

Case Number:	CM15-0133833		
Date Assigned:	07/22/2015	Date of Injury:	05/18/2007
Decision Date:	08/25/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/10/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 51-year-old female sustained an industrial injury to the low back on 5/18/07. The injured worker underwent lumbar fusion at L5-S1 with bilateral L4-5 decompression laminotomy in 2008. In a follow up evaluation dated 6/4/15, the injured worker complained of ongoing low back pain rated 8-9/10 on the visual analog scale as well as new pain in her feet. The injured worker stated that her worst pain was 10/10 and least pain was 5/10. The injured worker reported that Norco and Soma were effective for controlling her pain. The injured worker continued to work 30 hours per week. Physical exam was remarkable for lumbar spine with decreased range of motion, tenderness to palpation in the right lumbosacral paraspinal musculature, negative straight leg raise, hyperesthesia in the right L4 and L5 distribution with 5/5 lower extremity strength with the exception of 4/5 with right leg extension and ankle dorsiflexion. Current diagnoses included chronic low back pain status post fusion, lumbar post laminectomy syndrome and opioid dependence for chronic pain. The physician noted that the injured worker clearly had chronic pain in her low back, which would be indefinitely treated using conservative therapies. The injured worker had tolerated Norco for quite some time; however, the physician recommended trying a long acting opiate for better round the clock pain control and reducing short acting opiates. The treatment plan included requesting authorization for long acting Hydrocodone for three days and then titrating up as tolerated, changing Norco dosage and refilling Soma.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350 mg: Upheld

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

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

Decision rationale: According to the MTUS, 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:(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 ██████████); & (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 injured workers 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 out-injured worker setting. Tapering should be individualized for each injured worker. (Boothby, 2003) For more information and references, see Muscle relaxants. See also Weaning of medications. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.