

<b>Case Number:</b>	CM15-0012454		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	11/07/1997
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Ohio, North Carolina, Virginia  
 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 58 year old female sustained a work related injury on 11/07/1997. According to a progress report dated 12/03/2014, the injured worker was seen for a follow up regarding her chronic neck pain and history of complex regional pain syndrome. She continued to have stiffness without any changes since the last office visit. She had numbness in her hand. She reported low back pain with numbness to her leg without any precipitating event or trauma. Physical examination revealed limited range of motion in the wrist/hand, vertebral spine midline tenderness, moderate spasm bilaterally to the paraspinals and severe muscle tension at the bilateral upper trapezius musculature. Assessments included post-lami syndrome, complex regional pain syndrome, upper, fibromyositis, neck pain and genetic testing narcotic. According to the provider, medications were providing relief without uncontrolled side effects. The injured worker reported that she is better able to accomplish activities of daily living with use of the medication. She reported more difficulty accomplishing activities of daily living if a dose of the medication was missed. A prescription of Naproxen was not filled. Soma was prescribed for spasms, Percocet for breakthrough pain and MS Contin as a long acting medication. According to the oldest progress report dated 06/18/2014, the injured worker's medication regimen included Soma and Naproxen. On 12/24/2014, Utilization Review non-certified Soma 350mg 1-2 tabs every 6 hours #140 and Naproxen 500mg 1 tablet every 8 hours #90. According to the Utilization Review physician, in regard to Soma, there was no clear indication of acute muscle spasms. CA MTUS Chronic Pain Medical Treatment Guidelines, pages 29, 65 were cited. In regard to Naproxen, the duration of use was unclear as well as the specific efficacy from this medication. Chronic use of

Naproxen is not supported. CA MTUS Chronic Pain Medical Treatment Guidelines page 46 and the Official Disability Guidelines, Pain Chapter were cited. The decision was appealed for an Independent Medical Review.

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

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

**Soma 350mg #140:** 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 Muscle relaxants for pain and weaning of medications Page(s): 65 and 124.

**Decision rationale:** Carisoprodol (Soma, Soprodol 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. (See, 2008) (Reeves, 2003) For more details, see Carisoprodol, where it is not recommended. See also Weaning of medications. Side Effects: drowsiness, psychological and physical dependence, & withdrawal with acute discontinuation. Dosing: 250 mg-350 mg four times a day. In this case, the Soma has been in continuous use for 6 months or longer, a length of time that greatly exceeds the recommendations. The quantity of Soma requested also provides for a dosing frequency greater than what is recommended. The injured worker's clinical exam is essentially unchanged month to month. Soma 350mg #140 is not medically necessary with reference to the cited guidelines. Weaning is recommended. Carisoprodol (Soma): This medication is metabolized to meprobamate, a barbiturate. At the highest levels of barbiturate tolerance, the patient is at risk of delirium, seizures or even death with abrupt discontinuation. 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

**Naproxen 500mg #90:** 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 NSAIDS Page(s): 67.

**Decision rationale:** NSAIDs like Naproxen are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. In this instance, the injured worker has been taking Naproxen continuously for at least 6 months. The effect of the Naproxen is unclear as it appears her greatest relief has come from alternating doses of Soma and opioids. The injured worker has been taking a combination of variable prednisone doses and Naproxen for at least 6 months. That combination is known to increase the risk of gastric ulceration. Because of a lack of clear efficacy in this instance and the potentially concerning combination with prednisone, Naproxen 500mg #90 is not medically necessary.