

<b>Case Number:</b>	CM14-0140503		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/06/2009
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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. 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 injured worker is a 38-year-old woman with a date of injury of 6/6/2009. There is a notation mentioning a second date of injury of 4/16/2010. According to the last attached documented office visit on July 23, 2014, the worker continues to complain of neck pain, low back pain and bilateral forearm and hand pain. She has an unchanged pain level of 4/10 on Percocet and Soma. She is able to perform activities of daily living (ADLs) and prolonged sitting and standing. An exam is remarkable for mid-neck, right upper trapezius and low lumbar paraspinals. Her diagnoses include cervical discogenic pain, left upper limb radicular pain, carpal tunnel syndrome, lumbar discogenic pain and bilateral lower extremity radicular pain. She has had extensive psychological counseling as well.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 64-65.

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

**Decision rationale:** Carisoprodol (Soma) 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 the effects of other drugs; for example, it is used as a combination with Hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"), and as a combination with codeine (referred to as "Soma Coma"). There was a 300% increase in the number 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, 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 off high doses of Carisoprodol, and there is no standard treatment regimen for injured workers 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 500mg/day, and the taper is 30mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each injured worker. In summary, Carisoprodol (Soma) is not recommended. This medication is not indicated for long-term use. This injured worker has been on Carisoprodol since at least February 2014; therefore, the request is not medically necessary or appropriate.

**Percocet 10/325mg #155:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80 and 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

**Decision rationale:** Percocet is Acetaminophen/Oxycodone (generic available), which is a combination of an opioid and acetaminophen (APAP) and is used in the treatment of pain. The dose of acetaminophen should not exceed 3,000 mg per day. As per the Official Disability Guidelines (ODG) it is recommended that the dose not exceed 100mg oral morphine equivalents (MED) per day. Opioids may be recommended as a 2nd or 3rd line treatment at doses up to 100 mg daily oral morphine equivalent dose (MED). Escalation of doses greater than 100 mg (MED) should be done with caution, and generally under the care of pain specialists, and in certain cases, addiction specialists. The Food and Drug Administration (FDA) recommends that combined formulations of opioids with acetaminophen have no more than 325 mg of acetaminophen per tablet. It is stated that the worker takes up to 5 pills of Percocet daily. Oxycodone is a short-acting opioid analgesic indicated in the treatment of moderate to severe pain. Individualize dosing is based on prior analgesic treatment experience, and titrate as needed to provide adequate analgesia and minimize adverse reactions. Per the Medical Treatment

Utilization Schedule (MTUS), under the criteria for use of opioids, on-going management, actions should include: 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. Four domains have been proposed as most relative for ongoing monitoring: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. Another reason to continue opioids is if the worker has returned to work; however, this information has not been made available. The documentation provided on this worker states the worker had 4/10 pain, but none of the other information necessary for ongoing monitoring have been provided, including functional status, appropriate medication use and side effects. Nor is there any mention of a written contract, which is not a requirement, but a recommendation. In the absence of this documentation, this request is not medically necessary or appropriate.