

<b>Case Number:</b>	CM15-0168195		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	03/18/2008
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 is a 40-year-old male worker who injured his back on 3-18-2008 due to heavy lifting. The medical records reviewed indicated the injured worker (IW) was treated for paraplegia; polyneuropathy in other diseases classified elsewhere; and aftercare following surgery for injury. The notes from 4-20-2015 stated the IW is retired. An Initial Pain Management Consultation dated 4-3-2015 stated the IW had originally received physical therapy (PT) and epidural steroid injections and subsequently developed bilateral foot drop. Lumbar spinal fusion was performed in 2009, followed by PT and aquatic therapy. The IW had pain with dressing, putting on socks and shoes, doing housework, driving and sleeping through the night; he walked with the assistance of crutches and used leg supports for the foot drop. There was a reference to the IW's medical condition requiring a prescription for Viagra in a medical record review report dated 5- 11-2014. According to the 2-15-2011 urology notes, the IW had been treated for impotence with Levitra in 2007, but after the spinal fusion, it no longer worked. He was diagnosed with "organic impotence on a mixed neurogenic and vascular basis". The urologist believed the urological problem was caused by his sacral nerve root injury. Progress notes dated 6-24-2015 show the IW had pain in the lower back and neck. He had weakness in the legs and bilateral foot drop. He had shown no improvement with the left sacroiliac joint injection or the B12 injection. A request was made for Viagra 100 mg, #30, with 2 refills one tablet daily as needed. The Utilization Review on 8-13-2015 modified the request to allow Viagra 100mg#30 with no refills, as the medication should be prescribed by an appropriate specialist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Viagra 100mg #30, 1 by mouth each day, as needed, with 2 refills:** 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 Aetna Guidelines, Clinical Policy Bulletin: Erectile Dysfunction and Policy Number: 0007.

**Decision rationale:** The 49 year old patient complains of pain in lower back and neck along with weakness in legs and bilateral foot drop, as per progress report dated 06/24/15. The request is for Viagra 100mg #30, 1 by mouth each day, as needed, with 2 refills. The RFA for this case is dated 06/24/15, and the patient's date of injury is 03/18/08. Diagnoses, as per progress report dated 06/24/15, included lumbar spine pain, cervical spine pain, paraplegia, and polyneuropathy. Medications included Norco, Gabapentin and Viagra. The patient is status post lumbar spine surgery in 2009, as per progress report dated 04/03/15. Diagnoses included bilateral L5 and S1 radiculopathy, bilateral chronic foot drop, multilevel neural foraminal stenosis, multilevel lumbar spondylosis, multilevel degenerative disc disease, lumbosacral radicular pain, and chronic pain syndrome. The patient is retired, as per progress report dated 06/24/15. The MTUS, ACOEM and ODG Guidelines do not discuss Viagra specifically. Aetna Guidelines, Clinical Policy Bulletin: Erectile Dysfunction and Policy Number: 0007, require comprehensive physical examination and lab work for a diagnosis of erectile dysfunction including medical, sexual, and psychosocial evaluation. In this case, a prescription for Viagra is only noted in progress report dated 06/24/15. It is not clear if this is the first prescription for this medication or if the patient has taken Viagra before. The treater does not discuss the purpose of the medication or its efficacy. Additionally, there is not documentation of erectile dysfunction. There are no laboratory tests documenting patient's testosterone levels; no medical or psychosocial evaluation as required by the Guidelines. Some guidelines such as the AETNA consider life-enhancing medications not medically necessary. This request is not medically necessary.