

<b>Case Number:</b>	CM13-0014104		
<b>Date Assigned:</b>	03/17/2014	<b>Date of Injury:</b>	11/10/2007
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2013

### 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 Occupational Medicine and is licensed to practice in California and Oklahoma. 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 patient is a 47 year old female who was injured on 11/10/2007 due to wear and tear as a bus driver. Prior treatment history has included epidural steroid injections with epidurography with fluoroscopic guidance, lumbar epidural injection, continuous caudal approach, lumbar epidural injection, continuous catheter directed and H-wave neurostimulator which she found helpful. The patient underwent: 1) Removal of spinal cord stimulator wire from the lumbar spine on 06/23/2011. She had a retained fragment of wire removed from a prior spinal cord stimulator on 07/10/2011. 2) She underwent placement of external ventricular drain on 07/10/2011 and a placement of ventriculoperitoneal shunt via right parietal occipital burr hole; intraoperative programming of Medtronic Strata valve to an opening pressure of 1.0 performance level. 3) Left knee arthroscopic surgery on 09/28/2012 4) Low back pain status post L3-S1 lumbar fusion on 09/09/2009 08/07/2013 Medications Included: Norco Neurontin Lidoderm patch Lisinopril Lovastatin Antivert Lopressor Coumadin 08/01/2013 Medications Included: Norco Neurontin Lidoderm Drug Screen report dated 08/01/2013 tested positive for Carisoprodol and Meprobamate. Diagnostic studies reviewed include MRI of the left knee performed on 12/16/2010 revealed soft tissue edema surrounding the medial and posterior portions of the vastus medialis muscle, suggestive of a strain; joint effusion with a large popliteal cyst; horizontal longitudinal tear of the mid and posterior horns of the medial meniscus; probable complete vs almost complete tear of the mid and posterior horns of the medial meniscus; probable complete vs almost complete tear of the anterior cruciate ligament. CTA showed increased ventricles with possible retained fragment on 07/16/2011. Office note dated 07/02/2013 stated the patient had improved following hospitalization for meningitis. She completed her intravenous antibiotics and her PICC line had been removed. She has low back pain radiating to her left lower extremity. Her caudal epidural steroid injection performed on

March 7, 2013 gave initial significant improvement in her symptoms. She denied any recent injuries. The patient has persistent left hip pain, right buttock pain at the site of her previous spinal cord stimulator generator and ongoing neck pain which she rated 8/10. The patient was self procuring some of her medications. She noted improvement in her ability to participate preparing meals, caring for herself, and performing light exercise. Without the medicines, she was not able to participate in her day-to-day activities as much and she would be primarily confined to a bed or chair. Office note dated 08/01/2013 stated the patient was having increased left lower extremity pain without a new injury or trauma. In addition to increased left lower extremity pain, the patient had low back and buttock pain. The left lower extremity pain radiated from the left buttock posterior to the thigh and posterolateral calf and foot. She had neck pain and muscle spasm of the low back, buttock, and left leg. A caudal epidural steroid injection performed on March 7, 2013 provided 50% improvement in her symptoms for six to eight weeks. Progress report dated 08/01/2013 documented the patient to have complaints of increased pain into the left lower extremity and pain to the low back and buttock. The pain radiates into the left buttock, posterior thigh, and posterolateral calf to the foot. She continues to experience pain over the cervical spine. She has muscle spasms into the low back pain, buttock, and left leg. She describes throbbing, tight muscular pain and spasms. She has burning pain into the left lower extremity. The patient rates her pain at an 8-9/10 with medications. She has paraspinous tenderness with 1+ to 2+ muscle spasms. She has several palpable trigger bands palpated with positive twitch response and referred pain with palpation over the trigger points. On physical examination, findings revealed a positive straight leg raise. On muscle testing, anterior tibialis left 4/5 and right 5/5; peroneus longus/bravus left 4/5 and right 5/5; extensor hallucis longus left 3/5 and right 4/5. She had hypesthesia in the left L5-S1 dermatome. Her patellar reflex 2+ and symmetrical bilaterally; Achilles reflexes trace on the left and 1+ on the right. The patient was diagnosed with 1) History of low back pain status post L3-S1 lumbar fusion, September 9, 2009; 2) Bilateral lower extremity radicular symptoms; 3) Cervical pain with bilateral upper extremity radicular symptoms; 4) Painful scar in the right superior buttock at the site where the spinal cord stimulator generator; 5) Psychiatric diagnosis; 6) Status post cerebrovascular accident x2 with the ongoing Coumadin therapy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**TRIAL SOMA QID X2 WEEKS PRN #60:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** CA MTUS Details that SOMA is: "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with Tramadol to

produce relaxation and euphoria; (4) as a combination with Hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & (5) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both carisoprodol and meprobamate, both of which act on different neurotransmitters. (Bramness, 2007) (Bramness, 2004) A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2007) (Reeves, 2004) There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is to switch to Phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of Phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient." Requesting provider is recommending a two-week trial of treatment with this medication. It appears to be for the purpose of determining if long-term use of the medication is required. However, this may just be semantics in the clinic note. The treatment with SOMA is appropriate for a short term in my opinion according to the guidelines cited above. Therefore, it is medically necessary.

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**LIDODERM PATCHES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines LIDOCAINE PATCH Page(s): 56-57.

**Decision rationale:** CA MTUS treatment guidelines detail: "Lidoderm® is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. " This medication is only FDA approved treatment postherpetic neuralgia. According to the records that were sent to me, this patient is not half postherpetic neuralgia. Therefore, in my opinion this medication is not medically necessary.