

<b>Case Number:</b>	CM13-0027926		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	12/29/1997
<b>Decision Date:</b>	03/18/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty Certificate in Pediatric Rehabilitation Medicine and is licensed to practice in Illinois 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 physician 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 64-year-old female who reported an injury on 12/29/1997. The mechanism of injury involved heavy lifting. The patient is currently diagnosed with history of left upper extremity pain, history of fusion of the wrist with hardware removal, possible ganglion cyst, medial and lateral epicondylitis on the left, history of triggering of the 3rd digit, and dyspepsia. The most recent Physician's Progress Report was submitted on 07/01/2013 by [REDACTED]. The patient presented with persistent throbbing pain in the left wrist. Physical examination revealed painful range of motion, exquisite tenderness to palpation, negative Phalen's and Tinel's testing, diffuse atrophy along the left upper extremity, tenderness over the medial and lateral epicondyle, and palpable hemoclips in the dorsum of the wrist. Treatment recommendations included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Biofreeze gel 4 oz, qty: 4.00:** Upheld

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

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

**Decision rationale:** California Medical Treatment Utilization Section (MTUS) Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the documentation submitted, there is no evidence of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. It is also noted that the patient continuously utilized this medication. Despite ongoing use, the patient has continued to report persistent throbbing pain in the left upper extremity. Based on the clinical information received, the request is non-certified.