MAXIMUS Federal Services

Case Number:	CM14-0103444		
Date Assigned:	07/30/2014	Date of Injury:	01/29/2009
Decision Date:	09/19/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/03/2014

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 Physical Medicine & Rehabilitation, 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 65-year-old male who reported an injury on 01/29/2009. The mechanism of injury was not provided within the documentation submitted for review. The injured worker's diagnoses were noted to be trigeminal neuralgia, cervical radiculopathy, lumbar radiculopathy, carpal tunnel syndrome, shoulder pain left, adhesive capsulitis of left shoulder, and adjustment disorder with mixed anxiety and depressed mood. Prior treatments were noted to be medications. Diagnostics were not noted within this progress report. The subjective complaints in a progress report dated 07/03/2014 include chronic cervicogenic pain, left facial neuralgia, chronic degenerative shoulder and wrist pain, lumbar radicular pain, dorsal arm and wrist pain, and depression. Objective findings include hypersensitivity to light touch over the left face. There was no left facial weakness. There was tenderness over the trapezius, shoulder, and mid lumbar region to palpation. Antalgic movements, particularly with walking, were noted. Current medications include ProAir inhaler, Augmentin, Tegretol, Soma, Penlac, Lexapro, and Synalar. The treatment plan is for medications. In addition, depression will be followed by a specialist and closely monitored. A follow-up visit was set in 4 months. The provider's rationale for the request was not provided within the documentation; nor was the Request for Authorization form submitted with this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg #90 tab 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The request for Carisoprodol 350 mg quantity 90 tabs 1 refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend Soma. This medication is not intended for long-term use. There is little research in terms of weaning of high dose Soma and there is no standard treatment regimen for patients with known dependence. It is not noted within the progress report submitted for review an efficacy with use of prior Soma. The guidelines do not recommend Soma. The provider's request does not include a dosage frequency. Therefore, the request for Carisoprodol 350 mg quantity 90 tabs 1 refill is not medically necessary.