
Notice of Independent Medical Review Determination

Dated: **11/26/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/17/2013
Date of Injury:	2/12/2008
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006323

- 1) MAXIMUS Federal Services, Inc. has determined the request for **BCFL cream** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 2mg #15** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Vicodin 5/500mg #15** is not **medically necessary and appropriate**.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **BCFL cream** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 2mg #15** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for Vicodin 5/500mg #15 is not medically necessary and appropriate.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This injured worker's date of injury was 2/2/2008. His diagnoses are chronic low back pain from a lumbar sprain/strain and lumbosacral radicular symptoms.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for BCFL cream:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-113, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-113, which are part of the MTUS..

Rationale for the Decision:

BCFL cream is a compounded cream containing the following active Ingredients: Baclofen 2%, Cyclobenzaprine 2%, Flurbiprofen 15%, Lidocaine 5%. This cream is marketed for use on the skin to reduce painful areas of injury or muscle spasms. The first two agents relax muscles when taken orally. The third is an NSAID and the last is an anesthetic used by injection or topically on the skin. Products like BCFL are considered experimental, because there is no evidence from prospective studies that its use in the treatment of chronic low back pain is equal or superior to other more established methods. Certain individual components of this cream, Lidocaine, have a medical indication when applied topically in the treatment of neuropathy, when other first line treatments have failed. Lidocaine is not medically indicated for “non-neuropathic pain.” In addition, “any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended.” The employee has chronic back pain, this compounded cream is not medically indicated for this employee. **The request for BCFL cream is not medically necessary and appropriate.**

2) Regarding the request for Zanaflex 2mg #15:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Tizanidine (Zanaflex, generic available), Pg. 66, which is part of the MTUS.

Rationale for the Decision:

Tizanidine is indicated for the management of muscle spasticity. The FDA has not approved tizanidine for the treatment of chronic low back pain. Some patients have developed elevation of liver enzymes when taking this drug. Tizanidine is not medically indicated for this employee with chronic low back pain. **The request for Zanaflex 2mg #15 is not medically necessary and appropriate.**

3) Regarding the request for Vicodin 5/500mg #15:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 80, which is part of the MTUS.

Rationale for the Decision:

Vicodin contains acetaminophen 500 mg. and hydrocodone (an opioid) 5 mg. This combination demonstrates efficacy in pain management of low back pain for a limited time, up to 16 weeks. Beyond that there is no convincing data that functioning is improved. Additionally, patients who take longterm opioid therapy run a high risk of lifetime substance abuse disorders. Vicodin is not medically indicated for this patient with chronic low back pain. **The request for Vicodin 5/500mg #15 is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.