

Case Number:	CM15-0083566		
Date Assigned:	05/05/2015	Date of Injury:	08/11/2005
Decision Date:	06/04/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	05/01/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54-year-old male, who sustained an industrial injury on 08/11/2005. He reported back pain that radiated down his right lower extremity. Treatment to date has included x-rays, chiropractic care, medications, spine surgery and electrodiagnostic testing. According to the most recent progress report submitted for review and dated 02/16/2015, the injured worker suffered from intractable pain affecting his back and legs and which affected his walking and activities. He had previously failed all conservative and surgical options and also failed to improve from a spinal cord stimulator system. He was unable to tolerate a functional restoration program due to inability to sit for more than 15 to 20 minutes at a time. He had been relying on medications to control his chronic intractable pain and keep him functional. Pain was rated 8 to 9 at its worst and 4 to 5 with medications. Medications helped him to get out of bed and perform daily activities. Current medications included MS Contin, Cymbalta, Norco, Soma and Elavil. Diagnoses included status post L4-5 and L5-S1 lumbar fusion with failed back syndrome, lumbar disc desiccation L1-2 and L2-3, lumbar stenosis at L3-4, lumbar spine hypertrophic facet joint, lumbar radiculopathy, failed spinal cord stimulator trial, chronic pain condition, urinary incontinence, chronic hypertension, chronic reactive clinical depression secondary to chronic pain syndrome, low testosterone secondary to chronic pain and chronic opioid regimen and dental caries possibly secondary to chronic narcotic use. Treatment plan included MS Contin, Norco and Soma. Urine drug screening one month prior was consistent with prescribed medications. Currently under review is the request for Fortesta gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fortesta gel #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/fortesta.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Testosterone replacement for hypogonadism Page: 110-111.

Decision rationale: Per guidelines, the etiology of decreased sexual function, a symptom of hypogonadism, is confounded by several factors including natural decreased testosterone that occurs with aging, side effect of medications such as certain SSRIs and anti-epileptic drugs, comorbid conditions of diabetes, and hypertension and vascular diseases. Although testosterone replacement may be recommended in limited circumstances in patients taking long-term high-doses of oral and intrathecal opioids, clear exhibition of symptoms and signs of hypogonadism such as gynecomastia must be documented along with low testosterone level identified by testing. Submitted reports have not demonstrated support for this medication. The Fortesta gel #1 is not medically necessary and appropriate.