

<b>Case Number:</b>	CM14-0060447		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	09/11/2008
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 59 year old female, who sustained an industrial injury on 9/11/08. The PR2 dated 7/16/13 noted that the injured worker had complaints of right shoulder pain. The diagnoses have included right rotator cuff impingement; acromioclavicular (AC) joint arthrosis. Treatment to date has included cortisone injections; home exercises; right shoulder X-rays demonstrate a type II acromion with degenerative changes of the AC joint; Magnetic Resonance Imaging (MRI) scan demonstrated supraspinatus and infraspinatus tendinitis, bursitis and AC joint arthritis; cortisone and lidocaine injection which gave her marked relief. According to the utilization review performed on 4/23/14, the requested Retro Biofreeze with roll-on gel x 2 and Retro Flexeril by mouth every day #60 has been non-certified. There was not a completed utilization review submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Biofreeze with roll-on gel x 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Biofreeze cryotherapy gel

**Decision rationale:** The patient presents with bilateral shoulder pain, left being greater than the right, and lower back pain. The current request is for Retro Biofreeze with roll-on gel x 2. The treating physician states, "She is also provided a 2-month supply of Flexeril, gabapentin, and Biofreeze topical roll-on gel." (22B) The ODG guidelines state, "Recommended as an optional form of cryotherapy for acute pain." In this case, the treating physician documented in the 6/26/13 report that the patient's pain in getting worse. The progress reports do not state the frequency or when the medication needs to be used. The current request has not established medically necessity and the recommendation is for denial.

**Retro Flexeril p.o. q.d. #60:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Page(s): 41-42.

**Decision rationale:** The patient presents with bilateral shoulder pain, left being greater than the right, and lower back pain. The current request is for Retro Flexeril p.o. q.d. #60. The treating physician states, "She is also provided a 2-month supply of Flexeril." (22B) The MTUS guidelines state, Recommended as an option, using a short course of therapy. Treatment should be brief. In this case, the treating physician has documented that the patient should taking Flexeril on an as needed basis once a day. Flexeril can be taken three times per day and it does not appear that, because the sig is not for TID and is on an as needed basis, the medication is being prescribed for acute and not chronic daily use. The current request is medically necessary and the recommendation is for authorization.