, and sleep disorders. Recommendations included that an urodynamic study be performed to evaluate the probability of a neurogenic bladder due to urinary incontinence and a cystoscopy evaluation to be performed under sedation to evaluate bladder anatomy. His complaints included voiding dysfunction that consisted of daytime urinary frequency of up to 15 to 20 times per day and reports of nocturia several times per night. He further complained of sexual dysfunction characterized by an increasing difficulty to achieve and maintain an adequate erection. He stated that he aggravated his back when engaged in sexual intercourse and that he urinated as many as 25 times per day. He said that he could not sit through a movie and drink a beverage without interrupting the movie to urinate. He complained of interrupted sleep secondary to night time urgency and nocturia 3 to 4 times, but had no complaints of urinary incontinence. There were no comorbidities which contributed to arteriogenic erectile dysfunction. It was noted that conservative treatment modalities have failed, but the modalities were not specified. He was to have completed a voiding diary for his urinary frequency, but that was not available for review. Serum testosterone levels were drawn, but the lab results were not available for review. Complex uroflowmetry was performed and considered to be within normal range and post void urinary residual volume was negligible which was inconsistent with a previous physician's finding of incomplete evacuation of the urinary bladder. He suffered from recurrent herpetic outbreaks, but that was not further addressed in the clinical documentation. There were no complaints of hematuria or dysuria. On examination, the testes

were descended bilaterally without abnormalities. There were no epididymal masses or inguinal hernias. The phallus was well developed and uncircumcised without rashes or urethral discharge. Digital exam revealed a small, nontender, and benign prostate gland. Rectal sphincter tone was normal. Diabetes, hepatic/renal disease, and infection were ruled out. His urine specific gravity was within normal limits. His voiding curve was physiologic with a bell shape configuration. There was no graphic evidence of intermittent urinary flow which ruled out a urinary sphincter spasm or pelvic floor hyperactivity. There was no high pressure voiding spikes which ruled out detrusor instability. It was noted that those combined findings safely ruled out neurologic impairments to the bladder or pelvic floor, which included internal and external urinary sphincter muscles. His urinary flow rate was within normal limits. A pelvic ultrasound was performed which revealed no suspicious hyperechoic lesions, pelvic masses or enlarged pelvic lymph nodes. This supported the absence of physiologic or anatomic obstruction to urinary flow. His medications included tramadol and Aleve of unspecified dosages. The rationale as noted above was to evaluate the probability of a neurogenic bladder and his bladder anatomy. There was no Request for Authorization included in this injured worker's chart.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Preoperative clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cytoscopy under sedation and urodynamic study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Diagnosis and Treatment of Interstitial cystitis/bladder pain syndrome (<http://www.guideline.gov/content.aspx?id=32489&search=cystoscopy>)(<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3126081>)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American College of Radiology Guidelines, Amended 2014 (Resolution 39), ACR Practice Parameter for the Performance of Adult Cystography and Urethrography

**Decision rationale:** The request for cystoscopy under sedation and urodynamic study is not medically necessary. Per the American College of Radiology Guidelines, the indications for cystoscopy include evaluation of recurrent urinary tract infections, suspected vesicoureteral reflux, bladder morphology, bladder diverticula, suspected rupture, suspected fistula, integrity of

postoperative anastomosis or suture lines, bladder output obstruction, incontinence, hematuria, neoplasia, and postvoid residual volume. There was no evidence of any of the above conditions in the submitted documents. His diagnosis of incomplete bladder emptying was negated by subsequent urologic examinations and evaluations. It was noted that there were no physiologic or anatomic obstruction to urinary flow. There were no pelvic masses or enlarged lymph nodes. The recommendation for an urodynamic study to evaluate the probability of a neurogenic bladder due to urinary incontinence is not medically necessary due to urinary incontinence being ruled out. The clinical information submitted failed to meet the evidence based guidelines for cystoscopy. Therefore, this request for cystoscopy under sedation and urodynamic study is not medically necessary.