

<b>Case Number:</b>	CM14-0192449		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	02/09/2010
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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. 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: Florida, New York, Pennsylvania  
Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

DOI 9 Feb2010. The injured worker is reported to have been involved in a head on collision in his vehicle on the way to work. He apparently is amnesic for the actual event leading to the collision. It was 5 AM, he was wearing his seatbelt, it was a [REDACTED], it was dark and on a narrow road, he was travelling approximately 65mph. He awoke in the hospital, underwent exploratory lap. He apparently had difficulty with L gaze and on CT was found to have a R parietal lobe hemorrhage, possible subarachnoid hemorrhage and a cortical contusion. Mildly displaced #'s of the transverse processes on L1-L4 on the L were noted. At the time of discharge the member was experiencing headache, lightheadedness, impaired memory, photophobia, depression, fatigue and difficulty with sleep. Neuropsych eval was apparently accomplished finding showing impaired auditory verbal comprehension skills and impaired verbal learning. He showed impaired fine motor dexterity bilaterally. Mental status evaluation found evidence for significant depression and anxiety. His major complaints were headache, neck, upper and middle back pain. Usually 7/10. Some relief noted with massage. He gets about 70% relief with his pain meds but finds it difficult to lift and carry objects. He can only sit for an hour and experiences pain with walking. The patient denied any GI symptoms. Examination revealed approximately 50% in ROM of the neck. Sensation, strength and ROM in the UE are essentially WNL. Palpation revealed paraspinal tenderness. The listed diagnoses included: Traumatic Brain Injury, Temporary Loss of Memory, Transverse Process #'s L1-L4, Chronic Back Pain, Liver laceration and a History of ED. Medications at this visit 28Mar14 included Ultram 150mg daily, Tylenol Extra Strength (amount unkn) and Naprosyn 500mg bid. After this initial report medications

were adjusted and added Hydrocodone 10/325 tid, Protonix 20 qd and Viagra 50mg daily as needed. The issue under review relates to non-certification for Viagra and Protonix.

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

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

#### **Viagra 50mg #10: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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: Up-to-date, Evaluation of Male Sexual Dysfunction, Cunningham GR, Khera M, accessed 6Jan14.

**Decision rationale:** The MTUS does to speak specifically to Erectile Dysfunction and the use of Viagra. The documentation available lists a "history" of ED. At no point in the PHx or narrative is there any explanation as to the exact onset, severity and evaluation that was accomplished to elicit this diagnosis. The origin of ED can represent typically psychogenic (the largest %), vascular, neurologic, hormonal (such as "Low T"), drug induced and local penile factors (such as Peyronie's). Sexual history is important and can be elicited using a validated inventory such as the International Index of Erectile Function (IIEF), appropriate physical exam and use of evaluations such as the Rigi-Scan for Nocturnal Penile Tumescence (NPT) providing accurate, reproducible information or Duplex Doppler Imaging looking for arterial obstruction or venous leaks. The rapidity of onset of the condition with an abrupt onset followed by continuing ED is felt to be a hallmark for Psychogenic ED. In those reporting a failure to produce an adequate erection but continue to experience spontaneous erections through the night suggest psychological causes and makes vascular or neurologic causes unlikely. A non-sustained erection after penetration is most commonly anxiety related or a venous leak. Interpersonal conflict is one of the most common but rarely acknowledged causes. With the absence of details as to the evaluation, frequency, severity, response to treatment as well as timing of onset in relation to the accident a causal link and assignment as an industrial injury cannot be made. Therefore, the request is not medically necessary and is not supported.

#### **Protonix 20mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 68.

**Decision rationale:** To help establish the risk associated with NSAID's for gastrointestinal events look for the following information: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or

(4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Based on that assessment for following recommendations can be made: 1. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, Naproxen, etc.) 2. Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) Non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). A review of the available records could find no indication for any GI complaints or past history of conditions those covered above. Long term use has been associated with complications to include increased hip # as noted above. As such, use of a Non-Selective NSAID without the use of a PPI could be supported. The need for GI protective medications has not been proved. The request is not medically necessary.