

<b>Case Number:</b>	CM14-0033491		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	12/03/2007
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 41 year old female with a history of a work related injury on 12/3/07. Her diagnoses include right cervical facet joint pain at C2-C3 and C3-C4, cervical facet joint arthropathy, cervical brachial syndrome, thoracic outlet syndrome, upper extremity sprain/strain, upper extremity tendonitis and degenerative joint disease, and bilateral upper extremity repetitive stress injury. She complains of bilateral upper extremity pain with pain in the forearms, wrists, and hands with numbness and paresthesias. On exam there is restricted range of motion of the cervical spine with cervical facet joint and upper extremity provocation maneuver positive. Treatment has included medical therapy and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CARISOPRODOL 350MG 1 TAB BY MOUTH THREE TIMES A DAY #90 WITH 2 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

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

**Decision rationale:** Per the reviewed literature, Carisoprodol ( Soma) is not recommended for the long-term treatment of musculoskeletal pain. The medication has its greatest effect within

two weeks. It is suggested that the main effect of the medication is due to generalized sedation and treatment of anxiety. Soma is classified as a Schedule IV drug in several states. It can cause physical and psychological dependence as well as withdrawal symptoms with abrupt discontinuation. The documentation does not indicate there are palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per the California MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**ZIPSOR 25MG 1 TAB BY MOUTH FOUR TIMES A DAY #120 WITH 2 REFILLS:**

Overtuned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

**Decision rationale:** Zipsor is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the claimant has significant cervical and upper extremity pain and the medication has proved beneficial in conjunction with physical therapy for pain control. She has tried and failed medical therapy with Ibuprofen and Naproxyn. Medical necessity for the requested treatment has been established. The requested treatment is medically necessary.