

<b>Case Number:</b>	CM13-0061083		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/12/2011
<b>Decision Date:</b>	05/08/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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 is licensed to practice in Texas and Oklahoma. 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 43-year-old male who reported an injury on 10/12/2011. The mechanism of injury was not provided for review. The injured worker's treatment history included multiple medications, epidural steroid injections, physical therapy, and chiropractic care. The injured worker was evaluated on 11/01/2013. It was documented that the injured worker's medication schedule included gabapentin, naproxen, Polar Frost gel 4%, and omeprazole. Physical findings included limited lumbar range of motion secondary to pain, with tenderness to palpation of the paravertebral musculature to the left side. The injured worker had positive facet loading on the left side and positive straight leg raising at 70 degrees. Evaluation of the cervical spine noted that there was limited range of motion secondary to pain, with tenderness to palpation of the paravertebral musculature, and a positive Spurling sign with radiating pain into the upper extremities. The injured worker's diagnoses included lumbar radiculopathy, cervical facet syndrome, cervical radiculopathy, shoulder pain, and wrist pain. The injured worker's treatment plan included continuation of medications, a referral for psychiatric evaluation, and modified work duties.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POLAR FROST 4% #150:** 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.

**Decision rationale:** The requested Polar Frost 4% #150 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of topical analgesics, as they are largely experimental and not supported by scientific data. Additionally, the clinical documentation indicated that the injured worker has been on this medication for an extended period of time. There is no functional benefit related to the medication to support continued use. Additionally, the request as it is submitted did not include duration of treatment, frequency of treatment, or intended body part for this topical agent.