

<b>Case Number:</b>	CM14-0124170		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	06/10/2003
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Physical Medicine Rehab 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:

According to the records, the claimant is a 53-year-old female who sustained work related injuries on 6/10/03. She sustained injuries to both upper extremities from repetitive computer job duties. The attending physician report dated 6/10/14 indicates the patient has a history of bilateral upper extremity, wrist and hand pain. He goes on to state that she has no pain currently in the shoulders, wrist, or elbow. Exam findings indicate normal wrist ROM with end range pain. Notes indicate tenderness in the volar aspect of the wrists and dorsum of the hand. He notes positive Phalen's sign. Tenderness is noted in the thoracic spine. Limitation is noted in shoulder ROM, with positive impingement sign on the left. The records indicate the claimant is permanent and stationary with permanent work restrictions. The current diagnoses are: 1. Bilateral wrist and hand tendinitis 2. Bilateral carpal tunnel syndrome 3. Bilateral shoulder strain 4. Thoracolumbar strain 5. Insomnia 6. Insomnia secondary to chronic pain 7. Intermittent GI upset due to pain medications The utilization review report dated 7/7/14 denied the request for Soma 350mg, One Tablet BID PRN #30 per month, for relief of chronic pain and muscle spasm based on lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg, one tablet bid prn #30 per month, for relief of chronic pain and muscle spasm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma). Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter: Muscle Relaxants (for pain), Carisoprodol (Soma), SAMHSA, 2011.

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

**Decision rationale:** The claimant has persistent bilateral upper extremity pain. The request is for Soma 350mg, one tablet bid prn #30 per month, for relief of chronic pain and muscle spasm. The MTUS guidelines states Carisoprodol (Soma) is not indicated for long term use. This medication is approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. Guidelines recommend against the chronic use of muscle relaxants, especially Soma, in the chronic pain setting. Because the claimant has been on Soma since before June of 2007, the current request does not fall within the MTUS guidelines. Therefore, this request is not medically necessary.