

<b>Case Number:</b>	CM15-0137469		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	08/08/2000
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 60 year old female, who sustained an industrial injury on August 8, 2000, incurring lower back, upper back, and upper extremity injuries. He was diagnosed with cervical spine sprain, thoracic spine sprain, lumbar disc herniation, and bilateral carpal tunnel syndrome. Electromyography studies of the upper extremities and lumbar spine revealed radiculopathy. Treatment included carpal tunnel surgery, muscle relaxants, pain medications, sleep aides, and activity restrictions. Currently, the injured worker complained of ongoing low back pain, neck, and upper back, and wrists, hands and feet pain. She complained of generalized numbness and tingling of the entire back, hips, and neck. The treatment plan that was requested for authorization included a prescription for Bio freeze gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Biofreeze gel 3.5 ounce, 2 tubes:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back (Acute & Chronic) - Biofreeze cryotherapy gel.

**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, Biofreeze Cryotherapy.

**Decision rationale:** Biofreeze is camphor and menthol for topical application. Per ODG guidelines Biofreeze is "Recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a nonprescription 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." (Zhang, 2008) As the injured worker's condition is characterized by chronic low back pain, the medication is not appropriate as it is recommended for acute pain. The request is not medically necessary.