

Case Number:	CM15-0168078		
Date Assigned:	09/08/2015	Date of Injury:	12/08/2004
Decision Date:	10/13/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	08/26/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

This 51 year old female sustained an industrial injury on 12-08-04. Diagnoses include myofascitis and rotator cuff strain. Treatments to date include MRI testing, shoulder surgery, physical therapy and prescription pain medications. The injured worker has continued complaints of left shoulder pain. The pain has affected the injured worker's activity level. The injured worker has remained off work. The injured worker's mood was noted as angry. Upon examination of the left shoulder, range of motion was diminished. Spasms were noted in bilateral trapezius. Documentation reports left shoulder pain ranging from 3 to 4 out on a scale of 10. A request for Biofreeze QTY: 3 and Counsel (Psychotherapy) QTY: 15 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze QTY: 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Drugs.com, Biofreeze.

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: The claimant has a remote history of a work-related injury in December 2004 and is being treated for chronic left shoulder pain. When seen, there was an angry mood. There was worsened analgia. There was decreased range of motion due to spasms. There was bilateral shoulder tenderness with muscle spasms. Biofreeze and cognitive behavioral therapy are being requested. Biofreeze Gel contains menthol, which is used as a topical analgesic in over the counter medications such as Ben-Gay or Icy Hot. It is recommended as an optional form of cryotherapy for acute pain. In this case, the claimant is being treated for chronic pain without identified new injury or exacerbation. There are other single component topical treatments with generic availability that could be considered. Biofreeze Gel is not medically necessary.

Counsel (Psychotherapy) QTY: 15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Second Edition, Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive behavioral therapy (CBT).

Decision rationale: The claimant has a remote history of a work-related injury in December 2004 and is being treated for chronic left shoulder pain. When seen, there was an angry mood. There was worsened analgia. There was decreased range of motion due to spasms. There was bilateral shoulder tenderness with muscle spasms. Biofreeze and cognitive behavioral therapy are being requested. In term of psychotherapy, guidelines recommend an initial trial of 6 visits over 6 weeks and with evidence of objective functional improvement, a total of up to 13-20 individual sessions over 7-20 weeks. In this case, the number of treatments requested is in excess of that recommended and objective functional improvement in response to any previous treatment is not documented. The request is not medically necessary.