

<b>Case Number:</b>	CM15-0199749		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	12/15/1993
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/12/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 58 year old female, who sustained an industrial injury on 12-15-1993. The injured worker is undergoing treatment for: lumbar disc displacement, muscle spasm, lumbar degenerative disc disease. On 7-27-15, and 8-28-15, she reported stabbing low back pain with spasms that has worsened over the last 6-8 months. She indicated there was pain radiation into the bilateral lower extremities, head and neck with the right side being worse than the left. She rated her pain 7 out of 10 and indicated activity such as bending, going up or down stairs, pushing and pulling increased her pain. She is noted to use a walker for ambulation. She stated her pain would increase to 9 out of 10 without medications which help to decrease her pain to 6-8 out of 10. Physical examination revealed decreased bilateral lower extremity strength, tenderness in the right sciatic notch and epigastric area, tenderness in the right greater trochanter, decreased sensation to the left foot, lumbosacral spasm. The provider noted she showed no signs of aberrant behavior. The treatment and diagnostic testing to date has included: magnetic resonance imaging of the lumbar spine (8-27-15), urine drug screens are noted to have been in compliance. Medications have included: Percocet, Soma, ibuprofen, Norvasc, Plavix, aspirin, Gralise, Zanaflex, Norco, and trazodone. The records indicate she has been utilizing muscle relaxants since at least April 2015, possibly longer. Current work status: not documented. The request for authorization is for: Soma 350mg quantity 60; and 30 day use of a TENS unit. The UR dated 9-16-15: non-certified the requests for Soma 350mg quantity 60; and 30 day use of a TENS unit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma), Muscle relaxants (for pain).

**Decision rationale:** Regarding the request for carisoprodol (Soma), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Soma specifically is not recommended for more than 2 to 3 weeks. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the carisoprodol. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Soma 350 mg #60 is not medically necessary.

**30 day use of a TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Regarding the request for 30 day use of a TENS unit, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Also, guidelines recommendations by types of pain: neuropathic, phantom limb, chronic regional pain syndrome, multiple sclerosis, and spasticity in spinal cord injury. Within the documentation available for review, there is no documentation of any specific objective functional deficits which a TENS unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. Finally, the patient does not have one of the types of pain listed causing the spasms for which a TENS is recommended. In the absence of clarity regarding those issues, the currently requested 30 day use of a TENS unit is not medically necessary.