

Case Number:	CM14-0165334		
Date Assigned:	10/10/2014	Date of Injury:	01/25/2002
Decision Date:	12/31/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/07/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 52-year-old male presenting with a work-related injury on January 20, 2002. The patient complained of upper back, bilateral shoulder, low back, right upper and lower leg and right knee pain. The patient is the sacroiliac joint effusion, status post bilateral shoulder pain, status post right shoulder joint replacement review. On May 2, 2014 the physical exam was significant for decreased range of motion of the left shoulder, and lack of strength on the left shoulder with resistance. The patient was diagnosed with discogenic low back pain, secondary to multilevel disc bulges, spondylolisthesis L1 over L2, L3, chronic right knee pain secondary to full fitness tear of the lateral role cartilage loss, history of bilateral heel spurs, bilateral shoulder pain status post right shoulder joint replacement. The patient's medications included MS Contin, soma, Norco, gabapentin, and buprenorphine. A claim was made for Soma 350mg quantity 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 27.

Decision rationale: Soma 350mg quantity 60 are not medically necessary. Ca MTUS states that Soma is not recommended. This medication is not indicated for long-term use. Carisoprodol is commonly prescribed, centrally acting skeletal muscle relaxant and his primary active metabolite is meprobamate (schedule for controlled substances). Carisoprodol is now scheduled in several states but not on the federal level. Since been suggested that the main affect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sentences and relaxants effects. In regular basis to maintain concern is the cannulation of medical date. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: Increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with tramadol to produce relaxation and euphoria; as a combination with hydrocodone, and affected some abusers claim is similar to heroin; the combination with codeine. There was a 300% increase in numbers of emergency room episodes related to Terrace Woodall from 1994 2005. Intoxication appears to include subjective consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both cars up at all 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 occur. This is similar to withdrawal from meprobamate. There is little research in terms of weaning of high dose carries up at all and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of a stroke. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg per day and the taper is 3 mg per day with a slower taper in an outpatient setting. Tapering should be individualized to reach patient. There was no specific time limit for the prescription of this medication or a weaning protocol; therefore Soma is not medically necessary.