



Case Number:	CM15-0111750		
Date Assigned:	06/18/2015	Date of Injury:	03/27/2014
Decision Date:	07/21/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/09/2015

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: California

Certification(s)/Specialty: Internal Medicine

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 29 year old female, who sustained an industrial injury on 03/27/2014. She has reported injury to the low back, and the left hip, knee, lower leg, and ankle. The diagnoses have included lumbar spine pain; sprains/strains, lumbosacral joint/ligament; contusion of left knee; contusion of back, buttock; left-sided sacroiliitis; and left ankle sprain. Treatment to date has included medications, diagnostics, TENS (transcutaneous electrical nerve stimulation) unit, physical therapy, home exercises, and left sacroiliac joint injection. Medications have included Celebrex, Soma, and Norco. A progress report from the treating physician, dated 05/01/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of continued lower back pain, which stops her from doing her usual activities; she has achy pain across her lower back that extends into her left buttock and back of her left upper leg; standing, walking, lifting, and bending can cause aggravation of her pain; she had lumbar injections in her back this week, and has noticed no improvement with injections; and she is currently taking Celebrex, Norco, and soma for the pain. It is noted that the use of the TENS unit is not helpful. Objective findings included appears in mild distress and changes the position with some caution due to low back discomfort; continued tenderness of the lumbar paraspinal muscles, mostly on the left side at L4 through S1 levels; no appreciable spasms; continued pain with movement; flexion with complaints of pain; straight leg raising test is mildly positive on the left; and she no longer has and tenderness of her left knee. The treatment plan has included the request for Norco 5/325mg #90; and Soma 350mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-pain treatment agreement Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81; 88-89.

Decision rationale: Based on MTUS guidelines, opioids (such as Norco 5/325) have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials for long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (≤ 70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment. Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate. There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. Current studies suggest that the "upper limit of normal" for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in the range from 120-180 mg morphine equivalents a day. Criteria for long-term users of opioids (6-months or more) include: 1) Re-assess: Has the diagnosis changed; What other medications is the patient taking and are they effective or producing side effects; Document pain and functional improvement and compare to baseline; Document adverse effects; Does the patient appear to need a psychological consultation; Is there indication for a screening instrument for abuse/addiction; In this case, there does not appear to be clear documentation of functional improvement with the pain medication and there is no pain contract in place. Lastly, long-term use of opioid medications are not recommended due to the abuse potential and risk for dependence as well as the multiple side effects that can be experienced. Therefore based on MTUS guidelines, the request for Norco 5/325 # 90 is not medically necessary.

Soma 350mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Carisoprodol (Soma) Page(s): 29.

Decision rationale: Based on MTUS guidelines, Soma is not recommended. This medication is not indicated for long-term use. Soma is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Soma 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. Soma 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 some abusers claim is similar to heroin & (5) as a combination with codeine. There was a 300% increase in the numbers of ER episodes related to soma from 1994 to 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 soma 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 occur. This is similar to withdrawal from meprobamate. There is little research in terms of weaning of high dose soma and there is no standard treatment regimen for patients with known dependence. In this case, the patient has been on this medication for at least several months, and this far exceeds any short-term therapy for which the medication is indicated. Also, Soma is not recommended by MTUS guidelines due to the high risk for abuse, and dependence and potential for significant side effects. Therefore, based on the evidence in this case and the MTUS guidelines, the request for Soma 350 mg #60 is not medically necessary.