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| <b>Case Number:</b>   | CM14-0214533 |                              |            |
| <b>Date Assigned:</b> | 01/07/2015   | <b>Date of Injury:</b>       | 05/28/2008 |
| <b>Decision Date:</b> | 03/03/2015   | <b>UR Denial Date:</b>       | 12/12/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/22/2014 |

### 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: California  
 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:

This 56-year old man reported knee injuries due to cumulative trauma from his usual job duties, with an injury date of 5/28/08. Past medical history is notable for obesity, with a body mass index of 30.4. Treatment has included a right total knee replacement on 8/18/08 and a left unicompartmental arthroplasty in 1/10. The records contain progress notes from the current primary treater dated 5/9/14 to 11/24/14. It is not clear what the patient's work status has been during this time period. It is sometimes listed as "permanent and stationary 1/24/04", and sometimes listed as "modified with no restrictions, current job congenial with current level of disability". Several of the notes document that the patient was terminated by his employer in 7/14 because they could not accommodate his restrictions, and that the patient was unsuccessful in claiming harassment and wrongful termination. At every visit the patient's medications are noted to include Norco 10/325 and Soma 350 mg. The rationale for continuing these to medications is always the same: that they slightly decrease the patient's pain level, and allow him to increase his activity level. Specific activities listed as made possible by Norco and Soma include walking on a treadmill for 10 minutes, riding a stationary bicycle for 10 minutes, taking out the garbage, and standing to do laundry and self-care. These activity levels do not change from 5/9/14 to 11/24/14. Every note contains the results of a urine drug screen dated 5/16/14 which was positive for Hydrocodone, Oxycodone, Carisoprodol and marijuana metabolites. The provider never specifically comments on these results. Requests for Norco 10/325 #90 and Soma 350 mg #60 were modified in UR on 12/12/14 from Norco #90 to #19, and from Soma #60 to

#13 to allow for weaning. MTUS Chronic Pain, Opioids and Carisoprodol were cited as the basis for the decision.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**90 tablets of Norco 10/325 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60, Criteria for Use of Opioids, Steps to Take Before a Thera.

**Decision rationale:** Norco 10/325 is brand-name Hydrocodone 10 mg with Acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Opioids should be discontinued if there is no improvement in function. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. This patient has been prescribed Norco since at least 5/9/14, and probably for much longer. No assessment is documented as to whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. It is quite concerning that the patient had a drug screen on 5/16/14 that was consistent with use of non-prescribed medications (Oxycodone and marijuana) and which should have raised concerns about aberrant drug behavior. The provider does not appear to have addressed these concerns. No specific functional goals were set or followed. Although the treater states that the patient is able to walk on a treadmill or use an exercise bike for 10 minutes if he uses Norco, it is not clear how often he does so, how often he did before he began Norco, and whether this activity is a functional goal. Most importantly, Norco was not discontinued when it became clear that it has not produced any functional improvement. The patient's activity level is not documented as improving in any way, and he appears to have regressed from working to not working while taking Norco. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Norco 10/325 #90 is not medically necessary. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because an inconsistent drug screen should have raised concerns about aberrant drug behavior that have not been addressed, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.

**60 tablets of Soma 350 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60 and Carisoprodol, page 29.

**Decision rationale:** Soma is brand-name Carisoprodol, which is a centrally acting skeletal muscle relaxant. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The second guideline states that Carisoprodol is not recommended, and is not indicated for long-term use. Its primary metabolite, meprobamate, is a controlled substance. Carisoprodol has substantial abuse potential. It also may augment the effects of other drugs including benzodiazepines and hydrocodone. Some abusers claim that the combination of Carisoprodol and hydrocodone produces effects that are similar to those of heroin. The records in this case reveal that this patient has been taking Soma for at least 6 months and probably longer. There is no documented evidence that Soma has improved his level of function in any way. Although the treater states that the patient is able to walk on a treadmill or use an exercise bike for 10 minutes if he uses Soma, it is not clear how often he does so, how often he did before he began Soma, and whether this activity is a functional goal. These activities are not documented as improving in the 6 months for which records are available. The patient has stopped working during the time he has been taking Soma, which would argue that his functional level has actually declined. Soma is not an appropriate medication for a patient who may have abuse potential, which appears to be the case for this patient. Given its sedating effects, especially in Norco, it seems quite likely that Soma is contributing to this patient's low functional level. Taking the evidence-based guidelines cited above and the clinical findings in this case into account, Soma 350 mg #60 is not medically necessary. It is not medically necessary because it is not recommended by MTUS guidelines, because it should not be taken long-term, because it is not an appropriate drug for a patient who may have abuse potential, and because its use has not resulted in any functional improvement in this patient and may in fact be contributing to his ongoing low level of function.