

Case Number:	CM14-0082996		
Date Assigned:	07/21/2014	Date of Injury:	05/16/2001
Decision Date:	09/22/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/04/2014

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 and is licensed to practice in Illinois. 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:

The injured worker is a 49-year-old male who reported an injury on 05/16/2001. The mechanism of injury was the injured worker was lifting two 75 pound boxes of paper. Prior treatments include an implantation of a spinal cord stimulator and spine surgery. The injured worker underwent myelogram of the lumbar spine and cervical spine on 04/19/2012. The injured worker underwent a CT with a myelogram. The injured worker underwent a CT of the thoracic and lumbar spine. Additionally, the injured worker underwent a CT of the lumbar spine without contrast. The documentation of 04/14/2014 revealed the injured worker was asking for a refill of his oral medications. The injured worker's pain was noted to be constant with mild intensity, with a slight improvement in pain in the right hip, right knee and throughout his right buttocks. The injured worker's medications were noted to include levorphanol 2 mg 1 tablet three times a day, Norco 7.5/325 mg 1 tablet twice a day, Lyrica 75 mg 1 tablet 3 times a day, Zolof 50 mg daily, Cialis 10 mg as needed, hydrochlorothiazide 25 mg daily, Androgel, lidocaine cream as needed, Colace 100 mg 1 to 3 tablets at bedtime, Cymbalta 60 mg per day, and Remeron 15 mg oral dissolving tablets one half to 1 tablet at night. Discontinued medications were noted include OxyContin 10 mg 1 tablet 3 times a day and baclofen 10 mg 1 3 times a day. The physical examination revealed the injured worker had a slightly antalgic gait. The faber test was positive for pain just posterior to the greater trochanteric bursa on the left lower extremity. Sensation was decreased all throughout the left lower extremity to soft touch. The injured worker had tenderness to palpation over the right iliotibial band. The treatment plan included medications: levorphanol 2 mg 1 tablet by mouth 3 times a day, Norco 7.5/325 mg 1 tablet by mouth twice a day as needed with no refills. There was a detailed Request for Authorization with the requested medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrochlorothiazide 25 mg: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/hctz.html>.

Decision rationale: Per drugs.com, hydrochlorothiazide is utilized for fluid retention, and is used to treat high blood pressure. The clinical documentation submitted for review failed to indicate the duration of use. There was a lack of documentation indicating the efficacy for the medication. The injured worker's blood pressure readings were not supplied for review. The request as submitted failed to indicate the frequency and the quantity of medication being prescribed. Given the above, the request for Hydrochlorothiazide 25 mg is not medically necessary.

Lidocaine Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 112.

Decision rationale: The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There was a lack of documentation indicating the duration of use. There was a lack of documentation of a failure of first line therapy. There was a lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency, quantity, and strength for the requested cream. Given the above, the request for Lidocaine Cream is not medically necessary.