

<b>Case Number:</b>	CM13-0025613		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	06/04/2003
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	08/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### 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 Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 a 56-year-old female who reported an injury on 06/04/2003. The mechanism of injury was not provided in the medical records. The patient's symptoms were noted to be low back pain. She also reports radiating pain down both of her legs, which extends to her knees, and is more prominent in her right leg. The physical exam findings include decreased range of motion of the lumbar spine, tenderness over her surgical scar from lumbar fusion, tenderness over the right sacroiliac joint, and tenderness over the left sacroiliac joint, normal deep tendon reflexes in the lower extremities, normal motor strength of the lower extremities, and negative straight leg raise testing. Her diagnoses are listed as degenerative disc disease of the lumbar spine, sacroiliac sprain/strain, and lumbosacral spondylosis. A request was made for Bio-freeze gel, use as need for pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF BIOFREEZE GEL, USED AS NEEDED FOR PAIN:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Guidelines further state that many topical agents are compounded as monotherapy or a combination for pain control and the use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The documentation submitted for review did not show evidence of a trial of antidepressants or anticonvulsants prior to the patient's use of a topical analgesic. Additionally, there was no information in her medical records stating the specific use of Bio-freeze gel and how it will be useful for therapeutic goal. Moreover, there was no documentation regarding the patient's outcome following use of this topical analgesic, or any side effects she may have experienced. With the lack of detailed documentation regarding the prescription for this topical analgesic, the request is not supported. Therefore, the request for Bio-freeze gel, use as needed for pain, is not medically necessary.