

<b>Case Number:</b>	CM15-0026365		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	07/06/2011
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 28 year old male, who sustained an industrial injury on 07/06/2011. He has reported subsequent back, bilateral knee and right foot pain and was diagnosed with thoracolumbar sprain/strain, disc herniation at T6-T8, right knee contusion and left knee strain. Treatment to date has included oral and topical pain medication and Cortisone injections. In a progress note dated 11/18/2014, the injured worker complained of persistent low back, bilateral knee and right foot pain. Low back pain was rated as 9/10, left knee pain as 8/10, right knee pain as 6/10 and right foot pain as 2/10. Objective examination findings were notable for decreased range of motion of the lumbar spine, tenderness of the paraspinals and midline, decreased strength and sensation at 4/5 on the left, decreased range of motion of the bilateral knees with tenderness over the medial and lateral joint lines. A request for authorization of Soma refill was made. On 02/04/2015, Utilization Review non-certified a request for Soma 350 mg 1 tablet every 8 hours as needed #60. The rationale for denial was not given.

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 & 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**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 that the patient has failed first line treatment options. 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 carisoprodol (Soma) is not medically necessary.