

Case Number:	CM15-0208259		
Date Assigned:	10/27/2015	Date of Injury:	03/31/2012
Decision Date:	12/11/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/22/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 44 year old female, who sustained an industrial injury on 3-31-2012. Diagnoses include cervical strain, status post right shoulder surgery, status post right elbow surgery in 2-11 and 2014, internal derangement of right wrist, and right hand strain. Treatments to date documented in the records submitted include shockwave therapy. On 7-21-15, she complained of no change in the pain of the neck and right upper extremity, shoulder to right hand, associated with numbness and tingling of the hand. Current medications or effectiveness of medication on decreased pain or increased functional ability was not documented in the records submitted. However, the records did show Biofreeze and Tramadol was ordered on 3-12-15. The physical examination documented decreased sensation to the right shoulder and thumb. The appeal requested authorization for Biofreeze Gel 3.5% #1 with three refills and Tramadol 50mg #60 with three refills. The Utilization Review dated 9-23-15, denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze Gel 3.5% #1 x 3 (script date 09/03/2015): 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 Official Disability Guidelines (ODG) Pain (Chronic) and Low Back, Topical Analgesics and Biofreeze.

Decision rationale: Biofreeze is a compound topical analgesic containing camphor and menthol. ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." ACOEM and MTUS are silent regarding the use of camphor. ODG states in the low back chapter regarding biofreeze, "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)". Medical documents do not indicate that the Biofreeze is to be used for acute low back pain, which is the indication per ODG. As such, the request for Biofreeze Gel 3.5% #1 x 3 (script date 09/03/2015) is not medically necessary.

Tramadol 50 mg #60 x 3 (script date 09/03/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram).

Decision rationale: Tramadol is classified as a central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. MTUS states that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain

after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Tramadol 50 mg #60 x 3 (script date 09/03/2015) is not medically necessary.