

Case Number:	CM14-0135976		
Date Assigned:	09/03/2014	Date of Injury:	01/29/2010
Decision Date:	09/30/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	08/23/2014

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 Emergency Medicine and is licensed to practice in 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 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 37 year old female who reported an injury on 01/29/2010. The mechanism of injury was reported as lifting heavy boxes. Her diagnoses included right shoulder pain, thoracic spine pain, low back pain, neck pain, and carpal tunnel syndrome. It was noted the injured worker was provided with physical therapy and chiropractic treatment. She had MRIs in November 2011 which showed mild dorsal disk/spur at C3-C4 and C5-C6 and an MRI of her lumbar spine showed no significant pathology. She also had subsequent nerve conduction studies along with electromyography. Her surgical history was not provided. The note from 02/19/2014 noted the injured worker reported her pain level at 5/10 with constant low back pain, which increased to 10/10 when she swept the floor. The physician noted that the physical findings did not show an excessive amount of objective findings to go along with the examinees reported subjective pain. On 08/13/2014 the injured worker reported continuous difficulty with right shoulder pain. With her medications she was able to do light house cleaning for a maximum of half an hour. She was not able to reach overhead because of the discomfort. The physical examination findings included right shoulder forward flexion of approximately 90-100 degrees, and right shoulder abduction of approximately 80-90 degrees. The medications included Norco 10/325 1 tablet twice daily as needed, Relafen, Celexa, and Biofreeze gel. The treatment plan was for Retrospective Biofreeze gel roll-on 2 tubes. The rationale for the request was not submitted. The request for authorization form was submitted 08/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Biofreeze gel roll-on #2 tubes: Upheld

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

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

Decision rationale: Based on the clinical information submitted for review, the request for retrospective Biofreeze gel roll-on 2 tubes is not medically necessary. As stated in California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Also, they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The injured worker reported constant low back pain and right shoulder pain. Her medications were noted as Relafen, Celexa, Norco 10/325mg, and Biofreeze gel. The guidelines indicate that topical analgesics are largely experimental with few trials to determine efficacy and are primarily recommended for neuropathic pain. There is no clinical documentation showing that the injured worker suffered from neuropathic pain. There is a lack of documentation regarding significant pain relief and objective functional improvements with the use of Biofreeze. Furthermore, there is a lack of documentation that explains how the requested medication will be useful for her specific therapeutic goal as it is required by the guidelines. Also, it is unknown as to directions as to how the medication will be used, to include frequency and site of application. As such, the request for retrospective Biofreeze gel roll-on 2 tubes is not medically necessary.