

Case Number:	CM14-0011381		
Date Assigned:	02/21/2014	Date of Injury:	07/07/2009
Decision Date:	10/01/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/28/2014

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 Internal Medicine, ABIM 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 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 31 year old male who suffered a motor vehicle accident in 2009 and subsequently had a subdural hematoma that was surgically evacuated. He has problems related to fatigue, depression, anxiety and cognitive slowing since that time. His libido is also diminished. The patient's physician requested Follicle Stimulating Hormone (FSH), Prolactin and testosterone levels in September 2013. These showed normal Prolactin and FSH levels. The testosterone level was 389 units (normal is 300-900). The concern of the physician is for post head trauma associated hypopituitarism with hypogonadism. There was also a request made for Thyroid Stimulating Hormone (TSH), T3 and T4 measurement. An appointment with the endocrinologist had been accomplished as of 4/2014 but the report is not available to the reviewer. Current request is also for LH, FSH, T3, T4 and TSH as well as testosterone and prolactin. Vitamin D levels have also been requested. The request for Thyroid Stimulating Hormone (TSH) had been previously approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laboratory Test - FSH: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Ed. 2010. McGraw Hill.

Decision rationale: The endocrinologist's consultation report is not available for review in provided medical records. The requesting physician's medical records do not indicate that the patient has any abnormalities other than fatigue and depression with poor mental or cognitive functioning. Although hypogonadism would potentially exacerbate or cause these symptoms, hyperprolactinemia would cause feminization of the male breasts with gynecomastia. This finding is not presented. Some patients only experience tenderness of the nipples and sub-areolar nipple tissue or a slight discharge from the nipples but this is not noted. As such, there is no evidence that the patient indeed has hyperprolactinemia clinically. If the prolactin level is expected to be high due to hypopituitarism, then other signs and symptoms of hypopituitarism should exist, such as hypothyroidism related cold intolerance, weight gain, loss and thinning of hair, constipation and psycho-motor retardation, but other than the mental slowing (which is common in post head trauma patients) nothing else is noted in the record. Further, hypopituitarism should result in hypoglycemia due to loss of growth hormone activity and changes of the skin, muscle atrophy and so on, due to loss of growth hormone activity. Additionally, hypopituitarism also would result in hypothalamic hypogonadism which would cause muscle atrophy, increase in fat mass, muscle strength diminution and anemia, none of which are described in the clinical records. Finally, the patient has normal levels of testosterone with normal suppression of FSH and normal levels of Prolactin documented in 9/2013. Since that time, no changes have occurred clinically. The patient's complaints are well explained by the presence of post cranial trauma state. Overall, the preponderance of clinical documentation and laboratory evidence does not suggest hypopituitarism. An alternative diagnosis exists. FSH, prolactin and testosterone levels were normal previously and no changes have ensued clinically since then. TSH has been approved for measurement. Therefore, the request for laboratory test - FSH is not medically necessary and appropriate.

Laboratory Test - Vitamin D: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: HPIM, 18th Ed, McGraw Hill, 2010.

Decision rationale: The prevalence of hypovitaminosis D is considerable in the asymptomatic population and although the evidence in a 30 year old otherwise healthy male (with the exception of post cranial trauma syndrome) is lacking specifically, there is considerable evidence that vitamin D plays an important role in bone health. Hypovitaminosis D should be treated in every case where it is found, merely from a nutritional standpoint. Given that the incidence of hypovitaminosis D is very high, it is reasonable to perform a one time screening for Vitamin D levels in this male who is asymptomatic from a bone health standpoint. Therefore, the request is approved.

Laboratory Test - Prolactin: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Ed. 2010. McGraw Hill.

Decision rationale: The endocrinologist's consultation report is not available for review in provided medical records. The requesting physician's medical records do not indicate that the patient has any abnormalities other than fatigue and depression with poor mental or cognitive functioning. Although hypogonadism would potentially exacerbate or cause these symptoms, hyperprolactinemia would cause feminization of the male breasts with gynecomastia. This finding is not presented. Some patients only experience tenderness of the nipples and sub-areolar nipple tissue or a slight discharge from the nipples but this is not noted. As such, there is no evidence that the patient indeed has hyperprolactinemia clinically. If the prolactin level is expected to be high due to hypopituitarism, then other signs and symptoms of hypopituitarism should exist, such as hypothyroidism related cold intolerance, weight gain, loss and thinning of hair, constipation and psycho-motor retardation, but other than the mental slowing (which is common in post head trauma patients) nothing else is noted in the record. Further, hypopituitarism should result in hypoglycemia due to loss of growth hormone activity and changes of the skin, muscle atrophy and so on, due to loss of growth hormone activity. Additionally, hypopituitarism also would result in hypothalamic hypogonadism which would cause muscle atrophy, increase in fat mass, muscle strength diminution and anemia, none of which are described in the clinical records. Finally, the patient has normal levels of testosterone with normal suppression of FSH and normal levels of Prolactin documented in 9/2013. Since that time, no changes have occurred clinically. The patient's complaints are well explained by the presence of post cranial trauma state. Overall, the preponderance of clinical documentation and laboratory evidence does not suggest hypopituitarism. An alternative diagnosis exists. FSH, prolactin and testosterone levels were normal previously and no changes have ensued clinically since then. TSH has been approved for measurement. Therefore, the request for laboratory test - Prolactin is not medically necessary and appropriate.

Laboratory Test - Serum LH/FSH: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Principles of Internal Medicine, 18th Ed. 2010. McGraw Hill.

Decision rationale: The endocrinologist's consultation report is not available for review in provided medical records. The requesting physician's medical records do not indicate that the

patient has any abnormalities other than fatigue and depression with poor mental or cognitive functioning. Although hypogonadism would potentially exacerbate or cause these symptoms, hyperprolactinemia would cause feminization of the male breasts with gynecomastia. This finding is not presented. If the prolactin level is expected to be high due to hypopituitarism, then other signs and symptoms of hypopituitarism should exist, such as hypothyroidism related cold intolerance, weight gain, loss and thinning of hair, constipation and psycho-motor retardation, but other than the mental slowing (which is common in post head trauma patients) nothing else is noted in the record. Additionally, hypopituitarism also would result in hypothalamic hypogonadism which would cause muscle atrophy, increase in fat mass, muscle strength diminution and anemia, none of which are described in the clinical records. Finally, the patient has normal levels of testosterone with normal suppression of FSH and normal levels of Prolactin documented in 9/2013. Since that time, no changes have occurred clinically. The patient's complaints are well explained by the presence of post cranial trauma state. Therefore, the request for laboratory test - Serum LH/FSH is not medically necessary and appropriate.