

Case Number:	CM13-0037537		
Date Assigned:	12/18/2013	Date of Injury:	09/07/1993
Decision Date:	04/09/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/23/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 September 7, 1993. A utilization review determination, dated October 9, 2013 recommends non-certification of Testim (testosterone). The non-certification is due to lack of documentation of testosterone level, findings of hypogonadism, physical examination supporting such a diagnosis, and discussion regarding side effects. A progress report, dated October 23, 2013 includes subjective complaints of severe low back pain due to lumbar degeneration. The note also indicates that the patient has "severe hypogonadism secondary to his current chronic opioid use." Current medications include Testim (testosterone), fentanyl, and others. The past medical history includes hypogonadism. A review of systems is negative. The diagnoses include pain in the ankle and foot, pain in the lower leg, lumbago, pain in the thoracic spine, brachial neuritis or radiculitis, cervicgia, and postlaminectomy syndrome in the cervical region. A progress report, dated November 16, 2011 includes a treatment plan stating that the patient will be sent out for a testosterone level due to the well-documented possibility of hypogonadism secondary to opioid use. A progress note, dated 2010 recommends continuing testosterone use for hypogonadism secondary to opiate use.

IMR ISSUES, DECISIONS AND RATIONALES

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

TESTIM 50MG/5GM GEL (TESTOSTERONE) X 2 TUBES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Testosterone replacement for hypogonadism (related to opioids), pages 110-111, and the Journal of Advanced Pharmacologic Technology Res. 2010 Jul-Sep; 1(3): 297-301.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that testosterone replacement is recommended for patients taking high dose long-term opioids, with documented low testosterone levels. The Guidelines also indicate 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, the 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, there is no documentation of a thorough history and physical examination directed towards the patient's endocrine function, no subjective complaints supporting a diagnosis of hypogonadism, and no lab reports supporting a diagnosis of hypogonadism. Furthermore, there is no indication that the physician prescribing the testosterone replacement has special knowledge in the field (as recommended by guidelines), has been monitoring the patient's testosterone level, and has discussed side effects or risks of long term use with the patient. In the absence of such documentation, the currently requested Testim testosterone replacement is not medically necessary.