

Case Number:	CM15-0193774		
Date Assigned:	10/07/2015	Date of Injury:	07/22/2011
Decision Date:	11/23/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/02/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 43 year old female, who sustained an industrial injury on 7-22-2011. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine degenerative scoliosis, status post spinal cord stimulator (SCS) trial in 2013, and failure of L4-L5 disc replacement necessitating posterior stabilization with pedicle screws L4-L5, 12. On 9-16-2015, the injured worker reported ongoing difficulty with pain in the mid back, low back, hips, and in the right thigh, with spasms and burning, rated 5 out of 10 in intensity. The Secondary Treating Physician's report dated 9-16-2015, noted that over the previous month the injured worker rated her highest level of pain as 9 out of 10, her lowest level of pain 2 out of 10, and her average pain 5 out of 10 in intensity. The injured worker was noted to have continued to perform her therapeutic exercises, working 32 hours a week. The injured worker's current medications were noted to include Lyrica, Topamax, Zanaflex, Mobic, Oxycontin, Percocet, and Amitiza. The injured worker reported beginning to experience relief within 30 minutes of taking her medication, with the relief lasting approximately 4-6 hours. The physical examination was noted to show the lumbar spine with moderate scoliosis and well healed surgical scar, with restricted range of motion (ROM), tenderness, spasm, and tight bands on examination of the paravertebral muscles, and bilateral positive straight leg raise. Prior treatments have included pool and land therapy, right selective nerve root blocks in 2012, dual percutaneous dorsal column stimulator therapy with stimulator lead placement times two in 2013, acupuncture, surgery, and "multiple medications". The treatment plan was noted to include medications prescribed at the visit of Biofreeze, with prescriptions for Oxycontin, and Percocet. The request for authorization was noted to have requested medication-topical Biofreeze 4% Gel, SIG: apply

to CW QID Qty: 1 Refills: 5. The Utilization Review (UR) dated 9-29-2015, denied the request for medication- topical Biofreeze 4% Gel, SIG: apply to CW QID Qty: 1 Refills: 5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication - Topical Biofreeze 4% Gel, SIG: apply to CW QID Qty: 1 Refills: 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Wikipedia, biofreeze (<http://en.wikipedia.org/wiki/Biofreeze#Ingredients>).

Decision rationale: Regarding the request for Biofreeze, Wikipedia indicates that the ingredients of bio freeze include menthol, aloe, and numerous other constituents. CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines do not contain support for the topical use of menthol, aloe, or any other of the constituents of Biofreeze. Within the documentation available for review, there is no indication that the patient has failed antidepressant and anticonvulsants. As such, the currently requested Topical Biofreeze 4% Gel, SIG: apply to CW QID Qty: 1 Refills: 5 is not medically necessary.