

Case Number:	CM14-0183908		
Date Assigned:	11/10/2014	Date of Injury:	03/13/2011
Decision Date:	12/26/2014	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/04/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 66-year-old male with a 3/13/11 date of injury. The injury occurred when he bent and reached over to pick up an old large printer, he felt a sharp pain in his lower back and pain radiating down his right lower extremity. According to a progress report dated 10/6/14, the patient stated that his medications kept his pain at a mild to moderate level, rated approximately a 3/10. With his medications, he was able to do light housework. Without his medications, his pain would be at a severe level, and he would be almost immobilized. Objective findings: no significant changes. Diagnostic impression: low back pain, lumbar radiculopathy, and right hip pain with moderate degenerative changes. Treatment to date: medication management, activity modification, lumbar medial branch blocks, physical therapy. A UR decision dated 10/24/14 denied the request for Biofreeze. The Biofreeze is supported by the ODG for acute back pain therapy only. Its use in this chronic pain condition is not supported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze Gel, 2 bottles: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Low Back

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: CA MTUS does not address this issue. According to ODG, Biofreeze is recommended as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. However, in the present case, there is no documentation that the patient is experiencing acute pain. It is noted that this patient has been using Biofreeze on a chronic basis. In addition, there is no documentation that the patient has had a trial with standard ice packs. Therefore, the request for Biofreeze Gel, 2 bottles was not medically necessary.