

Case Number:	CM15-0000375		
Date Assigned:	01/09/2015	Date of Injury:	05/04/2013
Decision Date:	03/06/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/02/2015

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
 Certification(s)/Specialty: Family Practice

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 male patient, who sustained an industrial injury on 05/14/2013. A primary treating physician note dated 12/04/2014 reported him with decreased range of motion to the cervical spine with paraspinal muscle spasm noted. Bilateral elbows have decreased range of motion bilaterally with tenderness over the lateral epicondyle. Bilateral wrists and hands also found with decreased range of motion. His left knee is also found with tenderness and decreased range of motion. The following diagnosis are applied; lumbar spine strain/sprain, bilateral lateral epicondylitis, bilateral elbow strain/sprain, status post right wrist open reduction and internal fixation, status post right wrist removal of hardware, right wrist pain, left knee strain/sprain and per MRI of right wrist tear of the ulnar attachment of triangular fibrocartilage; a 5 mm posterior ulnar variance and tenosynovitis. On 12/23/2014 Utilization Review non-certified a request for Biofreeze Gel, noting the CA MTUS Chronic Pain Guidelines Topical Analgesics 12/15/2014 the injured worker submitted an application for IMR for review of services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze gel 240gm with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of topical analgesics as a treatment modality. These guidelines state the following: Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adenosine, cannabinoids, cholinergic receptor agonists, prostanooids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. In these guidelines, the only two agents deemed possibly effective are lidocaine and capsaicin; for certain forms of neuropathic disease. In this case, the patient has no evidence of a neuropathic disease as the source of chronic pain. There is insufficient documentation that other approved modalities of treatment have been given a sufficient trial. There is no basis for the components of this topical gel (camphor and menthol) to provide effective analgesia. Under these conditions, Biofreeze Gel is not considered as a medically necessary treatment.