

Case Number:	CM14-0024417		
Date Assigned:	06/11/2014	Date of Injury:	09/20/1996
Decision Date:	07/15/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/26/2014

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 Occupational 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 53-year-old injured on September 20, 1996 when he fell from the steps of a satellite truck resulting in low back pain. Current diagnoses include degenerative cervical disc disease, cervical spondylosis without myelopathy, spinal stenosis in the cervical region, brachial neuritis/radiculitis, degenerative lumbar/lumbosacral disease, lumbosacral spondylosis, arthrodesis status post removal of internal fixation device, scoliosis, sprain/strain of the sacroiliac joint, and sacroiliitis. The clinical note dated December 20, 2013 indicated the injured worker presented complaining of increase in neck pain with radiation down the bilateral upper extremities with associated numbness and tingling in the bilateral arms and hands, right greater than left. The injured worker also reports cramping, fatigue, and weakness in the bilateral upper extremities. The injured worker also complained of increased lower back pain with radiation into the buttocks, left greater than right. The injured worker also reported radiation of low back pain into the bilateral lower extremities with associated numbness and cramping in the legs and feet. Prior treatments include combined anterior/posterior decompression and fusion from L3 to L5 in August of 2010 as well as exploration of the lumbar fusion with removal of the retained hardware on March 22, 2013, physical therapy, and medication management. The documentation indicates medications include Prilosec, Mobic, Ambien, Valium, and up to 10 Norco 10/325mg per day. The initial request for Biofreeze roll-on #4 for treatment to the cervical and lumbar spine was initially non-certified on February 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

BIOFREEZE ROLL ON #4, FOR TREATMENT TO THE CERVICAL AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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 - Lumbar & Thoracic (Acute & Chronic), Biofreeze® cryotherapy gel.

Decision rationale: As noted in the Official Disability Guidelines, Biofreeze gel 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. The clinical documentation indicates the intent to use the medication for chronic pain. Additionally, there is no indication the injured worker requires prescribing of a nonprescription topical cooling agent if required on an as needed basis. The request for Biofreeze roll on #4, for treatment to the cervical and lumbar spine, is not medically necessary or appropriate.