

Case Number:	CM15-0132178		
Date Assigned:	07/20/2015	Date of Injury:	12/01/2012
Decision Date:	09/23/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, North Carolina
Certification(s)/Specialty: Family Practice

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 52 year old male injured worker suffered an industrial injury on 12/1/2012. The diagnoses included traumatic brain injury with multiple complications and protracted hospital stay. The diagnostics included brain and cervical magnetic resonance imaging. The treatment included medications and surgeries. On 6/15/2015 the transitional care living center where the injured worker resided had a team conference that indicated the injured worker had multiple deficits in mobility, visual deficits, impairments in independent personal safety and care with cognitive impairments. The injured worker had not returned to work. The requested treatments included Testosterone gel 1.02% with 6 refills and Testosterone level after 2 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Testosterone gel 1.02% with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism Page(s): 110-111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism Page(s): 110.

Decision rationale: CA MTUS Guidelines state that testosterone replacement for hypogonadism is recommended in limited circumstances for patients taking high-dose opioids with documented low testosterone levels. In this case, there is an absence of objective findings and symptoms of hypogonadism documented. There is no record of any investigation to determine the cause of hypogonadism. Therefore, due to the lack of documentation, the request for testosterone gel is not medically necessary or appropriate at this time.

Testosterone level after 2 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/8875519>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement therapy for hypogonadism Page(s): 110.

Decision rationale: In this case there is also a request for a testosterone level 2 weeks after starting testosterone gel therapy. Since the testosterone replacement has not been recommended, the 2-week level is no longer necessary. In this patient, there is a lack of objective findings and symptoms consistent with hypogonadism. There is also no evidence of investigation as to the cause of hypogonadism. It is also questionable as to whether 2 weeks is an adequate amount of time perform performing another testosterone level. Therefore, the request is not medically necessary or appropriate.