

<b>Case Number:</b>	CM14-0155891		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	10/10/2003
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 claimant was injured on 10/10/03. Hydrocodone/APAP and Soma are under review. On 01/08/14, she complained of anxiety, grief, fear, uncertainty, etc. and had shooting pains in her neck and back with weakness and difficulty walking. Continued individual and group therapy were recommended. She has seen a counselor for a number of visits. On 01/09/14, she appeared depressed and anxious and stated her chronic severe pain and limited mobility surrounding her work injury continued to worsen and it made her feel extremely depressed. She had worse pain with the cold weather. She was having difficulty with her activities of daily living with low self-esteem and worthlessness. She appeared anxious and depressed. She was not using any orthopedic devices. She was dressed neatly and appropriately. She had low energy with sadness. She was diagnosed with depressive disorder. Group therapy sessions were recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Hydrocodone/APAP 10/325 mg #120 DOS 8/25/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Medications for Chronic Pain Page(s): 110,94.

**Decision rationale:** The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "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." There is also no indication that periodic monitoring of the claimant's pattern of use and response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. There is no evidence that a signed pain agreement is on file at the provider's office. There is no indication that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the retrospective request for use of hydrocodone-APAP 10/325 mg #120 DOS 8/25/14 has not been clearly demonstrated. Therefore, the request is not medically necessary.

**Retrospective review for Carisoprodol 350 mg #90 DOS 8/25/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, Medications for Chronic Pain Page(s): 60,94.

**Decision rationale:** The MTUS guidelines state on page 60 that 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: a) increasing sedation of benzodiazepines or alcohol; b) use to prevent side effects of cocaine; c) use with tramadol to produce relaxation and euphoria; d) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & e) 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)". Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication." In this case, there is no evidence of spasm to support the continued use of Soma. The claimant's pattern of use of this medication is unclear and there is no objective measurable evidence of functional improvement based on the use of Soma. The medical necessity of ongoing use of Carisoprodol 350 mg #90 for chronic complaints has not been clearly demonstrated. Therefore, the request is not medically necessary.