

Case Number:	CM15-0141439		
Date Assigned:	07/31/2015	Date of Injury:	02/18/2015
Decision Date:	08/28/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/21/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 54 year old male, who sustained an industrial injury on February 18, 2015. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having low back pain, post-operative pain, bilateral inguinal hernia, and male genital disorder not elsewhere classified. Treatment and diagnostic studies to date has included status post laparoscopic bilateral inguinal hernia repair with mesh implantation, exercise, and medication regimen. In a progress note dated June 17, 2015 the treating physician reports complaints of pain to the left testicle, low back, and bilateral inguinal region. Examination reveals thickening of the epididymis with slight tenderness, but no physical evidence of recurring hernias. The treating physician requested an ultrasound of the left testicle to assess the palpable mass at the left epididymis. The treating physician also requested physical therapy of the lumbar spine with an unknown number of visits for the injured worker's back noting that the pain is likely secondary to his groin pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound left testicle: 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 imaging.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Virginia compendium at <http://www.med-ed.virginia.edu/courses/rad/testicularUS/>.

Decision rationale: This claimant was injured in February with low back pain, post-operative pain, bilateral inguinal hernia, and an unspecified male genital disorder. Treatment and diagnostic studies to date have included status post laparoscopic bilateral inguinal hernia repair with mesh implantation, exercise, and medication regimen. As of June 17, 2015 there is pain to the left testicle, low back, and bilateral inguinal region. The treating physician requested an ultrasound of the left testicle to assess the palpable mass at the left epididymis. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG is also silent. Per the University of Virginia compendium at <http://www.med-ed.virginia.edu/courses/rad/testicularUS/>, such ultrasound studies are best at defining cystic structures, as the ultrasound can clearly determine if a lesion is fluid filled. Scrotal translumination is a basic physical exam procedure that can give some information regarding if there is a cystic nature to the lesion. I did not find this on physical examination. At present, a scrotal ultrasound would be premature. The request is not medically necessary.

Physical therapy lumbar-unknown number of visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 of 127.

Decision rationale: As shared, this claimant was injured in February with low back pain, post-operative pain, bilateral inguinal hernia, and an unspecified male genital disorder. Treatment and diagnostic studies to date have included status post laparoscopic bilateral inguinal hernia repair with mesh implantation, exercise, and medication regimen. As of June 17, 2015 there is pain to the left testicle, low back, and bilateral inguinal region. The treating physician requested an ultrasound of the left testicle to assess the palpable mass at the left epididymis. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over

treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request is not medically necessary.