

<b>Case Number:</b>	CM14-0198640		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	04/01/2010
<b>Decision Date:</b>	01/22/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Rehab 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:

This patient sustained an injury on 4/1/10 while employed by [REDACTED]. Request(s) under consideration include Viagra 50mg #10 and IF unit, electrodes, batteries, wipes. Diagnoses include superior Glenoid labrum lesions; shoulder osteoarthritis; brachial neuritis/radiculitis; synovitis/tenosynovitis; and shoulder/arm sprain/strain. Conservative care has included medications, therapy, and modified activities/rest. Hand-written illegible report of 9/16/14 from the provider noted the patient with pain, R. shoulder surgery. Exam showed positive impingement; TTP at AC joint/supraspinatus/ trapezius; decreased range in flex/abd (illegible degrees). Diagnoses include s/p right shoulder scope 9/2/13 repair labral tear/ synovectomy/ chondroplasty. Treatment included medications, scope vs. open rotator cuff repair. The patient remained TTD 6 mos. Hand-written illegible report of 10/17/14 noted shoulder complaints with numbness/tingling right hand. Exam showed shoulder tenderness at trap/SS/SA/AC with flex/abd/IR/ER of 135/ 122/ 65/ 68 degrees; cervical spine tenderness at paraspinals with limited range and positive compression. Treatment was for schedule of right shoulder arthroscopy on 10/22/14; reschedule EMG/NCV and TTD for 10-12 weeks. The request(s) for Viagra 50mg #10 and IF unit, electrodes, batteries, wipes were non-certified on 11/3/14 citing guidelines criteria and lack of medical necessity.

### 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:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Testosterone replacement for hypogonadism (related to opioids) Page(s): 110-111.

**Decision rationale:** This patient sustained an injury on 4/1/10 while employed by [REDACTED]. Request(s) under consideration include Viagra 50mg #10 and IF unit, electrodes, batteries, wipes. Diagnoses include superior Glenoid labrum lesions; shoulder osteoarthritis; brachial neuritis/radiculitis; synovitis/tenosynovitis; and shoulder/arm sprain/strain. Conservative care has included medications, therapy, and modified activities/rest. Hand-written illegible report of 9/16/14 from the provider noted the patient with pain, R. shoulder surgery. Exam showed positive impingement; TTP at AC joint/supraspinatus/trapezius; decreased range in flex/abd (illegible degrees). Diagnoses include s/p right shoulder scope 9/2/13 repair labral tear/ synovectomy/ chondroplasty. Treatment included medications, scope vs. open rotator cuff repair. The patient remained TTD 6 mos. Hand-written illegible report of 10/17/14 noted shoulder complaints with numbness/tingling right hand. Exam showed shoulder tenderness at trap/SS/SA/AC with flex/abd/IR/ER of 135/ 122/ 65/ 68 degrees; cervical spine tenderness at paraspinals with limited range and positive compression. Treatment was for schedule of right shoulder arthroscopy on 10/22/14; reschedule EMG/NCV and TTD for 10-12 weeks. The request(s) for Viagra 50mg #10 and IF unit, electrodes, batteries, wipes were non-certified on 11/3/14. Per guidelines, the etiology of decreased sexual function, a symptom of hypogonadism, is confounded by several factors including natural decreased testosterone that occurs with aging, side-effect of medications such as certain SSRIs and anti-epileptic drugs, comorbid endocrinological and vascular disorders in erectile dysfunction such as conditions of diabetes, and hypertension. There is little information in peer-reviewed literature as to how to treat opioid induced androgen deficiency and long-term safety data of testosterone replacement are not available. Although testosterone replacement may be recommended in limited circumstances in patients taking long-term high-doses of oral and intrathecal opioids, clear exhibition of symptoms and signs of hypogonadism such as gynecomastia must be documented along with low testosterone level identified by testing. Submitted reports have not demonstrated support for this medication without any specific sexual dysfunction complaints, remarkable objective clinical findings, or clinical diagnosis of such. The Viagra 50mg #10 is not medically necessary and appropriate.

**IF unit, electrodes, batteries, wipes:** Upheld

**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  
Transcutaneous Electrotherapy, Interferential Current Stimulation (ICS) Page(s): 115-118.

**Decision rationale:** This patient sustained an injury on 4/1/10 while employed by [REDACTED]. Request(s) under consideration include Viagra 50mg #10 and IF unit, electrodes, batteries, wipes. Diagnoses include superior Glenoid labrum

lesions; shoulder osteoarthritis; brachial neuritis/radiculitis; synovitis/tenosynovitis; and shoulder/arm sprain/strain. Conservative care has included medications, therapy, and modified activities/rest. Hand-written illegible report of 9/16/14 from the provider noted the patient with pain, R. shoulder surgery. Exam showed positive impingement; TTP at AC joint/supraspinatus/trapezius; decreased range in flex/abd (illegible degrees). Diagnoses include s/p right shoulder scope 9/2/13 repair labral tear/ synovectomy/ chondroplasty. Treatment included medications, scope vs. open rotator cuff repair. The patient remained TTD 6 mos. Hand-written illegible report of 10/17/14 noted shoulder complaints with numbness/tingling right hand. Exam showed shoulder tenderness at trap/SS/SA/AC with flex/abd/IR/ER of 135/ 122/ 65/ 68 degrees; cervical spine tenderness at paraspinals with limited range and positive compression. Treatment was for schedule of right shoulder arthroscopy on 10/22/14; reschedule EMG/NCV and TTD for 10-12 weeks. The request(s) for Viagra 50mg #10 and IF unit, electrodes, batteries, wipes were non-certified on 11/3/14. The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not demonstrated here. Submitted reports have not adequately demonstrated functional improvement derived from Transcutaneous Electrotherapy previously rendered. The IF unit, electrodes, batteries, wipes is not medically necessary and appropriate.