

Case Number:	CM15-0104989		
Date Assigned:	06/09/2015	Date of Injury:	06/18/2014
Decision Date:	07/15/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/01/2015

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: Physical Medicine & Rehabilitation

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 44 year old male, who sustained an industrial injury on 6/18/14. He reported initial complaints of abdominal pain. The injured worker was diagnosed as having cephalgia secondary to stress; Otagia bilaterally; chronic cervical strain/sprain; chronic cervical/thoracic sprain/strain; chronic lumbar spine sprain/strain with right lower extremity radiculopathy with multilevel disc herniation; chronic sprain/strain with impingement syndrome bilateral shoulders.; chronic sprain strain left elbow; lateral epicondylitis left; bilateral wrist sprain/strain; bilateral stenosing tenosynovitis; anxiety/depression/insomnia. Treatment to date has included physiotherapy (14 sessions); chiropractic therapy (12 sessions); acupuncture (21 sessions); medications. Diagnostics included EMG/NCV study bilateral lower extremities (11/5/14); MRI right shoulder (9/9/14); X-rays of the thoracic and lumbar spine. Currently, the PR-2 notes dated 4/10/15 indicated the injured worker complains of headaches; ear ache with buzzing in his ears; neck pain; upper back pain lower back pain; bilateral shoulder pain; left elbow pain; bilateral wrists/hand pain with tingling sensation; bilateral ankle foot pain; anxiety, depression, sexual dysfunction, loss of appetite, irritability and difficulty sleeping. The physical examination, the provider notes tenderness to the ears with no hearing loss; palpation of the abdomen revealed tenderness over the anterior abdominal wall with no masses. The cervical spine reveals tenderness over the bilateral paracervical musculature, trapezii and levator scapulae. His range of motion was accomplished with associated pain for flexion 40 degrees, extension 60 degrees and bilateral rotation 70 degrees and bilateral bending 40 degrees. The thoracic spine notes tenderness over the bilateral dorsal musculature greater on the right and

most pronounced at the thoracolumbar transition region. There is tenderness noted over the bilateral para lumbar musculature greater on the right with spasm at the thoracolumbar junction at L1-2 and L5-S1 Levels. Range of motion revealed flexion 30-40 degrees, extension 15-20 degrees and bilateral bending 15-20 degrees with pain. Straight leg raise was 70 degrees on the right and 80 degrees on the left with low back pain and right extremity paresthesia and pain. His right shoulder examination notes tenderness over the AC joint, bicipital groove, and region of the rotator cuff. Drop arm test is questionable; anterior apprehension test is negative. Hawkin's and Neer's test are positive. Range of motion revealed flexion of 160 degrees, extension of 40 degrees, abduction 160 degrees, adduction 50 degrees, external and internal rotation of 80 degrees with associated pain. The Apley's test is positive. The left shoulder notes tenderness over the bicipital groove; drop arm test/anterior apprehension test is negative. Range of motion revealed flexion 170 degrees, extension 50 degrees, abduction 170 degrees, adduction 50 degrees, external rotation 90 degrees and internal rotations 80 degrees with pain. The Apley's test is equivocal; Hawkin's and Neer's tests are positive. The bilateral elbows were examined and noted the left elbow with tenderness over the lateral extension muscle mass, range of motion is full with associated pain and tennis elbow test is positive. Bilateral wrist noted tenderness over the region of the carpal tunnel and anatomical snuff bow. His range of motion is full with associated pain and equivocal for Tinel's sign and positive for Finkelstein's test. An EMG.NCV study lower extremities dated 11/5/14 revealed electrodiagnostic evidence of chronic right S1 radiculopathy with no evidence of lumbosacral plexopathy, peripheral neuropathy or mononeuropathy involving the left tibial nerve and bilateral peroneal and sural nerves. A MRI of the lumbar spine dated 9/9/14 notes an impression of lumbosacral transitional segment S1; straightening of the lumbar lordotic curvature th at may reflect an element of myospasm; beginning disc desiccation at L2-L3, L4-L5 and L5-S1 with loss of disc height at l5-S1 and L2-L3 broad based disc herniation abutting the thecal sac with no significant spinal canal stenosis or neural foraminal narrowing. Broad based disc herniation abutting the thecal sac and causing narrowing of the bilateral foramen. There is a L5-S1 broad based disc herniation abutting the thecal sac and causing narrowing of the bilateral recess and neural foramen with contact on the visualized bilateral LS exiting nerve roots. The provider's treatment plan on this date consisted of recommendation of therapeutic activity; chiropractic therapy for the neck, upper and lower back and bilateral shoulders and IF 4 unit for home therapy. The provider has also requested authorization of Testicular/scrotum ultrasound to rule out a hernia and abdominal ultrasound to rule out a hernia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Testicular/Scrotum Ultrasound to Rule Out Hernia: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hernia chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hernia Chapter, under Imaging has the following regarding ultrasound.

