

Case Number:	CM15-0195378		
Date Assigned:	10/09/2015	Date of Injury:	01/18/2006
Decision Date:	11/18/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	10/05/2015

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: Arizona, California

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:

This injured worker is a 48 year old male, who sustained an industrial injury on 01-18-2006. The injured worker was diagnosed as having postlaminectomy syndrome of lumbar region, degenerative of lumbar intervertebral disc, lumbar radiculopathy and chronic pain syndrome. On medical records dated 08-14-2015 and 06-24-2015, the subjective complaints were noted as low back pain. Pain was rated at 7 out of 10. Pain radiates to lower extremities that is associated with numbness, tingling, weakness, heaviness, right foot drop and unstable gait without assistance. Objective findings were paralumbar spasm was noted as 2+ tenderness to palpation on the right. Atrophy noted in the quadriceps. Straight leg raise was positive on the left and range of motion of the spine was limited due to pain. Treatments to date included medication, physical therapy, acupuncture, and chiropractic therapy. Current medications were listed as Roxicodone and Nexium. The Utilization Review (UR) was dated 08-31-2015. A Request for Authorization was dated 08-17-2015. The UR submitted for this medical review indicated that the request for Androgel 1.62%, Qty 1 with no refills was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Androgel 1.62%, Qty 1 with no refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, pg 129.

Decision rationale: Androgel contains topical testosterone. According to the guidelines, long-term opioid use can lead to hypogonadism and low testosterone. Replacement is appropriate in those with low testosterone levels. The physician letter on 9/17/15 indicates the claimant has hypertestosteronism (rather than hypo). Exam findings of hypogonads or low testosterone level was not provided. The use of Androgel was not justified and the request is not medically necessary.