

<b>Case Number:</b>	CM15-0197544		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	05/06/2009
<b>Decision Date:</b>	11/23/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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 York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric 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:

This injured worker is a 55 year old female, who sustained an industrial injury on 05-06-2009. The injured worker was diagnosed as having right shoulder sprain, lumbar sprain, gastritis, carpal tunnel syndrome right side and status post carpal tunnel release. On medical records dated 09-02-2015 and 03-11-2015, the subjective complaints were noted as low back pain and pain in right hand, wrist, and elbow and shoulder area. Numbness and tingling sensation was noted mostly in right hand and forearm. Pain was rated at 7-8 out of 10 without medication and 4-5 out of 10 with medication. Objective findings were noted as tenderness to palpation at the AC joint and subacromial space. Range of motion was noted to be restricted and with pain. Right wrist tenderness was noted. Lumbar spine stiffness and tenderness to palpation was noted at L4-L5 and L5-S1 and straight leg raise was positive bilaterally. Treatments to date include medication and home exercises. The injured worker was noted to be totally temporary disabled. Current medications were listed as Norco, Prilosec, Flexeril and Gabapentin. The Utilization Review (UR) was dated 09-16-2015. A request for Bio freeze gel #120 gram was submitted. The UR submitted for this medical review indicated that the request for Bio freeze gel #120 gram was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Biofreeze gel #120 gram:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Biofreeze.

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

**Decision rationale:** Per the guidelines, topical analgesics are largely experimental with few randomized trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation of efficacy with regards to pain and functional status or a discussion of side effects specifically related to the topical analgesic. Regarding topical Biofreeze in this injured worker, the records do not provide clinical evidence to support medical necessity.