

Case Number:	CM15-0056294		
Date Assigned:	04/17/2015	Date of Injury:	05/05/2000
Decision Date:	05/15/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/24/2015

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: Georgia

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 50 year old male, who sustained an industrial injury on May 5, 2000. The injured worker was diagnosed as having low back pain with lumbar radiculopathy, status post L5-S1 fusion with L4-L5 disc replacement and subsequent L4-L5 fusion on July 28, 2010, lumbar degenerative disc disease, depression/anxiety, status post bilateral L4-L5 facet rhizotomy on March 23, 2009, hypogonadism secondary to opioid usage, history of elevated liver enzymes, status post left thoracotomy secondary to benign infectious lung mass performed April 29, 2013, and normalized testosterone levels per labs with testosterone supplementation. Treatment to date has included lumbar epidural injection, spinal cord stimulator, lumbar fusion, lumbar facet rhizotomy, AFO, and medication. Currently, the injured worker complains of low back and lower extremity pain. The Primary Treating Physician's report dated January 28, 2015, noted the injured worker reported being stable with the current medication regimen, with improvement in pain and function, however remains symptomatic. The injured worker reported continuing to note benefit from the caudal epidural steroid injection (ESI) performed on November 25, 2014. The injured worker's current medications were noted to include Hydrocodone/APAP, Gabapentin, Ibuprofen, Bupropion, Eszopiclone, Fortesta, Carisoprodol, and Omeprazole. Physical examination was noted to show mild bilateral lumbar paraspinal tenderness over the lumbosacral region with 1+ muscle spasms and significant weakness and foot drop requiring an AFO brace for the right leg. The treatment plan was noted to include request for authorization for the injured worker to continue Norco, Gabapentin, Carisoprodol, Fortesta, Bupropion, Eszopiclone, Ibuprofen, and Omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation to and from surgery center: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: Transportation to and from surgery center is not medically necessary. CA MTUS guidelines and ODG does not reference transportation; however reference is made towards home health services Per CA MTUS page 51, Home health services are "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or 'intermittent' basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." (CMS, 2004). The claimant does not have a medical condition that denotes he as homebound on part-time or full time basis. The request is not medically necessary.

Carisoprodol 350mg QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma.

Decision rationale: Carisoprodol tablets 350mg are not medically necessary. Ca MTUS states that Soma is not recommended. This medication is not indicated for long-term use. Carisoprodol is commonly prescribed, centrally acting skeletal muscle relaxant and his primary active metabolite is meprobamate (schedule for controlled substances). Carisoprodol is now scheduled in several states but not on the federal level. Since been suggested that the main affect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sentences and relaxants effects. In regular basis to maintain concern is the cannulation of medical date. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: Increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with tramadol to produce relaxation and euphoria; as a combination with hydrocodone, and affected some abusers claim is similar to heroin; the combination with codeine. There was a 300% increase in numbers of emergency room episodes related to Terrace Woodall from 1994 2005. Intoxication appears to include subjective consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both cars up at all 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 carries up at all and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of a stroke. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg per day and the taper is 3 mg per day with a slower taper in an outpatient setting. Tapering should be individualized to reach patient. There was no specific time limit for the prescription of this medication or a weaning protocol; therefore, Carisopodrol is not medically necessary.