

<b>Case Number:</b>	CM14-0116906		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	10/02/2009
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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. 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 54-year old laborer reported upper and lower back pain after she felt a pop as she was forcibly closing a box on 10/2/09. Diagnoses at the time of the request for IMR were listed as lumbosacral strain and degenerative disc disease, bilateral L5 radiculopathy, and headaches. Her past medical history is notable for diabetes and hypertension. She has been treated with multiple medications which include several narcotics, physical therapy, chiropractic manipulation and acupuncture. Bilateral L5 epidural steroid injections were performed on 12/20/13. She has presented for emergency care at least twice, with complaints of global pain and an unusual symptom such as blurred vision or urinary incontinence. Both visits resulted in her being given morphine and feeling much better. An MRI of the LS spine performed 4/11/13 revealed degenerative changes and no significant cord or nerve root compression, unchanged since and MRI in 2010. Lower extremity electrodiagnostic studies have been performed twice, on 3/26/12 and 5/8/14, and were both normal. On 3/25/14 she presented to a mobile care unit with complaints of global pain and getting all wet about once per day, with numbness in the private areas. Her exam, particularly after morphine administration, did not support a diagnosis of cauda equina syndrome. Neurological evaluation and ambulation were normal. A urinalysis performed at that visit included a low specific gravity. A note dated 6/20/14 from her primary treater stated that she has new incontinence, not stress-related. The incontinence is not further described, and there is no documentation of evaluation of timing and character of incontinence, of daily fluid intake, of provoking factors such as cough, or of history or evaluation gynecologic abnormalities. A request was made for a urology referral, which was denied in UR on 7/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urology Consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation HARRISON'S TEXTBOOK OF MEDICINE; EVALUATION AND MANAGEMENT OF URINE INCONTINENCE.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 41-44. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Initial Approaches to Treatment, pages 43-44; and Cornerstones of Disability Prevention and Management, pages 79-80.

**Decision rationale:** The ACOEM Guidelines cited above state that determining whether a patient suffers from a pathologic condition may not always be straightforward. Performing multiple procedures and tests in this setting is described as an incomplete or inaccurate approach to patient assessment that may set the stage for the prolongation of medical care, delayed recovery and the development of a range of behaviors by the patient in order to prove that there is a real injury that precludes return to work. In cases of delayed recovery and prolonged time away from work, the clinician should determine whether specific obstacles are preventing the patient from returning to work. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert recommendations. The clinician should always think about differential diagnoses. This should involve stepping back and reevaluating the patient and the entire clinical picture. Symptoms or physical findings that have developed since the injury may not be consistent with the original diagnosis. A detailed history and physical exam should be conducted. Appropriate studies may be performed. The clinical findings in this case include multiple symptoms and non-specific findings. Many tests have been performed without yielding clear diagnoses. The primary treater has not stepped back and re-evaluated the patient and the clinical picture in the setting of new symptoms of incontinence. Such an evaluation is particularly important in this case, as there are multiple possible causes for the patient's incontinence. Her diabetes alone could result in incontinence if uncontrolled. She is taking several medications that could result in urinary retention or in increased somnolence, both of which could result in incontinence. The low specific gravity of her urine on 3/25/14 could mean that the patient drinks very large quantities of water, or that she has a disease such as a cancer that produces inappropriate anti-diuretic hormone. A referral for urologic evaluation would not be appropriate in many of these scenarios. Based on these clinical findings and the guideline references, an additional referral to urologist is not medically necessary because an appropriate assessment of the patient has not been made, and it is not at all clear that the referral would clarify the diagnosis and do no harm to the patient.