

Case Number:	CM13-0024968		
Date Assigned:	11/20/2013	Date of Injury:	04/16/2001
Decision Date:	01/30/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 is a male patient with a date of injury of April 16, 2001. A utilization review determination dated August 26, 2013 recommends noncertification of testosterone level and testosterone replacement. A progress report dated August 22, 2013 identifies subjective complaints stating, "the patient returns reporting continued high severity back and left leg pain and weakness. He also complains of low energy, impotence, and depression and states he has not had a testosterone level, liver or kidney function drawn for years. He received an incomplete prescription fill of MSContin last month because the pharmacy assured had insufficient stock to completely fill the order leaving the patient short." The note goes on to state, "patient is ready to continue tapering off narcotics." Physical examination identifies, "palpation reveals 2+ tenderness from L45 to the lumbosacral junction on the right and left sides with multiple trigger points. Range of motion - not tested because of pain with movement. Straight leg raising is positive on the left at 30°." Current diagnoses include status post multiple thoracic and lumbar fractures requiring 2 fusions from T11 to L2 with radiculopathy. The note goes on to identify a diagnosis of, "erectile dysfunction from hypogonadism/low testosterone, pain and spinal injury." The treatment plan identifies, "this patient with low energy and libido is on chronic opioids which are known to cause diminished testosterone levels causing impotence and decreased libido." The note goes on to state, "for the above reasons, we request authorization for blood testosterone level testing and testosterone replacement if necessary." The note indicates that the patient is using, "methadone 5 mg today and continue the MS IR 30 mg 3 PO Q8 hours then begin the MSContin taper reduction as previously outlined." A note dated September 27, 2012 states, "██████████ continues to complain of impotence. Lab tests including testosterone were ordered by ██████████ and he was f

IMR ISSUES, DECISIONS AND RATIONALES

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

Testosterone Level Test: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 110-111. Decision based on Non-MTUS Citation J Adv Pharm Technol Res. 2010 Jul-Sep; 1(3): 297-301

Decision rationale: Regarding the request for testosterone level test, Chronic Pain Medical Treatment Guidelines state that testosterone replacement is recommended for patients taking high dose long-term opioids with documented low testosterone levels. Guidelines go on to state that routine testing of testosterone levels in men taking opioids is not recommended; however, 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. An article in the Journal of Advanced Pharmacologic Technology states that there are numerous causes of hypogonadism. They go on to indicate that a thorough history and physical is indicated in an attempt to identify the underlying etiology of hypogonadism. Within the documentation available for review, it is unclear exactly how long the patient has had signs of impotence and decreased libido. There is no statement indicating whether these symptoms occurred before or after the industrial injury. Additionally, there is no documentation of a thorough history and physical examination directed towards the patient's endocrine function. Additionally, the requesting physician has indicated that the patient wishes to taper off narcotics. If the patient's hypogonadism is a result of the narcotics, it would be expected to resolve shortly after the discontinuation of the narcotics. This may eliminate the need for testosterone replacement. In the absence of clarity regarding these issues the currently requested testosterone level test is not medically necessary.

Testosterone Replacement: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 110-111. Decision based on Non-MTUS Citation J Adv Pharm Technol Res. 2010 Jul-Sep; 1(3): 297-301.

Decision rationale: Regarding the request for testosterone replacement, Chronic Pain Medical Treatment Guidelines state that testosterone replacement is recommended for patients taking high dose long-term opioids with documented low testosterone levels. Guidelines go on to state that routine testing of testosterone levels in men taking opioids is not recommended; however, 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. Due to risk of hepatoma, guidelines recommend that testosterone replacement should be done by a physician with special knowledge in the field. An article in the Journal of Advanced Pharmacologic Technology states that there are numerous causes of hypogonadism. They go on to indicate that a thorough history and physical is indicated in an attempt to identify the underlying etiology of hypogonadism. Within the documentation available for review, it is unclear exactly how long the patient has had signs of impotence and decreased libido. There is no statement indicating whether these symptoms occurred before or after the industrial injury. Additionally, there is no documentation of a thorough history and physical examination directed towards the patient's endocrine function. Additionally, the requesting physician has indicated that the patient wishes to taper off narcotics. If the patient's hypogonadism is a result of the narcotics, it would be expected to resolve shortly after the discontinuation of the narcotics. This may eliminate the need for testosterone replacement. Furthermore, there is no indication that the physician prescribing the testosterone replacement has special knowledge in the field, as recommended by guidelines. In the absence of such documentation, the currently requested testosterone replacement is not medically necessary