

Case Number:	CM14-0210326		
Date Assigned:	01/14/2015	Date of Injury:	01/16/2000
Decision Date:	02/17/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/15/2014

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 51-year-old female with a date of injury of January 16, 2000. She has been involved in two motor vehicle accidents. She has had cervical fusion surgery on two occasions and lumbar fusion surgery twice with an intervening surgery for hardware removal. She continues to complain of headaches, neck pain, right trapezius pain, right shoulder pain, left leg pain with burning and a left foot drop. The physical exam reveals trigger points and spasm of the right upper trapezius and to a lesser extent the left side. There is diminished cervical range of motion. There is a left sided foot drop and absent Achilles tendon reflex. The diagnoses include muscle spasms, myalgia/myositis, failed neck surgery syndrome, failed back surgery syndrome, insomnia, cervical radiculopathy, and cervical spondylosis. She has been managed chronically with opioids including Percocet and MS Contin, Lyrica, Lexapro, Ambien, and Soma, one daily alternating with every other day usage. She has also received trigger point injections on a fairly regular basis and that seems to provide the most relief. At issue is a request for Soma 350 mg #15. The utilization reviewer did not certify the medication because of the length of time it has been prescribed and in fact provided for a modified quantity to allow for tapering. The treating physician countered by stating that his office was well aware of the potential addiction risk with soma but felt compelled to continue prescribing it given the lack of other options.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350 mg, fifteen count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for Pain) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 65.

Decision rationale: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See 2, 2008)Classifications: Muscle relaxants are a broad range of medications that are generally divided into antispasmodics, antispasticity drugs, and drugs with both actions. (See, 2008) (van Tulder,2006).Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. (See, 2008) (Reeves, 2003) In this instance, Soma has been in continuous use for several months at least. The continued use of Soma is therefore no longer medically appropriate or necessary under the referenced guidelines.