

<b>Case Number:</b>	CM14-0217766		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	08/25/2006
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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. 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 53 year old male was injured on 08/25/2006 while being employed. He complains of low back pain, intermittent right leg pain from knee to calf, intermittent left neck pain about three times a week associated with a left temporal headache. He was noted to have episodes of loss of urine. Documentation also states he has difficulty with erections and urination. On physical examine he was noted to have tenderness on palpation over bilateral paravertebral musculature, a decreased range of motion with pain, positive straight leg raise test. He was noted to take Norco 10/325mg. Diagnoses were: lumbar or thoracic radiculopathy, sacroilitis, cervical spondylosis, lumbar spondylosis, post laminectomy lumbar and myofascial pain syndrome. Treatment plan included Refill of Norco 10/325 mg BID #60, and serum testosterone level due to the injured worker may have a low testosterone due to chronic opioid use, having difficulty with erection and urination, will check hormone first before referring to urologist and/or endocrinologist. His work status was noted clearly documented. The Utilization Review dated 12/11/2014 non-certified the request for testosterone, serum test as not medically necessary. The reviewing physician referred to CA MTUS Chronic Pain Medical Treatment Guidelines for recommendations.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Testosterone, Serum Test:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Pag.

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

**Decision rationale:** Testosterone, Serum Test is not medically necessary. According to CA MTUS guidelines, Testosterone is "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. There are multiple delivery mechanisms for testosterone. Hypogonadism secondary to opiates appears to be central, although the exact mechanism has not been determined. The evidence on testosterone levels in long-term opioid users is not randomized or double-blinded, but there are studies that show that there is an increased incidence of hypogonadism in people taking opioids, either intrathecal or oral. There is also a body of literature showing that improvement in strength and other function in those who are testosterone deficient who receive replacement. (Nakazawa, 2006) (Page, 2005) (Rajagopal, 2004) This appears to be more pronounced than in patients taking oral opiates than in patients receiving intrathecal opioids, and this difference seems to be related to differences in absorption." The patient is not on high dose opioids. Although long term opioid use is documented, Norco 10/325 mg BID is not consider high dose. Low testosterone is most likely seen in patients on long term, high dose, controlled release opioids like Morphine and Oxycontin.