MAXIMUS Federal Services

Case Number:	CM15-0006669		
Date Assigned:	01/26/2015	Date of Injury:	12/05/2012
Decision Date:	03/24/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/12/2015

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48-year-old male who reported an injury on 12/05/2012. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of plantar fasciitis. Past medical treatment consisted of medication therapy. Medications include topical analgesics. On 01/13/2013, the injured worker complained of foot pain. The injured worker rated the pain at a 2/10 to 4/10. There was no radiating pain, numbness or tingling. Physical examination of the foot noted focal tenderness elicited with palpation of the medial aspect of the left calcaneus. Neurovascular examination was normal. The range of motion of the ankle was limited due to the cast. The treatment plan is for the injured worker to continue with medication therapy. The rationale and Request for Authorization Form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gab/Lid/Aloe/Cap/Men/Cam (patch) 10%/2%/0.5%/0.25%/10%/5% gel, 120 count, refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for gab/lid/aloe/cap/men/cam (patch) 10%/2%/0.5%/0.25%/10%/5% gel, 120 count, refill is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines state that gabapentin is not recommended for topical application. Given that the guidelines do not recommend the use of gabapentin for topical use, the request would not be indicated. Additionally, the submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits. Furthermore, there were no other significant factors noted to justify the use outside of current guidelines. As such, the request is non-certified.