

Case Number:	CM14-0118656		
Date Assigned:	09/23/2014	Date of Injury:	06/02/2011
Decision Date:	11/14/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 47-year-old male with a 6/2/11 date of injury. At the time (6/5/14) of request for authorization for retro biofreeze roll-on #2, there is documentation of subjective (persistent low back and neck pain) and objective (morbidly obese, tenderness on cervical and lumbar paraspinal muscles with decreased range of motion at the waist in all places, and has fairly full range of motion at the neck) findings, current diagnoses (persistent headaches, chronic neck pain, right shoulder pain, chronic low back pain, and left lower extremity pain), and treatment to date (medications (including ongoing treatment with biofreeze roll-on #2, norco, neurontin, amitriptyline, Zoloft, and relafin)). Medical report identifies that patient continues to do well on the current medication regiment, brings pain level down from an 8/10 to 4/10, and allows patient to exercise and carry out activities of daily living with decreased pain and increase range of motion. There is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO BIOFREEZE ROLL-ON #2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, BIOFREEZE CRYOTHERAPY GEL

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; <http://www.drugs.com/drp/biofreeze-pain-relieving-gel.htm>

Decision rationale: An online search identifies that Biofreeze gel is a topical anesthetic used for the temporary relief from minor aches and pains of sore muscles and joints associated with arthritis, backache, strains and sprains. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of Biofreeze. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of persistent headaches, chronic neck pain, right shoulder pain, chronic low back pain, and left lower extremity pain. In addition, given documentation that patient continues to do well on the current medication regiment, brings pain level down from an 8/10 to 4/10, and allows patient to exercise and carry out activities of daily living with decreased pain and increase range of motion, there is documentation functional benefit and an increase in activity tolerance as a result of biofreeze roll-on use to date. However, there is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for of retro biofreeze roll-on #2 is not medically necessary.