

Case Number:	CM15-0091984		
Date Assigned:	05/18/2015	Date of Injury:	08/02/1999
Decision Date:	06/24/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/12/2015

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: California

Certification(s)/Specialty: Internal 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 68 year old female who reported an industrial injury on 8/2/1999. Her diagnoses, and/or impressions, are noted to include: chronic right knee pain with post-traumatic arthritis, status-post arthropathy and lower leg pain. No current imaging studies are noted. Her treatments have included medication management with urine toxicology screenings. The progress notes of 10/23/2014 reported the development of sweats, chills and diarrhea, rule-out rapid metabolism of her Butrans Patch; without medications the pain in her right low back, gluteal regions and legs, right > left, was rated 10/10, and with her medications was barely tolerable at 7/10; and that the pain is worse at night. Also noted was that she had not tried Galisal. Objective findings were noted to include guarding with transfer from sit to stand; tenderness to palpation in the right upper leg/knee, and over the right groin-hip region; as well as limited range-of-motion and decreased strength in the lower extremities. The physician's requests for treatments were noted to include Bio- Freeze for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze (right knee): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page 111-113.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. The primary treating physician's progress report dated 4/7/15 documented subjective complaints of right ankle, knee, hip and low back pain. Objective findings were documented. She is able to transfer from sit to stand and ambulates with nonantalgic gait. She has tenderness to palpation in right upper leg and knee and tenderness over left groin hip region. Diagnosis was chronic right knee pain. Date of injury was 08-02-1999. Biofreeze was requested. Biofreeze is a nonprescription topical agent with the active ingredient Menthol. Biofreeze is an over-the-counter topical gel. Topical analgesics in general are not supported by MTUS guidelines. Therefore, the request for Biofreeze is not supported by MTUS guidelines. Therefore, the request for Biofreeze is not medically necessary.