

Case Number:	CM14-0156386		
Date Assigned:	09/25/2014	Date of Injury:	06/17/2011
Decision Date:	10/29/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/24/2014

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 Family Practice, and is licensed to practice in Ohio, North Carolina and Virginia. 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 injured worker is a 27 year old male who sustained a back injury while twisting and lifting 60 pounds on 06-07-2011. He complains of pain radiating down both lower extremities with associated numbness and tingling. The physical exam reveals diminished lumbar range of motion, tenderness over the facet joints, and a normal lower extremity neurologic exam. An MRI revealed lumbar disc herniation L4-L5 and L5-S1 without any central canal or foraminal stenosis. A lumbar epidural steroid injection was ineffective. He has been taking Norco for pain and has been complaining of erectile dysfunction. The diagnoses are sciatica, lumbar disc displacement without myelopathy, unspecified major depression, and anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Viagra 25mg: 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. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Audio Digest-Family Practice, Volume 6 Issue 40, Hypogonadism in Older Men.

Decision rationale: The mechanism by which opioids cause erectile dysfunction is thought to be centrally mediated suppression of testosterone levels. An endocrine evaluation and/or testosterone levels should be considered in men who are taking long term, high dose oral opioids or intrathecal opioids and who exhibit symptoms or signs of hypogonadism, such as gynecomastia. If needed, testosterone replacement should be done by a physician with special knowledge in this field given the potential side effects such as hepatomas. There are multiple delivery mechanisms for testosterone. Hypogonadism secondary to opiates appears to be central, although the exact mechanism has not been determined. The evidence on testosterone levels in long-term opioid users is not randomized or double-blinded, but there are studies that show that there is an increased incidence of hypogonadism in people taking opioids, either intrathecal or oral. There is also a body of literature showing that improvement in strength and other function in those who are testosterone deficient who receive replacement. This appears to be more pronounced than in patients taking oral opiates than in patients receiving intrathecal opioids and this difference seems to be related to differences in absorption. The etiology of decreased sexual function, a symptom of hypogonadism, is confounded by several factors including the following: (1) The role of chronic pain itself on sexual function; (2) The natural occurrence of decreased testosterone that occurs with aging; (3) The documented side effect of decreased sexual function that is common with other medications used to treat pain (SSRIs, tricyclic antidepressants, and certain anti-epilepsy drugs); & (4) The role of comorbid conditions such as diabetes, hypertension, and vascular disease in erectile dysfunction. There is little information in peer reviewed literature as to how to treat opioid induced androgen deficiency. Efficacy of testosterone treatment: erectile dysfunction: younger men with clearly low testosterone had clear benefit from testosterone therapy; benefit in older men lower and questionable; little to no benefit in men with low-normal testosterone; libido: clear benefit seen in most studies; meta-analyses generally show moderate treatment effect on libido, inconsistent effects on erectile function, and no effects on other realms of sexual function (eg, orgasm, ejaculation); effects on response to phosphodiesterase-5 inhibitors (e.g., sildenafil [Viagra], tadalafil [Cialis]) inconsistent; In this instance, the root of the erectile dysfunction for the injured worker is likely to be low testosterone as a consequence of opioid therapy. It is recommended that a morning testosterone level is drawn or that the injured worker is referred to an endocrinologist. Response to medications such as Viagra is inconsistent for opioid induced hypogonadism. Therefore, Viagra 25 mg #10 is not medically necessary.