

Case Number:	CM15-0236112		
Date Assigned:	12/11/2015	Date of Injury:	05/17/1999
Decision Date:	01/21/2016	UR Denial Date:	11/16/2015
Priority:	Standard	Application Received:	12/03/2015

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 5-17-99. A review of the medical records indicates she is undergoing treatment for low back pain, lumbar intervertebral disc degeneration, arthropathy, and long-term use of opiate medications. Medical records (7-30-15, 8-26-15, 9-24-15, and 10-21-15) indicate ongoing complaints of head pain, neck pain, and low back pain. Her neck pain has varied from "2 out of 10" with medications to "7 out of 10" with medications (10-21-15, 8-26-15). She rates her back pain "2-4 out of 10" with medications. She is able to completed self-care, bathing, brushing teeth, cooking, dressing, driving, and shopping. She reports that she is unable to complete laundry and gardening. The physical exam (10-21-15) reveals complaints of fatigue. Diagnostic studies have included a urine drug toxicology screen on 10-21-15, showing consistent results. Treatment has included medications. Her medications include Biofreeze roll-on, Toradol injections, Motrin, Percocet, and Soma (since at least 12-21-10). The utilization review (11-16-15) includes a request for authorization of Soma 350mg #120. The request was modified to a quantity of 96.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg qty: 120.00 start: 10/21/15: 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.