

<b>Case Number:</b>	CM14-0131402		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	10/09/2013
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 44-year-old female who reported an injury on 10/09/2013. She reportedly was repositioning a patient and experienced a pulling sensation in her left hip and sharp pain in her lower back and left hip. On 06/06/2014, the injured worker presented with intermittent pain in the low back with pain radiating into the left lower extremity. Medications included Omeprazole, Nabumetone, Motrin, and Tylenol. Upon examination, the injured worker ambulated with an antalgic gait and had difficulty getting up on the tiptoes on the left side. There was guarding of the lumbosacral axis. Examination of the lumbar spine noted normal lordosis, increased tenderness to palpation with spasm of the lumbar paravertebral musculature, central and in the paralumbar location. There were palpable trigger points over the L5-S1 dermatome to the left side and tenderness over the facet joint over the sacroiliac joint. There was a positive left-sided straight leg raise, tension sign, bowstring test, and Patrick's FABER test. An x-ray of the lumbosacral spine performed on 06/06/2014 revealed early degenerative changes at L5-S1 with a slight of disc height. The diagnoses were herniated nucleus pulposus at L5-S1 with left-sided S1 radiculopathy and left sacroiliitis versus facet syndrome at L5-S1. The provider recommended Soma, topical cream, and a home health aide. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma:** Upheld

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

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

**Decision rationale:** The request for Soma is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) do not recommend Soma. The medication is not indicated for long term use. Soma is a commonly prescribed centrally acting skeletal muscle relaxant and it is suggested that the main effect of the medication is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. There is lack of exceptional factors provided in the documentation submitted to support approving outside the guideline recommendations. Additionally, the provider's request does not indicate a dose, frequency, or quantity of the medication in the request as submitted. As such, the medical necessity has not been established.

**Topical Cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The request for topical cream is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. Many agents are compounded as monotherapy or in combination for pain control, including non-steroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonist, adrenergic receptor agonist, and adenosine. There is little to no research to support the use of many of these agents. The provider's request does not indicate the dose, frequency, or site at which the topical cream is indicated for or what the topical cream is comprised of the request as submitted. As such, medical necessity has not been established.

**Home Health Aide:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Assistance.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Page(s): 51.

**Decision rationale:** The request for home health aide is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) recommend home health services to those who are home bound on a part time or intermittent basis, but generally for no more than up to 35 hours a week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, or personal care giving by home health aides, like bathing, dressing, or using the restroom when this is the only care needed. There was lack of documentation that the injured worker is home bound on a part time or intermittent basis. The provider's rationale for home health services was not provided. Medical care needed in the home was not provided. Additionally, the provider's request does not indicate the amount of home health aide hours or the frequency of the visits in the request as submitted. As such, medical necessity has not been established.