
Independent Medical Review Final Determination Letter

614

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

IMR Case Number:	CM13-0025211	Date of Injury:	03/28/2006
Claims Number:	[REDACTED]	UR Denial Date:	08/19/2013
Priority:	STANDARD	Application Received:	09/16/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
000037-2001			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 physician 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.

DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, neck, and shoulder pain reportedly associated with an industrial injury of March 28, 2006.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; prior left shoulder arthroscopy; prior lumbar discectomy and foraminotomy in 2011; prior cervical fusion surgery in October 2012; muscle relaxants; attorney representation; and extensive periods of time off of work.

In a utilization review report of August 19, 2013, the claims administrator partially certified the request for Soma for weaning purposes. The guidelines, it is incidentally noted, was mislabeled as originating from ACOEM as opposed to the MTUS Chronic Pain Medical Treatment Guidelines. The applicant's attorney later appealed, on September 16, 2013. Earlier notes of March 8, 2013, April 20, 2013, and June 5, 2013, are all notable for comments that the applicant will remain off of work, on total temporary disability.

In a note of August 7, 2013, it is again stated that the applicant will remain off of work on total temporary disability. No clear subjective complaints are voiced, although the claimant exhibits tenderness about the neck, shoulder, and right wrist. Full shoulder range of motion is appreciated. The applicant is given a left shoulder corticosteroid injection and prescriptions for Norco and Zanaflex.

IMR DECISION(S) AND RATIONALE(S)

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

1. Soma 350mg #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Occupational Medicine Practice Guidelines, Second Edition – Chronia Pain Management, Carisoprodol (Soma), pages 63-66, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 29, which is part of the MTUS.

The Physician Reviewer's decision rationale:

As noted on page 29 of the MTUS Chronic Pain Medical Treatment Guidelines, Soma or carisoprodol is not recommended for chronic or long-term use purposes, particularly in conjunction with other medications. In this case, the applicant is using at least two other analgesic medications, Norco and Zanaflex. Adding carisoprodol and Soma to the mix is indicated as the combination is thought to augment the effects of each drug alone. In this case, there is no compelling rationale attached to the request for authorization so as to try and offset the unfavorable MTUS recommendation, nor is there evidence of functional improvement effected through prior Soma usage so as to justify continuation of the same. The fact the claimant remains off of work, on total temporary disability, and continues to use numerous analgesic and adjuvant medications implies a lack of functional improvement as defined in MTUS 9792.20f. Therefore, the request remains non-certified, on independent medical review.

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.

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