

Case Number:	CM14-0133286		
Date Assigned:	09/18/2014	Date of Injury:	08/18/2002
Decision Date:	10/17/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/20/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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:

This is a 65-year-old male patient who sustained a remote industrial injury on 08/18/2002. Diagnoses include low back pain, lumbosacral facet arthropathy, L5-S1 disc protrusion with bilateral lateral recess stenosis, right L5 radiculopathy, bilateral sacroiliac ligament and this up with the, cervical spondylosis with right C3 neuroforaminal stenosis, and left knee arthralgia. Previous treatment has included transcutaneous electrical nerve stimulation, left knee partial medial meniscectomy in 1999, left knee partial lateral meniscectomy in 2002, left knee partial medial meniscectomy in 2004, L4-5 discectomy and fusion and posterior L4-L5 decompression and posterolateral instrumented fusion on 02/22/12. The patient has had knee injections as well as medications including Fentanyl 12g/hour patch, Tramadol 50 mg 2 tablets 2-3 times per day, Oxycodone/APAP 10/3/25 mg 1-2 tablets every day as needed, Tizanidine 4 mg 1/4 to 1 tablet 4 times daily as needed and Baclofen 10 mg 1-2 tablets twice daily as needed, as well as Testosterone Cypionate 300 mg/mL injection every 2 weeks. A request for Testosterone Cypionate 300 mg/mL injection every 2 weeks was not certified a utilization review on 07/29/14 with the reviewing physician noting that total testosterone was checked on 03/08/13 and found to be normal with testosterone supplementation; however, no recent updates of testosterone levels were noted in the past year to substantiate ongoing need for supplementation. Progress note dated 07/02/14 indicates the patient presented with low back pain rated at 4-5/10 with fentanyl and tramadol. Left knee pain was rated as 0/10. It was noted the patient has persistent fatigue, loss of stamina, and decreased libido while on narcotic analgesic medications. Total testosterone was checked on 03/08/13 and found to be normal with testosterone supplementation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Testosterone Cypionate 200mg/ml 1.0ml vial (200mg) IM injection q2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 110-111.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Testosterone replacement for hypogonadism (related to opioids)

Decision rationale: The ODG guidelines regarding testosterone replacement for hypogonadism (related to opioids) states "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." In this case, it is noted the patient has been on long-term high-dose opioids and has a history of low testosterone. The patient has been prescribed testosterone supplementation. It was noted in the prior review that the patient total testosterone was checked on 03/08/13 and found to be normal with testosterone supplementation; however, no recent updates of testosterone levels were noted in the past year to substantiate ongoing need for supplementation. Despite extensive records provided with this review dating back to 2004, documentation still does not contain recent laboratory studies indicating testosterone levels have been checked within the past year to substantiate ongoing use of testosterone supplementation. Without evidence of hypogonadism or laboratory studies documenting testosterone levels, testosterone supplementation is not considered medically necessary. Therefore, the request for Testosterone Cypionate 300 mg/mL injection every 2 weeks is not medically necessary.