

<b>Case Number:</b>	CM14-0211636		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	01/19/2010
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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. 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: New Jersey  
 Certification(s)/Specialty: Family Practice

### 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 69-year-old male who reported an injury on 01/19/2010. The mechanism of injury was not provided. His diagnoses was noted to include low back pain, paresthesia, GERD, constipation, insomnia, and sexual dysfunction. His past treatments were noted to include medication and surgery. His diagnostic studies were noted to include an official x-ray of the cervical and lumbar spines, performed on 10/13/2014, which were noted to reveal anterior fixation with interbody fusion at C3-4 and C6-7, moderate degenerative changes in the cervical spine, normal appearing posterior fixation and interbody cage at L5-S1, and moderate bony degenerative changes in the lower thoracic and upper lumbar spines. His surgical history was noted to include a nonsegmental instrumental arthrodesis and intraoperative fluoroscopy and interpretation performed on 03/05/2013. During the Qualified Medical Evaluation on 11/04/2014, the injured worker complained of neck and low back pain with paresthesias in the left forearm extending to the tip of the fingers. He also complained of gastrointestinal symptoms, insomnia, and sexual dysfunction. There was no physical examination performed during the assessment. His medication was noted to include Soma 350 mg twice a day, Lyrica 50 mg daily, Percocet 10/325 mg every 4 hours, lisinopril 20 mg daily, HCTZ 25 mg daily, simvastatin 40 mg daily, Pepcid AC once a day, levothyroxine 75 mcg daily. The treatment plan and rationale was not provided. The Request for Authorization form was dated 10/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg QTY: 150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines state that ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines specify that an adequate pain assessment should include the current pain level, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Additionally, there was no quantified information regarding pain relief, including a detailed assessment with the current pain on a VAS, average pain, intensity of pain, or longevity of pain relief. Furthermore, there was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. In the absence of this documentation, the ongoing use of Percocet 10/325 mg, quantity 150, is not medically necessary.

**Soma 350mg QTY: 60:** 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 California MTUS Guidelines do not recommend the use of carisoprodol. The medication is not indicated for long term use. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for its sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter the effects of other drugs. Since the start of carisoprodol 350 mg, there has been no documentation of a detailed assessment with the current pain on a VAS, average pain, intensity of pain, or longevity of pain relief. There was a lack of documentation regarding improved function, ability to perform activities of daily living, or adverse side effects from the use of carisoprodol. Additionally, the frequency was not provided. Due to the use of carisoprodol not being recommended by the guidelines, and the absence of pertinent information, the ongoing use of Soma 350 mg, quantity 60, is not medically necessary.