

Case Number:	CM14-0192092		
Date Assigned:	11/25/2014	Date of Injury:	01/21/1997
Decision Date:	01/12/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/17/2014

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 Family Practice, and is licensed to practice in Ohio. 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 52-year-old male with a date of injury of January 21, 1997. He complains of low back pain radiating to the right lower extremity with associated back spasms. The physical exam reveals tenderness to palpation and spasm of the paraspinal lumbar musculature with diminished lumbar range of motion. There is tenderness to palpation of both sacroiliac joints in a positive Faber's sign. There is diminished sensation of the left lateral leg and the right posterior leg. The diagnoses include lumbar radiculopathy, muscle spasm, lumbar degenerative disc disease, lumbar spinal stenosis, and chronic bilateral knee pain. Treatment has largely been with acupuncture, Norco and Soma. The Norco and Soma have been repeatedly denied or modified to allow for tapering. The record reflects that the injured worker has been utilizing Soma continuously for at least a year. This medication has been repeatedly non-certified with allowances made for refills to allow for tapering. Of note, urine drug testing previously has been positive for cocaine, methadone, benzodiazepines, and marijuana. A note from the treating physician dated November 4, 2014 states that the intention was to diminish the Soma 350 mg from twice daily to once daily, or #30 in a month. However there is a request for authorization for #60 tablets from November 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Carisoprodol (Soma).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Carisoprodol (Soma®)

Decision rationale: Carisoprodol (Soma) is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a Schedule-IV controlled substance). As of January 2012, carisoprodol is scheduled by the DEA as a Schedule IV medication. (DEA, 2012) It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. This medication is not indicated for long-term use. 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. In this instance, there has been an effort to wean the injured worker from Soma. The injured worker had been taking Soma 350 mg twice daily since January 7, 2014 without an actual further reduction since then. In view of the treating physician's stated desire to reduce the Soma usage to once daily on November 4, 2014, the request for #60, or enough for twice daily dosing on November 17, 2014 seems to make little sense. Because this medication is not recommended for long-term use and because ample opportunity has been given for weaning, Soma 350 mg #60 is not medically necessary.