

Case Number:	CM15-0083918		
Date Assigned:	05/06/2015	Date of Injury:	10/06/2004
Decision Date:	06/08/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	05/01/2015

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:

The injured worker is a 55-year-old injured worker, with a reported date of injury of 11/12/2008. The diagnoses include chronic right shoulder pain. Treatments to date have included Fentanyl, Norco, methocarbamol, home exercise program, physical therapy, Duragesic patches, Soma, Oxycodone, trigger point injections, chiropractic treatment, a transcutaneous electrical nerve stimulation (TENS) unit, and pool therapy/exercise. The visit note dated 04/09/2015 indicates that the injured worker complained of right shoulder pain. He also complained of left shoulder pain and neck pain. The injured worker reported that there was no change to the character or distribution of the right shoulder pain since the last visit. The intensity levels varied from about 6-8 out of 10 depending on activity. The objective findings include limited range of motion of the right shoulder, increased muscle bulk in the right forearm when compared to the left, and a steady gait. The injured worker will follow-up in two months. The treating physician requested Fentanyl 25mcg #10. It was noted that urine drug tests showed no evidence of abnormal behaviors. On 04/25/2015, Utilization Review (UR) modified the request to Fentanyl 25mcg #5, to allow for weaning. The UR physician noted that there was no evidence that a signed pain agreement was on file at the provider's office or that a pain diary had been recommended and was being kept by the injured worker and reviewed by the prescriber.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cialis 20mg quantity 10 with six refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse: PDESIS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids), Page: 110-111.

Decision rationale: Per MTUS Guidelines, the etiology of decreased sexual function, a symptom of hypogonadism, is confounded by several factors including the natural occurrence of decreased testosterone that occurs with decreased testosterone in aging, certain prescribed medications, in addition to comorbid endocrine and vascular disorders such as diabetes and hypertension as with this patient. There is also 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. There is no specific sexual dysfunction identified by subjective complaints, clinical examination or specific diagnosis to support for use of Cialis. Submitted reports have not adequately demonstrated support for treatment of non-specific sexual problems nor establish medical necessity for treatment of ED as it relates to this chronic injury without identified lumbar spine surgery with spinal cord injury. The Cialis 20mg quantity 10 with six refills is not medically necessary and appropriate.

Dexilant 60mg quantity 90 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk, Pages 68-69.

Decision rationale: Dexilant (Dexlansoprazole) is a delayed-release capsules, a proton pump inhibitor, is a medication for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Lansoprazole namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Dexilant 60mg quantity 90 with one refill is not medically necessary and appropriate.