

Case Number:	CM14-0139390		
Date Assigned:	09/05/2014	Date of Injury:	01/05/2004
Decision Date:	10/14/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	08/28/2014

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 Family Medicine 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:

The injured worker is a 67 year old male who was injured on 01/05/04 when he fell from a scaffolding and injured his left knee. Neither the specific injuries sustained nor the initial treatments rendered were addressed in the clinical notes submitted for review. Current diagnoses include S/P left knee repeat surgery, 08/2005; prior left knee surgery 09/2003; negative diagnostic dorsal median branch block, left L3, L4 and L5, 01/2005; left sided foraminal disc at L4-L5, 2004; and thoraco-lumbar pain. X-ray of the lumbar spine dated 09/11/12 revealed degenerative disc disease and spurring at L3-4, L4-5 and L5-S1 levels, and degenerative changes at the sacro-iliac joints bilaterally. X-ray of the left knee dated 09/11/12 revealed no acute fracture and mild narrowing at the medial joint. Clinical note dated 09/11/13 indicated the injured worker complains of persistent left knee and low back pain. He indicated that he continues to walk for exercise. The injured worker indicated he wanted to start Biofreeze gel again as it was beneficial in the past. There was no physical examination provided in the clinical note. Medications include Norco 10/325mg and Ibuprofen 800mg and Biofreeze gel #3 tubes was prescribed. Clinical note dated 02/26/14 indicated the injured worker complains of persistent low back and right knee pain. He indicated his low back pain level is 6/10 without medication, and with medication it goes down to 2-4/10. The injured worker indicated that with Norco he is able to continue walking and carry out activities of daily living, and Biofreeze gel is helpful in between medication doses. Clinical note dated 05/21/04 indicated the injured worker continues to have low back pain and left knee pain, with pain level of about 6/10, that goes down to about 2/10 with medications. Clinical note dated 08/06/14 indicated the injured worker continues to do well on current medication regimen. Before medication his pain is about 7/10 and with medications, it comes down to 2/10. The injured worker indicated that with medications, he is able to do a little bit of walking every day, help his wife with some light

household chores and allows him to interact with his grandchildren and family. Physical examination revealed tenderness in the lumbar paraspinal muscles, with decreased range of motion in all planes. He also has generalized tenderness and edema to the left knee. He has full extension of the knee with slightly limited flexion. Medications include Norco 10-325 mg, Ibuprofen 800mg, and Biofreeze gel. The previous request for 1 prescription of Biofreeze gel #3 tubes was non-certified on 08/06/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro-Biofreeze gel #3 TUBES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), online version, Low Back - Lumbar Thoracic (Acute and Chronic), Bio freeze cryotherapy gel.

Decision rationale: As noted in the Official Disability Guidelines, Biofreeze gel is recommended as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. The clinical documentation indicates the intent to use the medication for chronic pain. Additionally, there is no indication the patient requires prescribing of a nonprescription topical cooling agent if required on an as needed basis. As such, the request for Biofreeze gel #3 tubes cannot be recommended as medically necessary at this time.