MAXIMUS Federal Services

| Case Number: | CM14-0197847 | | |
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| Date Assigned: | 12/08/2014 | Date of Injury: | 12/13/1991 |
| Decision Date: | 01/23/2015 | UR Denial Date: | 10/27/2014 |
| Priority: | Standard | Application Received: | 11/25/2014 |

## 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 Interventional Spine and is licensed to practice in California. 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 patient is an 87 year old female with an injury date of 12/13/91. As per 09/30/14 progress report, the patient is status post facet radiofrequency rhizotomy at bilateral L4-S1 on 10/01/13. Currently, she complains of low back pain that radiates to the lower extremities, left greater than right. The patient is also experiencing numbness and muscle weakness in the lower extremities bilaterally. The sharp pain is rated as 6-8/10 with medications and 8-10/10 without them. The pain is worsened by physical activity and is accompanied by muscle spasms in the lower back. Physical examination reveals tenderness to palpation in the right paravertebral L3-5 levels along with spasm in the right paraspinous musculature. Range of motion was moderately restricted and painful on flexion and extension. There is decreased sensitivity to light touch in the right lower extremity and decreased motor strength in the extensor muscles along L3-5 dematome bilaterally. Straight leg raise is positive bilaterally. Medications, as per progress report dated 09/30/14, include Hydrocodone-acetaminophen, Capsaicin cream, Xolido cream, and cyclobenzaprine. The patient received transforaminal ESI at L3-4 on 07/08/14, as per progress report dated 08/05/14. The patient is currently not working, as per progress report dated 09/30/14. MRI of the Lumbar Spine, 05/29/12, as per progress report dated 09/30/14: Severe right concave lumbar scoliosis with L2, L3, and L4 anterior and left lateral subluxations; 3 mm combination disc protrusion and subluxation and osteophyte formation at L4-5; 3.5 mm L3-4 combination disc protrusion and subluxation; 3.6 mm L2-3 disc protrusion; Diagnoses,09/30/14: Lumbar disc displacement; Lumbar facet arthropathy; Lumbar radiculopathy; Left ankle pain; Chronic pain, other; Status post left ankle surgery. The treating physician is requesting for Xolido 2 percent cream apply BID # 118 ml. The utilization review determination being challenged is dated 10/27/14. The rationale was "the medical records do not establish that the

patient is intolerant to oral medications or that she exhausted attempts at all potential antidepressants and anticonvulsants." Treatment reports were provided from 05/07/14 - 09/30/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Xolido 2 Percent Cream Apply BID #118 ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49,Chronic Pain Treatment Guidelines Saliylate Topicals.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 113.

**Decision rationale:** The patient is status post facet radiofrequency rhizotomy at bilateral L4-S1 on 10/01/13, and currently complains of low back pain that radiates to the lower extremities, left greater than right, as per progress report dated 09/30/14. The request is for Xolido 2 percent cream apply BID # 118 ml. The MTUS has the following regarding topical creams (p111, chronic pain section): Lidocaine Indication: Neuropathic pain. 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). 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. Regarding Capsaicin, the Guidelines state "There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis)." Active ingredient of Xolido cream is Lidocaine Hydrochloride. The prescription for this topical formulation was noted in progress report dated 08/05/14. The treating physician does not explain why this cream was chosen over other creams, lotions and topical preparations. MTUS guidelines, however, do not allow for the use of "any other topical formulations of lidocaine" other than the patch. Hence, this compounded topical formulation is not medically necessary.