

Case Number:	CM14-0088851		
Date Assigned:	08/01/2014	Date of Injury:	07/24/2006
Decision Date:	09/29/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	06/12/2014

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 Internal 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 45 year old male who reported an injury to his low back. The clinical note dated 07/21/14 indicates the injured worker complaining of radiating pain from the low back into the left lower extremity. The injured worker also reported numbness and tingling as well. There is an indication the injured worker has been prescribed the use of Biofreeze topical gel in the past. The note indicates the injured worker able to carry out his activities of daily living with the use of the entire medication regimen to include Ultracet, Ibuprofen, and the Biofreeze gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze gel tube #1 dispensed on 4/15/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Biofreeze cryotherapy gel.

Decision rationale: The documentation indicates the injured worker having previously been prescribed the use of Biofreeze gel for the complaints of low back pain. There is an indication

the injured worker is utilizing additional medications as well. The continuation of the use of Biofreeze gel is indicated provided the injured worker meets specific criteria to include an objective functional improvement with the use of this medication. There is an indication the injured worker is able to complete his activities of daily living with the use of the medication regimen. However, no objective data was submitted supporting the continued use of this medication. Therefore, this request of Biofreeze gel tube #1 dispensed on 4/15/2014 is not medically necessary and appropriate.