

Case Number:	CM13-0041399		
Date Assigned:	12/20/2013	Date of Injury:	10/02/2002
Decision Date:	02/11/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/14/2013

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 ABFP 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:

37 yr. old male claimant sustained an injury due to a motor vehicle accident on 10/2/02, which resulted in back pain. His pain quality included stabbing, burning and constant throbbing. The symptoms were aggravated by heat, standing, laying or walking. His pain was controlled by TENS unit, Valium, Soma, and Norco. The claimant had noted his sex life to be deteriorated due to pain. He was noted to have testicular "hypofunction" with a total testosterone level on 2/1/13 of 240 (normal is 250-1100 ng/dl) and was placed on testosterone injections as well as testosterone cream. The cream was increased monthly based on libido. There was no mention of response to pain or sex life. A total testosterone level on 8/12/13 was low at 183 ng/dl. A subsequent request was made to use 1 tube of compounded testosterone powder, ethoxy liquid and versabase cream 30 grams between 9/25/2013 and 11/9/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 tube of compounded testosterone powder, ethoxy liquid and versabase cream 30 grams between 9/25/2013 and 11/9/2013: 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 Page(s): 110-111.

Decision rationale: Testosterone is 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 peer-reviewed literature as to how to treat opioid induced androgen deficiency. Sexual function: Current trials of testosterone replacement in patients with documented low testosterone levels have shown a moderate nonsignificant and inconsistent effect of testosterone on erectile function, a large effect on libido, and no significant effect on overall sexual satisfaction. (Bolona, 2007) (Isidori, 2005) The reasoning behind providing testosterone was to improve sex life. There was no clear documentation of prior testosterone use providing benefit. In addition, according to the MTUS guidelines it has not shown consistent benefit for sexual function. A physician should also perform the replacement with special knowledge