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| Case Number: | CM13-0062928 | | |
| Date Assigned: | 01/17/2014 | Date of Injury: | 06/04/2003 |
| Decision Date: | 05/20/2014 | UR Denial Date: | 11/19/2013 |
| Priority: | Standard | Application Received: | 12/09/2013 |

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. 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 58 year old male who was injured on 06/04/2003. The patient is being treated for lumbar strain with left lumbar radiculitis after a fall at work on 06/04/2003. MRI of the lumbar spine dated 10/19/2010 was reviewed. PR2 dated 12/07/2012 reported the patient's pain had remained stable and under control with the current medication. He had not had any recent exacerbations. Objective findings on examination of the lumbar spine were essentially unchanged compared to subsequent exams with the exception of a negative SLR (straight leg raising) test. The recommendation was for continued chiropractic/physical therapy once a week for twelve weeks due to exacerbation of the low back; continue Vicodin 5/500, Soma 350 mg, Naproxen sodium 550 mg; Ambien CR 12.5 mg, and Xoten-C lotion 113.4.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMA 350MG BID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION SOMA, Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION SOMA, Page(s): 29.

Decision rationale: According to the MTUS guidelines, SOMA (carisoprodol) 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"). There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 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. 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. 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. The employee has been on this medication since May 2013. However, in light for possibility of withdrawal would recommend modification of the request to certify SOMA for half the number of tablets requested for weaning over time.

CHIROPRACTIC/PHYSICAL THERAPY (6 SESSIONS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION MANUAL THERAPY & MANIPULATION..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE, Page(s): 98-99.

Decision rationale: According to the MTUS guidelines, chiropractic/physical therapy is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or

medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine.

VICODIN 5/500MG BID PRN #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION OPIOIDS, SPECIFIC DRUG LIST..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: With regard to on-going management of opioids, actions should include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication 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; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. Therefore, it is my opinion that the employee does not meet the above criteria based on the treating physician's notes. The employee appears to not take this medication and provider has sections in his notes labeled "Opioid Management Issues" which do not conform to the guideline above. I would recommend adjustment of request to #30 tablets to allow for taper or further documentation in medical records per guidelines.

AMBIEN 12.5MG #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES, STRESS & MENTAL ILLNESS CHAPTER, ZOLPIDEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) STRESS AND MENTAL ILLNESS CHAPTER. NON BENZODIAZEPINES SEDATIVE-HYPNOTICS; and the non-MTUS Citation: . RAMAKRISHNAN K, SCHEID DC. TREATMENT OPTIONS FOR INSOMNIA. AMERICAN FAMILY PHYSICIAN. 2007 AUG. 15; 76 (4) 517-526.

Decision rationale: The California MTUS guidelines do not address the use of Ambien. The provider is a neurologist and the ODG guidelines detail that this is first line for treatment of insomnia. The employee has documented pain and trouble sleeping. It is my opinion that this is medically necessary while opioids are discontinued.