

Case Number:	CM15-0078924		
Date Assigned:	04/30/2015	Date of Injury:	09/21/2000
Decision Date:	05/29/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/24/2015

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: 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:

The injured worker is a 56 year old female, who sustained an industrial injury on 9/21/00. She reported pain in her neck and back. The injured worker was diagnosed as having status post cervical spine fusion, cervical radiculopathy and lumbar radiculopathy. Treatment to date has included an LSO brace and Soma, Norco and Gabapentin since at least 12/8/14. As of the PR2 dated 3/2/15, the injured worker reports excruciating pain in the neck and back. She is using LSO brace that provides relief while standing. The treating physician noted a positive straight leg raise test and tenderness to palpation. The treating physician requested to continue Soma 350mg #120, Norco 10/325mg #120 and Gabapentin 300mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350 mg #120: 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 Carisoprodol Page(s): 29.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of carisoprodol, also known as Soma, as a treatment modality. The use of Soma 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. In this case, Soma is being prescribed as a long-term treatment for this patient's symptoms. As described in the above cited guidelines, the use of Soma is not recommended. Therefore, for this reason, Soma is not medically necessary.

Norco 10/325 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Norco. These guidelines have established criteria of the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the 4 As for Ongoing Monitoring. These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the 4 As for Ongoing Monitoring. The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. Finally, a urine drug screen was negative for

opioids, despite the evidence that the patient had been prescribed Norco. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Norco is not considered as medically necessary.

Gabapentin 300 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of anti-epilepsy drugs (AEDs), including gabapentin, for the treatment of chronic pain. AEDs are generally recommended for the treatment of neuropathic pain. However, there must be ongoing evidence that use of an AED has an impact on functional/pain outcomes. The MTUS guidelines defines these outcomes as follows: Outcome: A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the trigger for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, there is insufficient documentation that the patient has experienced any improvement after initiating treatment with gabapentin. Further, the latest urine drug screen did not detect the presence of gabapentin in spite of the ongoing prescriptions for its use. For these reasons, gabapentin is not considered as a medically necessary treatment.