MAXIMUS Federal Services

Case Number:	CM14-0202611		
Date Assigned:	12/15/2014	Date of Injury:	01/22/2009
Decision Date:	02/23/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	12/03/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 33 year old patient who sustained injury on Jan 22 2009.He was diagnosed with a migraine variant and cervical spondylosis. He had previously tried home exercise, physical therapy and activity modification. He was prescribed multiple medications: soma, ibuprofen, propanolol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 67, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67, 72, 70.

Decision rationale: Per MTUS, Ibuprofen (Motrin, Advil [otc], generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient

Clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO 3-4 times a day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain. Chronic usage of this medication would not be indicated. As this patient had been on this medication for over a year, it would not be medically necessary.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 67, 78.

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

Decision rationale: Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centlly acting skeletal muscle relaxant whose primary active metaboliteis 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"). (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) (Reeves, 2004) 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. (Boothby, 2003) For more information and references, see Muscle relaxants. See also Weaning of medications. Per review of the clinical documentation provided, the patient had been on this medication chronically and this medication is not medically necessary.

Propranolol 80mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 67, 78.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nlm.nih.gov/pubmed/15106196; http://www.ncbi.nlm.nih.gov/pubmed/2611887

Decision rationale: MTUS and ACOEM do not address this medication, therefore alternate guidelines were sought. Per guidelines cited many trials have relevant methodological shortcomings, there is clear evidence that propranolol is more effective than placebo in the short-term interval treatment of migraine. Evidence on long-term effects is lacking. Propranolol seems to be as effective and safe as a variety of other drugs used for migraine prophylaxis. Although propranolol is still the drug of first choice for migraine prophylaxis, the optimal antimigraine dose of this drug is still unknown. The main aim of our study is to clarify this point. Fifty-three patients suffering from severe migraine attacks were given propranolol at low doses, close to or up to 1 mg/kg body weight daily, for one month. If the patient responded, then treatment was maintained unchanged for a further two months. If the patient did not respond, propranolol was progressively increased until control was obtained. Thirty-nine (73.5%) patients responded to low doses, and 7 of the 17 patients whose dose had been increased, because of poor or absent response, showed improvement. Five patients did not finish the study because of intolerable side effects, which intensified as the dose was increased. Tolerance was not noticed. In addition to confirming the well-known utility of propranolol in migraine prophylaxis, our results show that low doses are effective in controlling serious migraine bouts in many patients. Fewer than a third of patients will need higher doses in controlling migraine attacks. This patient was known to have migraine headache and was treated with propranolol. Propanolol is a beta blocker which is used to treat migraine, especially for prophylactic purposes. The patient was suffering from persistent migraine and had been tried on many prior interventions and medications which were not effective. This medication would be medically necessary.