

Case Number:	CM15-0146549		
Date Assigned:	08/07/2015	Date of Injury:	12/07/1993
Decision Date:	09/03/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/28/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 sustained an industrial/work injury on 12-7-93. She reported an initial complaint of back pain. The injured worker was diagnosed as having status post herniated lumbar disc, right lower extremity radiculopathy. Treatment to date includes medication, surgeries (laminectomies), aquatic therapy, physical therapy, and epidural steroid injections. MRI results were reported on 4-2001, 7-2-02, 8-2003, and 10-2005. Currently, the injured worker complained of ongoing back pain with use of walker or cane for ambulation. Per the primary physician's report (PR-2) on 5-8-15 exam, noted scoliosis limited flexion, extension, lateral flexion and rotation, tenderness and spasms and mild straight leg raising on the right. The requested treatments include Hermacare shoulder wrap and Biofreeze 4% .

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermacare shoulder wrap #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel". There is no evidence to support the need for thermacare shoulder wrap in this case. The patient can use reusable home hot packs as she is not working and there is no clear advantage from using thermacare shoulder wraps. Therefore, the request for Thermacare shoulder wrap #90 with 3 refills is not medically necessary.

Biofreeze 4% 3 bottles with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment, guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. According to ODG guidelines, "Biofreeze 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. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication". There is no recent documentation supporting pain and functional improvement with previous use of biofreeze in this case. There is no documentation of failure or intolerance of oral first line drugs for pain management. Therefore, the prescription of Biofreeze 4% 3 bottles with 3 refills is not medically necessary.