

Case Number:	CM15-0200938		
Date Assigned:	10/16/2015	Date of Injury:	10/29/2012
Decision Date:	12/01/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/13/2015

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:

The injured worker is a 57 year old female who sustained an industrial injury on October 29, 2012. The worker is being treated for: neural encroachment with radiculopathy refractory. Subjective: January 14, 2015 low back pain with increasing left greater than right lower extremity symptoms. Complains of instability and multiple near falls with one actual fall. Complaint of increased spasm and recall "successful trial of antispasmodic." Inquiring if a DME brace support would help. Also states that during physical therapy utilization of TENS unit noted with benefit. March 20, 2015 "desires to refrain from narcotic analgesics." "recalls frequent inability to adhere to recommended exercise regimen without medication on board." April 15, 2015 low back pain with right lower symptom; "recalls refractory spasm prior to Flexeril." May 08, 2015 patient with renal symptom "no medications" due to kidney issues. Objective: March 20, 2015 "medications at current dosing facilitates maintenance of ADL's." Medications: June 15, 2015 prescribed Cymbalta, Flexeril. March 20, 2015 Duloxetine, Cymbalta, and Flexeril. February 11, 2105 Tramadol ER. April 15, 2015 Duloxetine, Naproxen, Pantoprazole, Flexeril. Treatment modalities: physical therapy session, medications. On September 30, 2015 a request was made for Soma 350mg #60 that was noncertified with recommendation for weaning by Utilization Review on October 07, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Soma 350 mg #60 with a dos of 9/30/2015: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

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 "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 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.