

Case Number:	CM15-0213518		
Date Assigned:	11/03/2015	Date of Injury:	09/18/1992
Decision Date:	12/21/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/30/2015

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 51 year old male, who sustained an industrial-work injury on 9-18-92. He reported initial complaints of back pain. The injured worker was diagnosed as having chronic low back pain, herniated nucleus pulposus, and sciatica. Treatment to date has included medication, home exercises, beneficial steroid epidural injections (2), and surgery (L5-S1 laminectomy and discectomy). Currently, the injured worker complains of increased low back pain that was intermittent, mild to moderate and dull pain. There was no radiation or weakness. There was occasional numbness in the right foot. Normal work duties resumed. Medications include Tylenol #4, Soma, and Ibuprofen. Medications were prescribed since at least 2-24-15. Per the primary physician's progress report (PR-2) on 9-22-15, exam noted 1+ tenderness to palpation of the lumbar spine at the midline and paraspinous muscles without spasm, absent DTR (deep tendon reflexes) in the lower extremities, sensation decreased in the dorsum of the right foot, normal motor strength, and normal heel-toe walk. Current plan of care includes medication and acupuncture. The Request for Authorization requested service to include Soma 350mg #60. The Utilization Review on 10-20-15 denied the request for Soma 350mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #60: Upheld

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

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 ██████████); & (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 outinjured 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. The request is not medically necessary.