

Case Number:	CM15-0220363		
Date Assigned:	11/13/2015	Date of Injury:	08/13/1993
Decision Date:	12/28/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	11/09/2015

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: Florida, New York, Pennsylvania
 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:

The injured worker is a 53-year-old female, who sustained an industrial injury on 08-13-1993. She has reported injury to the neck and low back. The diagnoses have included post-laminectomy syndrome, lumbar region; displacement lumbar disc without myelopathy; degeneration lumbar-lumbosacral intervertebral disc; lumbar spinal stenosis; sacroiliitis; post-laminectomy syndrome, cervical region; spinal stenosis in cervical region; degeneration cervical intervertebral disc; and status post posterior cervical thoracic revision, on 02-09-2015. Treatment to date has included medications, diagnostics, heat, ice, trigger point injections; epidurals; chiropractic therapy, physical therapy, spinal cord stimulator placement and removal, and multiple surgical interventions to the neck and low back. Medications have included Oxycodone, MS Contin, Soma, Cymbalta, Diazepam, and Trazodone (all since at least 02-26-2015). A progress report from the treating provider, dated 08-26-2015, documented an evaluation with the injured worker. The injured worker reported pain in the neck, shoulders, low back, and bilateral hips; the average pain level over the past week is rated at 9 out of 10 in intensity; the pain is described as constant, sharp, spasm, jabbing, throbbing, and aching; associated symptoms include fatigue, weakness, tenderness, and stiffness; the pain increases while walking, standing, twisting, and bending; and modifying factors include improvement with no movement. Objective findings included she is alert and oriented; limited range of motion and stiffness of the neck; tenderness over the bilateral cervical paraspinal muscles; lumbar ranges of motion are decreased with pain; tenderness over the bilateral lumbar paraspinal muscles; vertebral tenderness at the midline, lumbar region, and cervical region; gluteus medius tenderness is noted

bilaterally; trochanteric bursa tenderness is noted bilaterally; and gait is unsteady. The treatment plan has included the request for Soma 350mg, #270 (3 month supply). The original utilization review, dated 10-02-2015, non-certified the request for Soma 350mg, #270 (3 month supply).

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg, #270 (3 month supply): 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): Weaning of Medications, Carisoprodol (Soma).

Decision rationale: The members DOI are reported as 13 Aug 93. The injury was reported to be for both the neck and low back. She has a myriad on ongoing chronic diagnoses related to both her lumbar and cervical spine. She has undergone multiple cervical and upper thoracic fusion procedures. She remains dependent on narcotics, SOMA and multiple other medications to include Cymbalta, Trazodone and Diazepam. Pain is reported as 9/10 with multiple pain complaints and an examination showing decreased ROM stiffness and tenderness to palpation. Carisoprodol 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"). 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. 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. There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients 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 outpatient setting. Tapering should be individualized for each patient. The request is not medically necessary.