

Case Number:	CM14-0142906		
Date Assigned:	09/10/2014	Date of Injury:	08/31/2011
Decision Date:	10/07/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	09/03/2014

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 female with an 8/31/11 date of injury. At the time (8/1/14) of request for authorization for Biofreeze gel number two A (2) tubes, there is documentation of subjective (left-sided radiating symptoms) and objective (positive left leg lift as well as mild tenderness to the right lower extremity following the L4-5 dermatome) findings, current diagnoses (lumbar discogenic pain), and treatment to date (activity modification, epidural steroid injections, and medications (including Amitriptyline and Neurontin)). There is no documentation that 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:

Biofreeze gel number two (2) tubes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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 diagnosis of lumbar discogenic pain. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing use of Amitriptyline and Neurontin, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Biofreeze gel number two (2) tubes is not medically necessary.