

<b>Case Number:</b>	CM14-0150823		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	01/14/2004
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Family Practice and is licensed to practice in Texas and Mississippi. 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 56-year-old male who reported an injury on 01/14/2004. The mechanism of injury was not provided. Diagnoses included chronic pain and lumbar radiculopathy. Past medical treatment included medications and an intrathecal pump. Diagnostic testing included an MRI of the lumbar spine with and without contrast on 02/07/2005 and an EMG/nerve conduction study on 01/11/2011. Surgical history was not provided. The injured worker complained on 07/21/2014 of low back pain that radiated down the bilateral lower extremities. Pain was aggravated by activity and walking. The injured worker rated his pain as 6/10 in intensity with medications and 10/10 in intensity without medications. The physical examination revealed the injured worker's gait was antalgic and slow. On physical examination of the lumbar spine, the physician noted spasms. Tenderness was noted upon palpation in the spinal vertebral area of the L4 through S1 levels. The range of motion of the lumbar spine was moderately limited secondary to pain. The pain was significantly increased with flexion and extension. Medications included Cymbalta 60 mg, Soma 350 mg, OxyContin 60 mg, and Percocet 10/325 mg. The treatment plan was for Soma. The rationale for the request was not submitted. The Request for Authorization form was submitted on 08/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Carisoprodol (Soma) Page(s): 29, 64.

**Decision rationale:** The request for Soma is not medically necessary. The injured worker complained of pain to the lumbar spine radiating down the bilateral lower extremities. The California MTUS Guidelines state that Soma is not recommended and not indicated for long-term use. This medication is not recommended to be used for longer than 2-3 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The guidelines state Soma is not recommended and is not to be used for longer than 2-3 weeks. The medical records provided indicate a prescription for Soma since at least 03/31/2014. The guidelines state Soma is not recommended and is not indicated for long-term use. Therefore, continued use is not supported. In addition, the dosage, quantity, and frequency of the requested medication were not provided. Therefore, the request for Soma is not medically necessary.