

Case Number:	CM14-0106352		
Date Assigned:	07/30/2014	Date of Injury:	06/07/2007
Decision Date:	08/29/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/09/2014

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 & Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Oklahoma. 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 60-year-old male who reported an injury on 06/07/2007, due to an unspecified mechanism of injury. On 07/01/2014, he reported problems with engaging in intercourse and maintaining an erection. A physical examination revealed no tenderness, no calf tenderness, no edema, pulses were palpable, straight leg raising was limited to 20 degrees on the right and 55 degrees on the left with pain only on the right. Peroneal sensation and sensation in the bilateral L5 and S1 dermatomes were intact; bulbocavernosus reflex was absent; knee and ankle jerks were absent; and the extensors and flexors of the bilateral ankles and great toes were 5/5. Surgical history was not provided in the medical records. Diagnostic studies and relevant diagnostics were not provided in the medical records either. Medications included vitamins and food supplements, Medrox ointment, omeprazole, gabapentin, tizanidine, tramadol, glucosamine with chondroitin and vitamin D gel. Past treatments were not provided in the medical records. The treatment plan was for retro Xolido 2% cream. The Request for Authorization and rationale for treatment were not provided in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO MED: XOLIDO 2% CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: The request for retro med Xolido 2% cream is not medically necessary. The Request for Authorization form and rationale for treatment were not provided in the medical records. The most recent examination performed on 07/01/2014 was a urology examination, which showed that the injured worker was having trouble maintaining an erection. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Based on the clinical information submitted for review, the patient did have findings of decreased sensation at the L5 and S1 dermatomes. However, it is unknown how long the injured worker had been using this medication. In addition, there was no clear rationale for the use of this medication or a record of when it was prescribed. The request was noted to be retrospective, and without knowledge of when it was prescribed, the reason it was prescribed, and evidence of functional improvement with treatment, the request would not be supported. In addition, the requesting physician failed to mention the frequency of the medication within the request. The request is not supported by the guideline recommendations, as the frequency of the medication and its intended use is unclear. Given the above, the request is not medically necessary.