

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/2/2013
Date of Injury:	6/28/2002
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006027

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350mg QTY 120 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/26/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Soma 350mg, #120, Qty: 1** is not **medically necessary and appropriate**.

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in Texas. 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 treatments and/or services at issue.

### Expert Reviewer Case Summary:

The patient is a 62-year-old male who reported an injury on 06/28/2002. The mechanism of injury was not stated. The patient was noted to have pain in the cervical spine radiating into the upper extremities and pain in the lumbar spine radiating into the lower extremities. Physical findings included tenderness to palpation of the cervical and lumbar spine with evidence of spasms. The patient had a positive left-sided straight leg raising test. The patient's pain was being treated with medication management. The patient's diagnoses included cervical and lumbar degenerative disc disease, bilateral shoulder impingement, and bilateral carpal tunnel syndrome. The patient's treatment plan included medication management and monitoring of compliance. The patient's medications include Vicodin extended release 4 tablets a day and Soma 4 tablets a day.

### Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
  - Claims Administrator
  - Employee/Employee Representative
  - Provider

**1) Regarding the request for Soma 350mg, #120, Qty: 1:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), page 29, which is part of MTUS. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), page 29, which is part of MTUS.

Rationale for the Decision:

The employee does have cervical and lumbar musculature spasms. However, the long-term use of Soma is not supported by MTUS Chronic Pain guidelines recommendations. The guidelines indicate that there is a very high reported incidence of abuse. Furthermore, the clinical documentation submitted for review does provide evidence that the employee has been on this medication for an extended duration of time. Moreover, there is no documentation of functional benefit as a result of the use of this medication. As such, the requested Soma 350 mg QTY: 120 is not recommended. **The request for Soma 350 mg QTY:120 is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.