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| <b>Case Number:</b>   | CM14-0022100 |                              |            |
| <b>Date Assigned:</b> | 05/09/2014   | <b>Date of Injury:</b>       | 12/24/2007 |
| <b>Decision Date:</b> | 07/10/2014   | <b>UR Denial Date:</b>       | 01/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/21/2014 |

### 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 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 patient is a 59 year old male claimant who sustained a work injury on 12/24/07 involving the low back, left hand, and left shoulder. He had a diagnosis of rotator cuff tear of the left shoulder, myelopathy of L3-L4 region and peroneal motor abnormalities in both legs. He underwent a lumbar laminectomy in 2008. An exam note on 7/25/13 indicated he had 7/10 pain. Physical findings include paraspinal tenderness, left shoulder tenderness and reduced range of motion in both locations. The treating physician had chiropractic therapy electrical stimulation, topical Dendracin, SOMA and Ibuprofen for pain. A subsequent exam note on 12/23/13 indicated 5-8/10 pain. Exam findings were similar to July 2013. The treating physician continued transdermal medications, SOMA and Naproxen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SOMA 350 MG ONE TABLET TWO TIMES PER DAY #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA) Page(s): 29.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state regarding Carisoprodol, "Not recommended. This medication is not indicated for long-term use." The medical records provided for review do not document substantial objective or subjective improvement with the use of this medication. Based on the recommendations of the MTUS Chronic Pain Guidelines, the request for Soma is not medically necessary.

**TRANSDERMAL ANALGESICS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** According to the medical records provided for review, this patient has 7 months of use of topical analgesics with minimal changes in subjective and objective findings. There is a lack of evidence to support continued use. As such, the request is not medically necessary and appropriate.