

Case Number:	CM15-0030761		
Date Assigned:	02/24/2015	Date of Injury:	09/21/2011
Decision Date:	04/16/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/19/2015

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 (IW) is a 32-year-old male who sustained an industrial injury on 09/21/2011. The neck, left shoulder, left wrist, low back and upper mid-back were affected. Diagnoses include reflex sympathetic dystrophy of the upper limb; myalgia and myositis, unspecified; chronic pain syndrome; osteoarthritis localized primary involving shoulder region and displacement of cervical intervertebral disc without myelopathy. Treatment to date has included medications, stellate ganglion nerve blocks, epidural steroid injections, acupuncture, chiropractic treatment and physical therapy. EMGs were within normal limits. A left wrist arthrogram on 10/24/12 showed cartilage loss of lateral radial articulation with chondromalacia. According to the notes dated 10/21/14, the Injured Worker reported neck, left arm/wrist and shoulder pain. The notes indicated pain medications were beneficial, and temporary relief was obtained from the ganglion blocks. The requested services were part of the treatment plan for pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #120 with 1 Refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Carisoprodol (Soma, Soprodal 350, Vanadom, generic available), Opioids.

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 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 carisoprodol (Soma) is not medically necessary.