

Case Number:	CM14-0041474		
Date Assigned:	06/20/2014	Date of Injury:	08/04/2011
Decision Date:	07/18/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/15/2014

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 & Rehabilitation and is licensed to practice in Minnesota. 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 59-year-old male with an injury reported on 08/04/2011. The mechanism of injury was not provided within clinical notes. The clinical note dated 06/18/2014 reported that the injured worker complained of neck and back pain. The physical examination revealed tenderness to palpation over the posterior cervical spine with subscapularis spasms. There was tenderness at the base of the occiput noted also. The examination of the injured worker's motor strength revealed no atrophy noted. The sensory examination revealed sensation was intact to light touch and pinprick of all dermatomes in the bilateral upper extremities. Slight tenderness to palpation and muscular tension through the upper lumbar area was noted. The lumbar range of motion demonstrated forward flexion to 45 degrees and extension to 25 degrees. The injured worker's diagnosis included multiple level lumbar disc disease without radiculopathy. The provider requested Xolido and 1 pain management follow-up for lumbar epidural steroid injection; the rationales for the treatments were not provided. The Request for authorization was submitted on 03/15/2014. The injured worker's prior treatments include physical therapy; however, the date and the amount of physical therapy sessions were not provided within clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xolido: Upheld

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

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

Decision rationale: The request for Xolido is non-certified. The injured worker complained of neck and back pain. The treating physician's rationale was not provided within clinical documentation. The CA MTUS guidelines recommend Lidocaine 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). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Xolido is Lidocaine HCl 2% for temporary relief of pain and itching and minor skin irritation due to minor cuts and scrapes, sunburn, and minor burns. Per the guidelines, no other commercially-approved topical formulation of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Therefore, any other topical Lidocaine medication is not recommended. Furthermore, the requesting physician did not specify the utilization frequency, dose, or location of application of the medication being requested. As such, the request is not medically necessary.

1 Pain Management Follow Up For Lumbar ESI (Epidural Steroid Injection): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI (Epidural Steroid Injection). Decision based on Non-MTUS Citation Official Disability Guidelines- Pain, ESI (Epidural Steroid Injection).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs); Opioids, criteria for use Page(s): 46; 78.

Decision rationale: The request for 1 pain management follow-up for lumbar ESI (epidural steroid injection) is non-certified. The injured worker complained of neck and back pain. The treating physician's rationale for pain management follow-up was not provided within clinical notes. The CA MTUS guidelines recommend epidural steroid injections as an option for treatment of radicular pain. The guidelines state the consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. It is noted that the treating physician verbalized that the injured worker is making a slow but steady progress with conservative treatment and would feel the injured worker would benefit with continued conservative treatment. Given the information provided, along with the information indicating the injured worker has responded well to conservative care, there is insufficient evidence to determine appropriateness to warrant medical necessity of pain management follow-up. Therefore, the request is not medically necessary.

