

<b>Case Number:</b>	CM14-0077898		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	04/17/1996
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 Medicine and is licensed to practice in Ohio. 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 52 year old female with a prior anterior cervical fusion from C4-C7 and a prior L5-S1 fusion. We are not told her date of injury. She complains of chronic neck pain, peri-scapular pain, headaches, and numbness and tingling to the left upper extremity. She also has chronic low back pain radiating into the gluteal muscles and the right>left lower extremities. The physical exam reveals tenderness to palpation of the cervical and lumbar paraspinal musculature. There is diminished sensation to the C5-C7 regions of the upper extremity. Spurling's test is positive and Tinel's sign is positive at the occipital nerve. Diminished grip strength is documented. There is a positive straight leg raise sign on the right side more so than the left. Diminished right lower extremity strength is noted. The diagnoses include cervical and lumbar facet arthropathies and chronic neck and back pain. She has been treated with muscle relaxants, physical therapy, and topical and oral anti-inflammatories.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #120:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Carisoprodol (Soma®)

**Decision rationale:** Carisoprodol (Soma) is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a Schedule-IV controlled substance). It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. This medication is not indicated for long-term use. Muscle relaxants are not generally indicated beyond 2-3 weeks. In this instance, the Soma has been in use for a time period exceeding this and is therefore not medically necessary.

**Voltaren Gel 1% Gel 5/100mg #5 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

**Decision rationale:** Topical antiinflammatories are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. There is no evidence to support their use for neuropathic or radicular pain. Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this instance, there is no indication from the notes as to where the Voltaren gel is being applied or exactly what indication it is being used for. The diagnoses listed are not consistent with current recommendations for topical antiinflammatories. The Voltaren gel appears to be utilized here for a time period exceeding 12 weeks. Therefore, Voltaren Gel 1% Gel 5/100mg #5 with 2 refills is not medically necessary per the referenced guidelines.