

<b>Case Number:</b>	CM13-0028263		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	08/09/2012
<b>Decision Date:</b>	04/09/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 Pain Management has a subspecialty in Disability Evaluation 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:

Patient is a 27 year old male who worked as a catering attendant for [REDACTED]. According to the patient, available medical records and the pain diagram and questionnaire filled out by the patient, he states on August 9, 2012, while at work, lifting multiple kegs of beer and moving cakes and carts all day he developed back pain, which slowly traveled down into the right leg. Treated conservatively with chiro and rest, the patient did not stabilize as expected. No history of back pain. On October 16, 2012 an MRI of the lumbar spine was completed and showed two levels of disc pathology. Patient currently complains of low back pain, aching, burning. Numbness, pins and needles with burning and aching, traveling down into the right leg posterior thigh into the ankle, with some pins and needles into the left foot, stabbing across the back, going towards the hips and aching into the knees. There is stiffness in the upper back, weakness in the leg and lower back. Give way of leg and back. No swelling, grinding, [REDACTED] locking, and no bowel or bladder changes. Pain goes up to 7/10 and has a multitude of feelings from dull, sharp, burning, throbbing in the leg, mostly pins and needles with numbness and tingling. Patient has a medical history of diabetes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Androderm patch 4% (apply daily):** Overturned

**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 and 127. Decision based on Non-MTUS Citation The Impact of Opioids on the Endocrine System By NATHAN I E L K AT Z, M D, MS "Pain Management Rounds" 2005 Volume 1, Issue 9 MGH PAIN CENTER www.painmanagementrounds.org.

**Decision rationale:** CA-MTUS (Effective July 18, 2009) on page 110 section on Testosterone replacement for hypogonadism related to opioids. Recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. Hypogonadism has been noted in patients receiving intrathecal opioids and long-term high dose opioids. 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, 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. (Nakazawa, 2006) (Page, 2005) (Rajagopal, 2004) 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. Hypogonadism secondary to opiates appears to be central, although the exact mechanism has not been determined. (Abs, 2000) (Roberts, 2002) (Roberts, 2000) 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 peerreviewed literature as to how to treat opioid induced Final Determination Letter for IMR Case Number [REDACTED] androgen deficiency. Long-term safety data of testosterone replacement (overall): Not available. Cardiovascular risk: There have been no large randomized controlled trials to evaluate the cardiovascular risk associated with long-term testosterone use, although current studies weakly support that there is no association with important cardiovascular effects. (Haddad 2007) Osteoporosis: The extent to which testosterone can prevent and treat osteoporosis remains unclear. (Tracz 2006) (Isidori, 2005). [REDACTED]