

<b>Case Number:</b>	CM13-0022317		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	01/20/1998
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	09/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2013

### 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 Internal Medicine & Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 59 year-old with a date of injury of 01/20/98. A progress report associated with the request for services, dated 08/27/13, identified subjective complaints of low back pain radiating into the left lower extremity. The record states that her activity level is 2/10 without medications and 2-4/10 with medications. Objective findings included lumbar paraspinal tenderness and decreased range-of-motion. There was decreased sensation in the L4 distribution. Motor function was intact. Diagnoses included lumbar radiculopathy. Treatment has included NSAIDs, muscle relaxants, antidepressants, and oral opioids. She had an epidural injection in August of 2013 and has had multiple injections in the past. She also has a spinal cord stimulator. A Utilization Review determination was rendered on 09/03/13 recommending non-certification of "prescription of carisoprodol 350mg #60 with 1 refill (dispense generic unless written DAW) and prescription of hydrocodone / acetaminophen 10/325 mg, #180".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF CARISOPRODOL 350MG #60 WITH 1 REFILL (DISPENSE GENERIC UNLESS WRITTEN DAW): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Muscle Relaxants Page(s): 29, 63-66.

**Decision rationale:** Carisoprodol (Soma) is a centrally acting antispasmodic muscle relaxant with the metabolite meprobamate, a schedule-IV controlled substance. The Medical Treatment Utilization Schedule states that carisoprodol is not recommended. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. It has interactions with other drugs including benzodiazepines, Tramadol, and hydrocodone. It is associated withdrawal symptoms and is abused for the above mentioned effects. Based upon non-recommendation and also interactions with other concurrent therapy, there is no documented medical necessity for carisoprodol.

**PRESCRIPTION OF HYDROCODONE / ACETAMINOPHEN 10/325 MG, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** Hydrocodone is an oral opioid. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. The guidelines note that a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The Chronic Pain Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The MTUS Guidelines further state that opioid therapy is not recommended for the low back beyond 2 weeks. The patient has been on hydrocodone in excess of 16 weeks. The Official Disability Guidelines (ODG) state: "While long-term opioid therapy may benefit some patients with severe suffering that has been refractory to other medical and psychological treatments, it is not generally effective achieving the original goals of complete pain relief and functional restoration." Therapy with hydrocodone/acetaminophen appears to be ongoing. The documentation submitted lacked a number of the elements listed above, including the level of functional improvement as demonstrated by specific functional measures. Therefore, the record does not demonstrate medical necessity for hydrocodone/acetaminophen.

