

Case Number:	CM14-0114689		
Date Assigned:	08/04/2014	Date of Injury:	05/17/2003
Decision Date:	09/10/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/22/2014

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 & Rehabilitation, and is licensed to practice in Illinois. 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 55-year-old male who reported an injury on 05/07/2003. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his low back. The injured worker's chronic pain was managed with intermittent physical therapy and multiple medications. The injured worker was evaluated on 05/20/2014. Physical findings included tenderness to the thoracic and lumbar spine with bilateral wrist pain with range of motion. It was noted that the injured worker's condition had not improved since the previous visit. It was also noted that the injured worker's topical lidocaine had not been approved. The injured worker's diagnoses included lumbago and carpal tunnel syndrome. A request was made for Biofreeze 4% and an orthotic pillow. However, no justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze 4% topical gel, qty 1 for 30 days, with four refills: Upheld

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

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 Chapter, Biofreeze® cryotherapy gel.

Decision rationale: The requested Biofreeze 4% topical gel quantity 1 for 30 days with 4 refills is not medically necessary or appropriate. California MTUS Guidelines do not specifically address this medication. Official Disability Guidelines recommend the use of Biofreeze for acute exacerbations of chronic pain. The clinical documentation submitted for review does not provide any evidence that the injured worker has had an acute exacerbation of chronic pain. Additionally, there is no documentation that the injured worker is unresponsive to the application of ice and cold therapy and requires a topical cryotherapy medication. As such, the requested Biofreeze 4% topical gel quantity 1 for 30 days with 4 refills is not medically necessary or appropriate.

Orthotic pillow (memory foam cooling contour pillow) #1 for 30 days with 12 refills - to be provided by rehab super store: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, low back - lumbar and thoracic (acute and chronic) chapter, lumbar supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Equipment, Pillow.

Decision rationale: The requested orthotic pillow (memory foam cooling contour pillow) #1 for 30 days with 12 refills to be provided by rehab super store is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend a pillow for back support as an adjunctive treatment to a physical rehabilitation program. The clinical documentation submitted for review does not indicate that the injured worker is currently participating in any type of active therapeutic program to include a home exercise program that would benefit from the adjunctive treatment of a pillow. As such, the requested orthotic pillow (memory foam cooling contour pillow) #1 for 30 days with 12 refills to be provided by rehab super store is not medically necessary or appropriate.