Case Number:	CM15-0183082		
Date Assigned:	09/24/2015	Date of Injury:	03/26/1987
Decision Date:	11/06/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/17/2015

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: California
Certification(s)/Specialty: Family Practice

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 injured worker is a 64-year-old male who reported an industrial injury on 3-26-1987. His diagnoses, and or impressions, were noted to include: status-post lumbosacral pedicle screw fusion, cervical 3-4 & 6-7 fusions, and right shoulder "SAD" with distal clavicular resection; cervical degenerative disc disease; cervicalgia; low back pain with lumbar degenerative disc disease and lumbar radiculopathy; and bilateral carpal and cubital tunnel syndrome. No current imaging studies were noted. His treatments were noted to include: diagnostic computed tomography and x-ray studies; injection therapy and interventional pain management procedures; medication management; and rest from work. The progress notes of 8-26-2015 reported: increased neck and shoulder pain that would freeze-up and not move; neck flexion that caused pain to radiate to the top of the right shoulder; increased neck pain with movement; discomfort in the neck, upper & low back, shoulders and legs; tightness with restriction in the entire spine; that he continued to have more bad days than good; and that he had to sit flexed at the hips to alleviate some tension in his back. The objective findings were noted to include: 3 neck surgeries (1987, 1988 & 1999) with lumbar surgeries (1991, 1994 & 1995); an abnormal cervical exam with tenderness, marked cervical end-range-of-motion, stiffness-tenderness, and decreased cervical lordosis; taut muscle bands in the trapezial and levator scapulae; neck flexion resulted in pain radiation to top of right shoulder; right trapezial and levator scapulae trigger points, #8 identified; radiating pain in shoulder tip to back of head with decreased range-of-motion and positive central Spurling maneuver; tenderness in the lumbosacral muscles with decreased lumbar lordosis and prominence of the lumbar spinous processes; stood flexed at hips,

20 degrees, with knees bent, upper body off-set slightly to the left at mid-line; marked lumbar end- range-of-motion stiffness-tenderness, and tenderness at the bilateral sciatic and tibial nerves; bilateral sciatic notch tenderness; positive bilateral straight leg raise; abnormal to and heel walk with an antalgic gait and use of cane with forward bent posture that was hypo-lordotic in the cervical and lumbar spines; the inability to fully straighten due to iliopsoas muscle tightening; markedly limited strength in the upper and lower extremities that was limited with pain; paresthesias in the bilateral lower legs-feet; decreased deep tendon reflexes in the bilateral ankles and knees; and tenderness in the bilateral shoulders-elbows with decreased range-of-motion. The physician's requests for treatments were noted to include the continuation of his current medications. The Request for Authorization, dated 8-27-2015, was noted for: Hydromorphone 8 mg 2, 4 x a day, #240; Soma 350 mg 2, 4 x a day, #240; MS Contin 2-4, 3 x a day, #100; and Oxycodone 30 mg 5, every 4-6 hours, #750, all to be released on 9-4-2015. The Utilization Review of 9-2-2015 non-certified the request for the remaining Soma 350 mg #30, and the remaining MS Contin 100 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #240, 2 QID: 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: According to the MTUS guidelines, Carisoprodol (Soma) is not recommended. The MTUS guidelines state that this medication is not indicated for long-term use and 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"). The MTUS guidelines also note that there was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. The request for Soma 350mg #240, 2 QID is not medically necessary and appropriate.

MS Contin 100mg #330, 3-4 TID: 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): Opioids for chronic pain, Opioids, dosing.

Decision rationale: The long-term utilization of opioids is not supported for chronic non-malignant pain due to the development of habituation and tolerance. The MTUS guidelines do not support opioids for non-malignant pain. As noted in the MTUS guidelines, a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The MTUS guidelines also note that opioid tolerance develops with the repeated use of opioids and brings about the need to increase the dose and may lead to sensitization. As noted in the MTUS guidelines, it is now clear that analgesia may not occur with open-ended escalation of opioids. It has also become apparent that analgesia is not always sustained over time, and that pain may be improved with weaning of opioids. Per ODG, risks of adverse effects are documented in the literature at doses as low as 50 MED. Adverse effects include serious fractures, sleep apnea, hyperalgesia, immunosuppression, chronic constipation, bowel obstruction, myocardial infarction, and tooth decay due to xerostomia. Neuroendocrine problems include hypogonadism, erectile dysfunction, decreased libido, osteoporosis, and depression. This injured worker's MED far exceeds the MTUS guideline ceiling of 120 MED. The request for MS Contin 100mg #330, 3-4 TID is not medically necessary and appropriate.