

Case Number:	CM14-0194914		
Date Assigned:	12/02/2014	Date of Injury:	01/13/2003
Decision Date:	01/16/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/20/2014

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 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:

The patient is a 45 year old male with date of injury 01/13/03. The treating physician report dated 10/20/14 indicates that the patient presents with pain affecting the low back and radiating pain down both legs. The patient indicates that the pain level is 6/10 on medications and an 8.5/10 without medications. The physical examination findings reveal in the thoracic spine, no signs of scoliosis, asymmetry or abnormal curvature noted on inspection of the thoracic spine. ROM (range of motion) is restricted with flexion and extension. The Lumbar spine shows on inspection, surgical scars; ROM is restricted with flexion to 70 degrees, extension limited to 10 degrees, right lateral bending limited to 20 degrees, left lateral bending limited to 20 degrees and pain. On palpation, paravertebral muscles, hypertonicity, spasm, tenderness and tight muscle band is noted on both the sides. Gaenslen's and FABER tests were positive. The current diagnoses are: 1. Post Lumbar Laminectomy Syndrome; 2. Spinal/Lumbar DDD; 3. Lateral Epicondylitis (Right). The utilization review report dated 11/05/14 denied the request for Cialis and Dexilant based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cialis 20mg #6: 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: Aetna Guidelines: Clinical Policy Bulletin: Erectile Dysfunction

Decision rationale: The patient presents with chronic low back pain. The current request is for Cialis 20mg #6. The treating physician indicates that the request is to assist the patient performing sexual activities due to the opioid usage. There are no further information or examination findings supporting a diagnosis of erectile dysfunction. The MTUS and ODG guidelines do not address Cialis usage for erectile dysfunction. The AETNA guidelines have specific diagnostic workup criteria to determine a diagnosis of erectile dysfunction (ED). Additionally, laboratory tests are required before treatment of ED can be considered. In this case, the treating physician has been prescribing Cialis since at least August 2014. There are no diagnostic tests found in the medical records provided to clinically diagnose the patient with ED. There is nothing in the records to determine the specific etiology of the patient's ED. The treating physician has failed to follow any guidelines for this current request and the supporting documentation fails to show any medical necessity for the current request. Therefore, the request is not medically necessary.

Dexilant DR 60mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The patient presents with chronic low back pain. The current request is for Dexilant DR 60mg #30. Dexilant Treats heartburn, gastroesophageal reflux disease (GERD), or damaged esophagus. The treating physician indicates that the request is to assist the patient with GI upset/reflux due to chronic use of pain medications. The MTUS Guidelines state that a proton pump inhibitor is recommended with precautions as indicated below. MTUS goes on to states that the clinician should weigh indications for NSAIDs against both GI and cardiovascular risk factors, determining if the patient is at risk for gastrointestinal events (Age is more than 65 years. History of peptic ulcers, GI bleeding, or perforations. Concurrent use of ASA, corticosteroids, and/or anticoagulant. High-dose multiple NSAIDs). MTUS also states, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." In reviewing the reports submitted, the treating physician has indicated that the patient is at risk due to usage of NSAIDs with GI upset/reflux. Therefore, the request is medically necessary.