

<b>Case Number:</b>	CM15-0139527		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	01/25/2010
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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: Emergency 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 (n) 57 year old female, who sustained an industrial injury on 1-25-10. She reported pain in her neck, lower back, bilateral upper extremities and knees. The injured worker was diagnosed as having cervical sprain, bilateral shoulder sprain, lumbar sprain and contusion of the coccyx. Treatment to date has included a lumbar MRI on 6-1-12 showing a disc bulge at L5-S1, chiropractic treatments, a home exercise program, several x-rays and MRIs and an EMG on 8-29-12 showing cervical radiculopathy. Current medications include Ambien, Tramadol and Soma since at least 11-15-13. A urine drug screen on 10-28-14 was negative for Ambien, but was otherwise normal results. As of the PR2 dated 6-18-15, the injured worker reports intermittent flare-ups of pain in her neck region and lower back pain. She rates her neck pain a 5-6 out of 10 and her lower back pain a 7 out of 10. She rates her pain with medications a 3-5 out of 10 and an 8-9 out of 10 without medications. Objective findings include ambulation with a cane and favors right lower extremity, tenderness over the posterior cervical paraspinal and upper trapezius musculature and decreased lateral cervical rotation. The treating physician requested Soma 350mg #45, a lumbar support and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #45:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol and Muscle Relaxants Page(s): 29, 63-66.

**Decision rationale:** The requested Soma 350mg #45 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Carisoprodol, Page 29, specifically do not recommend this muscle relaxant, and Muscle Relaxants, Pages 63-66 do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has pain in her neck region and lower back pain. She rates her neck pain a 5-6 out of 10 and her lower back pain a 7 out of 10. She rates her pain with medications a 3-5 out of 10 and an 8-9 out of 10 without medications. Objective findings include ambulation with a cane and favors right lower extremity, tenderness over the posterior cervical paraspinal and upper trapezius musculature and decreased lateral cervical rotation. The treating physician has not documented duration of treatment, spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Soma 350mg #45 is not medically necessary.

**Retrospective request for a lumbar support, date of service 06/18/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports.

**Decision rationale:** The requested Retrospective request for a lumbar support, date of service 06/18/15, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Page 301, note lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports, also note Lumbar supports: Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The injured worker has pain in her neck region and lower back pain. She rates her neck pain a 5-6 out of 10 and her lower back pain a 7 out of 10. She rates her pain with medications a 3-5 out of 10 and an 8-9 out of 10 without medications. Objective findings include ambulation with a cane and favors right lower extremity, tenderness over the posterior cervical paraspinal and upper trapezius musculature and decreased lateral cervical rotation. The treating physician has not documented the presence of spondylolisthesis, documented instability, or acute post-operative treatment. The criteria noted above not having been met, retrospective request for a lumbar support, date of service 06/18/15 is not medically necessary.

**Urine drug screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure Summary: Pain, Urine drug testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**Decision rationale:** The requested Urine drug screen is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS) 2009: Chronic Pain Treatment Guidelines, Page 43, Drug testing, recommend drug screening "to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances); to diagnose substance misuse (abuse), addiction and/or other aberrant drug related behavior" when there is a clinical indication. These screenings should be done on a random basis. The injured worker has pain in her neck region and lower back pain. She rates her neck pain a 5-6 out of 10 and her lower back pain a 7 out of 10. She rates her pain with medications a 3-5 out of 10 and an 8-9 out of 10 without medications. Objective findings include ambulation with a cane and favors right lower extremity, tenderness over the posterior cervical paraspinal and upper trapezius musculature and decreased lateral cervical rotation. The treating provider has not documented provider concerns over patient use of illicit drugs or non-compliance with prescription medications. There is no documentation of the dates of the previous drug screening over the past 12 months nor what those results were and any potential related actions taken. The request for drug screening is to be made on a random basis. There is also no documentation regarding collection details, which drugs are to be assayed or the use of an MRO. The criteria noted above not having been met, Urine drug screen is not medically necessary.