

<b>Case Number:</b>	CM15-0182267		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	06/03/2009
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2015

### 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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 51 year old female, who sustained an industrial injury on 6-3-09. The injured worker was diagnosed as having left hip pain, lumbalgia, lumbar disc displacement without myelopathy and neuralgia, neuritis and radiculitis. The physical exam (3-20-15 through 7-24-15) revealed 8-9 out of 10 pain in the lower back, left groin and head. Treatment to date has included chiropractic treatments, physical therapy, a left hip arthrogram in 5-2014 showing a labral tear and a lumbar epidural injection (date of service not found). Current medications include Norco, Ibuprofen and Soma and Ambien (since at least 1-10-15). As of the PR2 dated 8-21-15, the injured worker reports pain in her lower back, left groin and headaches. She rates her pain 8-9 out of 10. There is no documentation of current or previous work status. Objective findings include decreased lumbar range of motion and a positive straight leg raise test. The treating physician noted the injured worker was anxious and depressed. The treating physician requested Soma 350mg #90, Ambien 10mg #30 and a consultation with a psychiatrist. On 9-4-15 the treating physician requested a Utilization Review for Soma 350mg #90, Ambien 10mg #30 and a consultation with a psychiatrist. The Utilization Review dated 9-15-15, non-certified the request for Soma 350mg #90, Ambien 10mg #30 and a consultation with a psychiatrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

**Decision rationale:** The MTUS notes that Soma (carisoprodol) is not recommended for longer than a 2 to 3 week period. It is metabolized to meprobamate, which requires classification as a schedule IV drug in some states. Withdrawal symptoms may occur with sudden discontinuation. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. The ODG guidelines state that Soma is not recommended. 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. Carisoprodol 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. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse: 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. In this case the medical records document long-term use of Soma since at least December 2014. The current request is for a 1 month additional supply. The guidelines clearly note that Soma is not approved for long-term use beyond 2-3 weeks. There is no documentation regarding efficacy of this medication. The request for Soma 350mg #90 is not consistent with the MTUS and ODG guidelines and is not medically necessary.

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Zolpidem (Ambien).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Drug formulary, Ambien (zolpidem).

**Decision rationale:** The ODG guidelines note that zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Ambien CR offers no significant clinical advantage over regular release zolpidem. Ambien CR is approved for chronic use, but chronic use of hypnotics in general is discouraged. Ambien CR causes a greater frequency of dizziness, drowsiness, and headache compared to immediate release zolpidem. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term

outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. Due to adverse effects the FDA now requires lower doses for zolpidem. Even at the lower dose of Ambien CR now recommended by the FDA, 15% of women and 5% of men still had high levels of the drug in their system in the morning. According to SAMHSA, zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time. In this case the medical records document use of Ambien since at least December 2014, well beyond the two to six weeks (short-term) recommendation for treatment. There is no documentation of a diagnosis of insomnia, insomnia evaluation or justification for use beyond the ODG guideline recommendations. The request for Ambien 10mg #30 is not medically necessary.

**Consultation with a psychiatrist:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 7, Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** The American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines for Independent Medical Examinations and Consultations, recommends referral to another practitioner or specialist when the patient might benefit from additional expertise. The ACOEM guidelines note that the practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The consultation service is to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. In this case the medical records note that there are symptoms of anxiety and depression and the note on 8-21-15 does indicate a diagnosis of depression. The primary treating physician has requested psychiatric consultation, feeling that the injured worker might benefit from additional expertise. As such, the request for consultation with a psychiatrist is medically necessary.