

Case Number:	CM14-0127107		
Date Assigned:	08/22/2014	Date of Injury:	05/25/2014
Decision Date:	09/23/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/11/2014

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 Preventive Medicine 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:

According to the records made available for review, this is a 50-year-old female with a 5/25/14 date of injury. At the time (7/21/14) of request for authorization for Biofreeze Gel, there is documentation of subjective (constant left wrist and left upper extremity pain shooting into the left forearm with numbness, tingling, and weakness; and left shoulder pain) and objective (decreased range of motion of the left upper extremity, severe edema of the dorsal aspect of the left hand with flexion contractures of the fingers, allodynia and hyperalgesia on the dorsal aspect of the left hand, diminished sensation along the medial and lateral border of the left forearm) findings. Current diagnoses includes left hand contusion, left wrist probable TFCC ligament tear, CRPS type I of left hand, neuropathic pain syndrome, left carpal tunnel syndrome, and chronic myofascial pain syndrome. Treatment to date includes occupational therapy and NSAIDs. In addition, the medical report identifies a request for a trial of Neurontin. There is no documentation that trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze Gel: 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 based on Non-MTUS Citation (<http://www.drugs.com/drp/biofreeze-pain-relieving-gel.htm>).

Decision rationale: An online search identifies that Biofreeze gel is a topical anesthetic used for the temporary relief from minor aches and pains of sore muscles and joints associated with arthritis, backache, strains and sprains. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of Biofreeze. Within the medical information available for review, there is documentation of diagnoses of left hand contusion, left wrist probable TFCC ligament tear, CRPS type I of left hand, neuropathic pain syndrome, left carpal tunnel syndrome, and chronic myofascial pain syndrome. However, given documentation of a request for trial of Neurontin, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.