

Case Number:	CM14-0138702		
Date Assigned:	09/05/2014	Date of Injury:	01/05/2013
Decision Date:	10/16/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	08/27/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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:

The records presented for review indicate that this 58 year-old male was reportedly injured on 1/5/2013. The most recent progress note, dated 7/15/2014, indicates that there were ongoing complaints of neck pain radiating into the left upper extremity and low back pain radiating into the left lower extremity. The physical examination demonstrated: positive trigger points palpated in the upper/lower trapezius along with paraspinal muscles. Cervical and lumbar spine range of motion is limited by pain. Bilateral shoulders limited range of motion with pain, and crepitus. Decreased sensation 1st, 2nd, and 3rd digits of the right hand, and all digits on the left. Decreased sensation in bilateral lower extremities along the lateral aspect of the leg. Muscle strength upper/lower extremities 4/5. Spurling's examination is positive bilaterally and cervical spine. Positive shoulder impingement bilaterally as well as positive Adson's test bilaterally. Positive SI joint compression test bilaterally. No recent diagnostic studies are available for review. Previous treatment includes medications and conservative treatment. A request had been made for Viagra 50 mg #10 with one refill and a lumbar corset and was not certified in the pre-authorization process on 8/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Viagra 50mg, #10 (with 1 refill): 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), Online Version, Pain Chapter, Erectile Dysfunction/Hypogonadism/Testosterone Replacement Therapy

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: The Merck Manual. Erectile Dysfunction, Viagra

Decision rationale: CA MTUS and ODG guidelines do not specifically address the use of this medication, therefore, alternative medical references were used for citation. Viagra is medication used to treat erectile dysfunction and pulmonary arterial hypertension. After review the medical records provided it was difficult to identify the medical need for the continued use of this medication. Therefore, this request is deemed not medically necessary.

Lumbar corset: 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), Online Version, Low Back Chapter, Back Supports and Braces

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) - Low Back Disorders - Clinical Measures; Devices (Electronically Cited).

Decision rationale: MTUS/ACOEM practice guidelines do not support the use of a LSO or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.