

<b>Case Number:</b>	CM15-0109481		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	08/30/1995
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 60 year old male, who sustained an industrial injury on 8/30/95. The injured worker was diagnosed as having lumbar disc disorder, lumbar radiculopathy, radiculopathy, and low back pain. Treatment to date has included physical therapy, a home exercise program, and medication. The injured worker had been taking Hydrocodone/Acetaminophen and Soma since at least 11/4/14. Pain on 3/11/15 was rated as 4/10 with medication and 9/10 without medication. Pain on 4/23/15 was rated as 2/10 with medication and 7/10 without medication. Currently, the injured worker complains of low back pain, abnormal gait, muscle spasms, numbness, tingling, and weakness. Impaired ability to sleep was also noted. The treating physician requested authorization for Hydrocodone/Acetaminophen 10/325mg #180 and Soma 350mg #60 with 3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone -acetaminophen 10/325mg #180 tablet every 4-6 hours as needed NTE 6/day:**  
 Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

**Decision rationale:** MTUS Guidelines support the use of opioids if there is meaningful pain relief, functional support/improvements and a lack of drug related aberrant behaviors. This individual meets the Guideline criteria. The Guidelines also support a combination of short half life and long half life opioids for difficult to control pain. The Hydrocodone-acetaminophen 10/325mg #180 tablet every 4-6 hours as needed NTE 6/day is supported by Guidelines and is medically necessary.

**Soma 350mg #60 with 3 refill, 1 table 3 times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, muscle relaxants.

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

**Decision rationale:** MTUS Guidelines specifically address the use of Soma (Carisoprodol) and do not recommend its use. This is due to the fact that the metabolite is the active component of the drug and this metabolite has the properties of a barbiturate. There are no unusual circumstances that justify an exception to Guidelines. The Soma 350mg #60 with 3 refills, 1 table 3 times a day is not supported by Guidelines and is not medically necessary.