

<b>Case Number:</b>	CM14-0033558		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/24/2010
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 40-year old male sustained multiple injuries when he fell approximately 45 feet on 6/24/10. He was working in a bucket at about 60 feet, when a cable snapped and the bucket fell to within 15 feet of the ground. Current diagnoses include closed head trauma with post-concussion syndrome, cervical sprain, cervical disc protrusion and C7 radiculopathy, bilateral shoulder and arm sprain with adhesive capsulitis, lumbar sprain with multilevel disc bulges and L5 radiculopathy, L ankle sprain, headache and groin pain. He is status post shoulder dislocation and has healed fractures of the L clavicle and scapula. 13 CT scans or plain x-rays were performed on the date of injury, which included nearly every part of the patient's body. They were positive only for a comminuted fracture of the L scapula, and an L mid-clavicular fracture. Subsequent MRIs in 2011 revealed diffuse degenerative changes of the lumbar spine with small disc protrusions. L shoulder MRIs performed in 2012 revealed mild bursitis only. The patient has been evaluated and treated by a pain management specialist, a neurosurgeon and a psychiatrist. Multiple interventions have been tried, none of which resulted in significant functional improvement. The primary treating physician re-evaluated the patient on 10/22/13. The patient had complaints of nearly global pain, which included the bilateral groin region and both testicles. He also complained of occasional incontinence, decreased libido and occasional impotence. There is no other history documented in regards to these complaints. Multiple other complaints were documented. Physical exam findings included a note that the patient is in a wheelchair and is unable to stand. Tenderness and decreased range of motion was documented for the neck, bilateral shoulders, lumbar spine, L foot and ankle. Motor power was graded as 2/5 in both upper extremities, which would mean that the patient is not able to move his limbs against gravity. No examination of the perineal or groin area was documented, and no urinalysis appears to have been performed. The primary treater listed 18 diagnoses, and stated that the

patient's problems and treatment are beyond the scope of his office. He recommended referrals to 8 different medical specialists, as well as repeats MRIs of 5 areas, and repeat electrodiagnostic studies. No clear rationale is given for any of these requests. A UR decision was made to deny many of these requests, including a urology referral, on 2/12/14. A request for IMR of the urology referral denial was made on 3/17/14.

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

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

**Referral to urology:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OMPG (Second Edition 2004) Chapter 7 Independent Medical Examinations and Consultations Page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 43-44; 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. Workers may believe that they have a physical injury when the real problem is a lack of fit with their job duties. Such workers often may have multiple symptoms with non-specific physical findings. 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 notes in this case notes do not document any such process. This patient has multiple symptoms without any clearly accompanying documented physical findings. It is not clear why he is in a wheelchair, or why he apparently cannot move his upper extremities against gravity. Both he and his primary treater appear to accept that he will be completely disabled for life. The treater has not stepped back and carefully reassessed the entire clinical picture. Ordering multiple referrals and tests in this setting is likely to reinforce this patient's perception that he is totally disabled and can never work again. In addition, the primary treater has not made clear why he feels a urology referral is necessary, whether for the patients groin and testicular pain, his occasional incontinence and impotence, or his decreased libido. All of these problems could be caused by factors that would not be grounds for a urology referral. The patient may have a hernia, a urinary tract infection or epididymitis. His decreased libido and erectile dysfunction could be psychological. No real attempt has been made to evaluate the patient's problems and

assess what sort of testing or referral may be needed. Based the clinical findings and the guideline references, a referral to a 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 result in more definitive diagnoses and do no harm to the patient.