

Case Number:	CM14-0154376		
Date Assigned:	09/24/2014	Date of Injury:	03/01/2004
Decision Date:	11/25/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/22/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 67 year old male with an injury date of 03/01/04. The most recent progress report dated 08/25/14 by [REDACTED] states that the patient presents with definite improvement in the left shoulder with pain rated 7/10. The 07/01/14 report by [REDACTED] states the patient has increased neck pain rated 7/10. The patient is temporarily totally disabled. Examination on 08/25/14 of the shoulder demonstrated active essentially equal passive motion. There is a degree of scapula-thoracic substitution as would be anticipated. The patient's diagnoses include: Rotator cuff complete rupture/bilateral, biceps tenosynovitis/bilateral, long head of biceps proximal tendon rupture; status post tenodesis 10/16/13, cervical radiculitis, status post C4-7 fusion (date unknown), shoulder pain left, osteoarthritis-shoulder/bilateral; rotator cuff arthropathy 10/16/13. Medications as of 07/01/14 are listed as Norco, Flector patches and Biofreeze gel. The utilization review being challenged is dated 09/11/14. Reports were provided from 03/31/14 to 08/26/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flector patch 1.3 % #60: 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.

Decision rationale: The patient presents with left shoulder and neck pain rated 7/10. The provider requests for Biofreeze roll on gel. ODG guidelines regarding Biofreeze states, "Recommended as an optional form of cryotherapy for acute pain. See also cryotherapy, cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)" In this case, the patient does present with shoulder and neck pain, but chronic and not acute. While Biofreeze indicated for acute pain, or acute flare-up of chronic pain, it is not supported for chronic condition. Therefore, Biofreeze roll on gel is not medically necessary and appropriate

Biofreeze roll on gel: 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 Gel.

Decision rationale: The patient presents with left shoulder and neck pain rated 7/10. The provider requests for Biofreeze roll on gel. ODG guidelines regarding Biofreeze states, "Recommended as an optional form of cryotherapy for acute pain. See also cryotherapy, cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)" In this case, the patient does present with shoulder and neck pain, but chronic and not acute. While Biofreeze indicated for acute pain, or acute flare-up of chronic pain, it is not supported for chronic condition. Therefore, Biofreeze roll on gel is not medically necessary and appropriate