MAXIMUS Federal Services

Case Number:	CM13-0053702		
Date Assigned:	12/30/2013	Date of Injury:	09/24/2010
Decision Date:	05/02/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	11/18/2013

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 Family Practice 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 injured worker is a 48-year-old female with a reported date of injury on 09/24/2010; the worker was injured while throwing out trash. The clinical note dated 01/13/2014 noted the injured worker was seen for a follow-up with complaints of pain. It was noted the injured worker's examination remained unchanged. The injured worker had bilateral knee braces and was utilizing bilateral forearm crutches to ambulate. The injured worker had guarded/restricted Final Determination Letter for IMR Case Number CM13-0053702 lumbar range of motion. The injured worker had diagnoses including bilateral knee osteoarthritis and facetogenic lower back pain. The injured worker's medication regimen included Celebrex 200 mg 1 tab daily, Clonidine HCL 0.1 mg tab daily, Losartan 10-20 one tab daily, Spironolactone -HCTZ 25 mg 1 tab daily, Zanaflex 2 mg 1 tab daily at bedtime, and Norco 10/325 mg 1 tab every 6 hours as needed for pain. The injured worker's treatment plan is to wait for authorization for bariatric consultation and surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

BIOFREEZE GEL (3 MONTH SUPPLY): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic, BiofreezeÂ® Cryotherapy Gel

Decision rationale: According to the Official Disability Guidelines, Biofreeze is recommended as an optional form of cryotherapy for acute pain. The clinical information provided for review noted the patient's injury was from 2010 and is therefore not in the acute phases of injury or pain to meet guideline indications for the requested topical. Also, the request as submitted did not include the frequency, area of the body the medication was to be used for or quantity being requested. The request for Biofreeze gel (3 month supply) is not medically necessary and appropriate.