

Case Number:	CM14-0129208		
Date Assigned:	09/05/2014	Date of Injury:	10/28/1952
Decision Date:	09/25/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/13/2014

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:

62 yr. old male claimant sustained a work injury on 10/28/02 involving the neck, hip, back, knees and elbow. Due to heavy lifting at work he did develop some scrotal pain in 2003. He was diagnosed with cervical spine strain, shoulder impingement syndrome, lumbar radiculopathy with disc bulging and neuroforaminal narrowing and facet arthropathy. He had undergone facet blocks for the cervical and lumbar spine to alleviate symptoms. A urologist note in 8/3/04 indicated the claimant had erectile dysfunction due to pain from injury along with epididymitis. At the time he was recommended to use Viagra and was treated for the epididymitis. A progress note on 3/24/14 indicated continued increase in back pain and radicular symptoms. The claimant was continued on oral analgesics and Cialis for erectile dysfunction. On 8/13/14, a request was made for Viagra, Cialis, Epidural steroid injections, Stim Electrotherapy, lumbar traction, back brace and a therma cool unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cialis #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com.

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: Erectile Dysfunction and National Guidelines.

Decision rationale: According to the National Guidelines, Phosphodiesterase type 5 inhibitors (PDE5Is) are first-line therapy. In this case, the Urologist recommended the use of such medications (Viagra) 11 years ago. There has been no recent assessment on the claimant's erectile dysfunction for at least 6 years. The request for Cialis is therefore not medically necessary.

Viagra 100mg #150: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>x Other Medical Treatment Guideline or Medical Evidence: National Guidelines for Erectile Dysfunction.

Decision rationale: According to the National Guidelines, Phosphodiesterase type 5 inhibitors (PDE5Is) are first-line therapy. In this case, the Urologist recommended the use of such medications (Viagra) 11 years ago. There has been no recent assessment on the claimant's erectile dysfunction for at least 6 years. The request for Cialis is therefore not medically necessary.

Epidural injections Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to the ACOEM guidelines, epidural steroid injections are not recommended. Invasive techniques are of questionable merit. Epidural Steroid Injections may provide short-term improvement for nerve root compression due to a herniated nucleus pulposus. The treatments do not provide any long-term functional benefit or reduce the need for surgery. The request, therefore, for a lumbar epidural steroid injections is not medically necessary.

Epidural injections Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300.

Decision rationale: According to the ACOEM guidelines, epidural steroid injections are not recommended. Invasive techniques are of questionable merit. Epidural Steroid Injections may provide short-term improvement for nerve root compression due to a herniated nucleus pulposus. The treatments do not provide any long-term functional benefit or reduce the need for surgery. The request, therefore, for a lumbar epidural steroid injections is not medically necessary.

Combo-STIM electrotherapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical stimulators (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS
Page(s): 113-115.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. The length of use was not specified. Recent clinical notes were not provided to support its use. The request for a TENS unit is not medically necessary.

Home lumbar traction unit: 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), Treatment Index, 5th Edition, 2007, Low Back, Traction.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. The length of use was not specified. Recent clinical notes were not provided to support its use. The request for a TENS unit is not medically necessary.

Back Brace, Lumbar Support: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and

Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, 2nd edition: Low back pain, Update 2008, Chapter 12, pages 138-139, Lumbar supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to the ACOEM guidelines, lumbar supports have not been shown to have lasting benefit. . Due to lack of evidence, the brace is not medically necessary.

Thermo Cool Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous Cryotherapy Unit.

Decision rationale: According to the ACOEM guidelines, at home cold therapy is as effective as that provided by a therapist. According to the ODG guidelines, continuous cold units are recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries. Based on lack of guidance on length, term and indication for use, as well as the guidelines above, the Thermo Cool unit is not medically necessary.