Decision rationale: The patient presents on 04/10/15 with unrated headache, earache with associated buzzing in ears, neck pain, upper/lower back pain, bilateral shoulder pain, bilateral wrist/hand pain, bilateral ankle/foot pain, and associated psychological disturbances. The patient's date of injury is 06/18/14. Patient has no documented surgical history directed at these complaints. The request is for Testicular/Scrotum Ultrasound to Rule out Hernia. The RFA is dated 04/17/15. Physical examination dated 04/10/15 reveals tenderness to palpation over the anterior abdominal wall, no masses noted. The patient is currently prescribed Naproxen. Diagnostic imaging pertinent to the request was not included. Per 04/10/15 progress note, patient is advised to return to work on 05/08/15. ODG Hernia Chapter, under Imaging has the following regarding ultrasound: "Not recommended except in unusual situations. Imaging techniques such as MRI, CT scan, and ultrasound are unnecessary except in unusual situations. (Treatment Planning) Ultrasound (US) can accurately diagnose groin hernias and this may justify its use in assessment of occult hernias. In experienced hands US is currently the imaging modality of choice when necessary for groin hernias and abdominal wall hernias. Postoperative complications may also be evaluated. Computerized tomography (CT) may have a place, particularly with large complex abdominal wall hernias in the obese patient. These hernias often contain loops of air-filled bowel, which preclude adequate penetration of the sound beam by US. Clinically obvious hernias do not need ultrasound confirmation, but surgeons may request ultrasound for confirmation or exclusion of questionable hernias or for evaluation of the asymptomatic side to detect clinically occult hernias. If positive, this allows bilateral hernia repair at a single operation." In regard to the request for testicular/scrotum ultrasound imaging to rule out hernia, the request is appropriate. This patient presents with chronic abdominal pain following a lift injury on 06/18/14. The provider is requesting an ultrasound so as to rule out an inguinal hernia. Progress note dated 04/22/15 states that the patient underwent abdominal CAT scan on 02/24/15, which returned normal results without evidence of a hernia or pathology in the abdomen. While these findings rule out the possibility of a hernia in the abdominal wall, an abdominal CAT scan is unlikely to have clearly resolved the scrotum or testicles. Therefore, ultrasound imaging of the region could provide insight into any possible inguinal hernia and is substantiated. The request is medically necessary.

Abdominal Ultrasound to Rule Out Hernia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hernia chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hernia Chapter, under Imaging has the following regarding ultrasound.

Decision rationale: The patient presents on 04/10/15 with unrated headache, earache with associated buzzing in ears, neck pain, upper/lower back pain, bilateral shoulder pain, bilateral wrist/hand pain, bilateral ankle/foot pain, and associated psychological disturbances. The patient's date of injury is 06/18/14. Patient has no documented surgical history directed at these complaints. The request is for Abdominal Ultrasound To Rule Out Hernia. The RFA is dated 04/17/15. Physical examination dated 04/10/15 reveals tenderness to palpation

over the anterior abdominal wall, no masses noted. The patient is currently prescribed Naproxen. Diagnostic imaging pertinent to the request was not included. Per 04/10/15 progress note, patient is advised to return to work on 05/08/15. ODG Hernia Chapter, under Imaging has the following regarding ultrasound: "Not recommended except in unusual situations. Imaging techniques such as MRI, CT scan, and ultrasound are unnecessary except in unusual situations. (Treatment Planning) Ultrasound (US) can accurately diagnose groin hernias and this may justify its use in assessment of occult hernias. In experienced hands US is currently the imaging modality of choice when necessary for groin hernias and abdominal wall hernias. Postoperative complications may also be evaluated. Computerized tomography (CT) may have a place, particularly with large complex abdominal wall hernias in the obese patient. These hernias often contain loops of air-filled bowel, which preclude adequate penetration of the sound beam by US. Clinically obvious hernias do not need ultrasound confirmation, but surgeons may request ultrasound for confirmation or exclusion of questionable hernias or for evaluation of the asymptomatic side to detect clinically occult hernias. If positive, this allows bilateral hernia repair at a single operation." In regard to the request for abdominal ultrasound imaging to rule out hernia, the patient has already undergone unremarkable CT imaging of the affected area. This patient presents with chronic abdominal pain following a lift injury on 06/18/14. The provider is requesting an ultrasound so as to rule out an inguinal hernia. Progress note dated 04/22/15 states that the patient underwent abdominal CAT scan on 02/24/15, which returned normal results without evidence of a hernia or pathology in the abdomen. Additionally, examination findings do not include any evidence of bulging masses, or other abdominal symptoms indicative of hernia - only diffuse tenderness to palpation. Given the unremarkable findings of previous CAT scans of the abdomen, and the lack of physical findings indicative of hernia, the request for additional imaging cannot be substantiated. The request is not medically necessary.