

<b>Case Number:</b>	CM14-0020888		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 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 injured worker is a 54 year old female who reported an injury on 07/24/2013, due to an unknown mechanism. The clinical note dated 09/16/2013 presented the injured worker with bilateral upper extremity pain, neck pain, and right shoulder pain. The physical exam of the cervical spine revealed slightly decreased rotation bilaterally with some pain with rotation, and decreased left lateral bending to about 20 degrees. The right shoulder had tenderness in the anterior joint, but full range of motion. The injured worker had a positive nerve compression test bilaterally, bilateral positive Tinel's at the wrist, and was mildly tender at the lateral epicondyles bilaterally. The provider recommended Biofreeze Gel. The request for authorization form was not provided with the medical documents.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BIOFREEZE GEL 4 OZ QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**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.

**Decision rationale:** The Official Disability guidelines recommend Biofreeze as an optional form of cryotherapy for acute pain. Biofreeze is a non-prescription 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. While the guidelines confirm that this is a low risk, low cost option the requesting physician's rationale for the request was unclear. Additionally, it was unclear at which site the medication was to be applied. Therefore, the request is not medically necessary.