

<b>Case Number:</b>	CM15-0072928		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	02/16/2007
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 70 year old male, who sustained an industrial injury on 2/16/07. Initial complaints were not noted. The injured worker was diagnosed as having postlaminectomy syndrome lumbar; sciatica; disorders of the sacrum; long term use of medications. Treatment to date has included status post right hip replacement (2009); status post anterior/posterior L2-L3 and L3-L4 interbody fusion (2009); spinal cord stimulator; MRI lumbar spine (7/5/12); urine drug screening; medications. Currently, the PR-2 notes dated 12/1/14 the injured worker complains of persistent low back pain and right hip pain. He uses a spinal cord stimulator for his back pain and radiculopathy. He has had his hip replaced and continues to have right hip pain as well as left hip pain. He is using a 20mcg per hour U trans-patch. He is interested in seeing if the patch is as effective as he once thought it was and is interested in decreasing the dosage. Currently his medications are prescribed as; Forestsra 10mg gel pump, Butrans 20mcg/hr patch, Naproxen 550mg, Simvastatin 10mg, Zolpidem Tartrate 10mg, Effexor 75mg and Flexeril 5mg. On this date, the provider's treatment plan added a ThermaCare heat wrap for his right hip and a decrease in the Butrans on a trial basis to 15mcg/hr instead of the 20mcg/hr, as well as continues a home exercise program. Subsequent PR-2 notes do document the requested testosterone medication request but these are after- the- fact. There is no medical documentation for the date of service 4/6/15. The provider requested retrospective Request for Testosterone 10mg #240 (DOS: 4/6/2015).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Request for Testosterone 10mg #240 (DOS: 4/6/2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R Page(s): 110 of 127.

**Decision rationale:** The MTUS notes that testosterone replacement for hypogonadism (related to opioids) is recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. 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. This is an oral testosterone, which is highly ineffective because the liver metabolizes most of it in the first pass through the liver. In this case, as levels are to be checked, and the other adverse levels that can result from testosterone, such as polycythemia, are not identified, I would concur that a regimen of oral testosterone is not prudent because it is largely an ineffective formulation, and other criteria are met.