

<b>Case Number:</b>	CM14-0028042		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	08/08/2012
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 Preventative Medicine, has a subspecialty in Occupational Medicine, and is licensed to practice in Texas. 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 employee is a 42 year old male who had a work related injury on 08/08/12. While the injured employee and a co worker tried to lift a generator, the co worker let go the injured employee immediately had low back pain with radiation into his left side and down his left leg into his toes. The injured employee had failed physical therapy and injections. MRI and x-rays showed spondylolisthesis grade 2 at L5 and S1. The injured employee underwent an anterior lumbar spinal fusion on 02/13/13. The injured employee had epidural steroid injections following the surgery with temporary relief. Apparently, he had 2 additional surgeries and now has an L5-S1 instrumented anterior posterior fusion. Physical examination normal gait and transitions. Back motion is moderately restricted. There was a prior utilization review on 02/24/14 non-certified the Carisoprodol 350mg #90. Diagnoses are chronic pain syndrome, depressive disorder, insomnia, major depressive affect disorder, recurrent episodes of severe degree psychotic behavior, generalized anxiety disorder, somatization disorder, spondylolisthesis, congenital, post-anterior lumbar spine fusion, residual foraminal stenosis at L5-S1 which is severe.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CARISOPRODOL 350 MG, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The request for Carisoprodol 350 mg # 90 is not medically necessary. According to Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long term use, it is approved for symptomatic relief of acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. Given the chronicity of the condition medical necessity is not established.