

**Health Decisions, Inc.**

**506 Winchester Dr.**

**Celina, TX 75009**

**P 972-800-0641**

**F 888-349-9735**

Notice of Independent Review Decision

**[Date notice sent to all parties]:** October 9, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Continued use of Vicodin, Xanax, and Elavil

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

The physician is Board Certified in Physical Medicine and Rehabilitation with over 17 years of experience.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

03-14-06: MRI Cervical Spine  
02-20-07: Clinic Note  
03-16-07: Repeat Impairment Rating Review  
03-28-07: Patient Encounter  
03-30-07: Office Note  
04-25-07: Patient Encounter  
05-15-07: Initial Assessment and Closure Report  
05-23-07: Patient Encounter  
06-05-07: Follow up  
07-11-07: Patient Encounter  
07-16-07: Office Note  
08-28-07: Patient Encounter  
09-26-07: Office Note  
11-27-07: Office Note

12-05-07: Medical Peer Review  
01-02-08: Designated Doctor Evaluation  
02-06-08: Functional Capacity Evaluation  
03-19-08: Patient Encounter  
03-21-08: Office Note  
06-03-08: Patient Encounter  
09-22-08: Office Note  
03-02-10: Patient Encounter  
09-01-10: Letter  
11-01-10: Patient Encounter  
12-02-10: Designated Doctor Exam  
02-22-11: Patient Encounter  
04-25-11: Patient Encounter  
07-14-11: Patient Encounter  
09-22-11: Patient Encounter  
10-20-11: Patient Encounter  
11-21-11: Patient Encounter  
12-11-11: Patient Encounter  
12-20-11: Patient Encounter  
01-19-12: Patient Encounter  
02-22-12: Patient Encounter  
07-18-12: Patient Encounter  
08-17-12: Patient Encounter  
10-25-12: Patient Encounter  
12-11-12: Patient Encounter  
12-28-12: Medical Peer Review  
01-11-13: Patient Encounter  
01-31-13: Patient Encounter  
02-13-13: Patient Encounter  
03-13-13: Patient Encounter  
04-11-13: Patient Encounter  
04-24-13: Patient Encounter  
05-15-13: Patient Encounter  
06-28-13: Medical Peer Review  
07-11-13: Patient Encounter  
08-08-13: Letter of Medical Necessity  
08-08-13: Patient Encounter  
09-05-13: Patient Encounter

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant tripped falling to the ground on to her hands and knees on xx/xx/xx. Her initial diagnosis was contusion to left shoulder, and myofascial neck pain without radiculopathy, superficial abrasion of the right palmar hand, and hyperextension sprain of bilateral wrists. According to the records, a MRI of the cervical spine was performed on 04-14-05 and revealed mild spondylitic changes of the lower cervical spine at C5-C6 and C6-C7 causing mild neural foraminal narrowing at those levels. She also underwent an EMG/NCV on 05-12-05 that

revealed a normal study. Treatment has included physical therapy, chiropractic treatment, work hardening program, TENS unit, prescription medications and injections. She has taking several medications to help with the pain and continues to need them for pain management. Multiple Patient Encounter notes were provided. These documents are illegible with circled Yes/No questions without clear physical exam findings.

March 14, 2006, MRI of the Cervical Spine without Contrast, Impression: Changes of spondylosis seen within the cervical spine. C4-C5 through C6-C7, resulting in impression on the anterior thecal sac and mild flattening. There is also bilateral neural foraminal narrowing at these levels. Underlying linear cord signal is seen. This may be artifactual but underlying edema in the cord cannot be entirely excluded.

May 15, 2007, according to an initial assessment and closure report, the claimant was scheduled for shoulder surgery on 6-13-07. She indicated that she will also need additional surgery on her left shoulder once her right one is healed. The claimant complained of moderate to severe pain in neck, back, knee, shoulders, and her wrists. She could not tolerate prolonged standing, due to pain in the back and the knees. Increased activity made it worse. The claimant continued to take medication to help with the pain management.

June, 5, 2007, the claimant was evaluated and continued to have pain in her left shoulder. She received a cortisone trigger point injection in her left shoulder. She tolerated the procedure well.

December 2, 2010, the claimant was seen for a Designated Doctor Exam to discuss returning to work. According to the summary, the claimant was forced to discontinue accommodated duty owing to pain and the need for daily opioid analgesia. Current medications included Hydrocodone, alprazolam, and fluoxetine. On physical examination of the cervical spine, moderate palpation produced tenderness in the paracervical muscles bilaterally, which were bunched and tight. Cervical motion was non-dysmetric but restricted by pain to the near and mid ranges of all six movement planes. Upper extremity strengths were 4/5 weak diffusely. On left shoulder exam, inflammation, edema, and visible deformity were absent. Upper extremity musculature was well maintained, include the deltoid, but abduction was pain-restricted to 90 degrees. The greater tubercle was quite tender to deep palpation.

December 28, 2012 performed a Medical Peer Review. Response: Based on the available documentation/information there does not appear to be any significant objective functional limitation occurring at this time that would be preventing a return back to work at any physical demand level. Rather it appeared that the patient did not have any significant positive objective physical exam findings and the diagnostic workup did not reveal any significant abnormalities objectively that would prevent a return back to work as well. Since there does not appear to be significant positive objective findings or functional limitations occurring there is no

support for ongoing prescription medication treatment. Of the medication that were available for review including Vicodin, Xanax, Zocor, Aciphex, Lasix and Elavil the Zocor, Aciphex and Lasix do not appear to be related. There was also no documentation of any specific objective neuropathic pain condition occurring that would support the need for Elavil. There was also no support for the ongoing treatment with the Vicodin and Xanax as opioids and benzodiazepines are not supported for long-term use based on the guideline criteria. There was also no documentation of any specific objective anxiety condition occurring to support the need for the Xanax. There was also no documentation of any significant or severe positive objective findings that would be accounting for a pain condition to support the need for the Vicodin. The patient should be followed by their primary care provider to manage the Zocor, Aciphex and Lasix outside of this workers' compensation claim. The Vicodin, Xanax and Elavil should be weaned and discontinued over approximately 30-60 days.

January 31, 2013, the claimant was given a letter of medical necessity stating that she requires the use of Vicodin, Xanax, and Elavil. The injuries she suffered are compensable injuries when she fell at a construction site, and caused chronic pain. She should continue to take the medications permanently.

June 28, 2013 performed a Medical Peer Review. Response: Based on the available documentation, ongoing treatment with Vicodin as a p.r.n. pain medication, which is an opioid, is not supported for long-term use for chronic pain. Xanax is an anxiolytic which is not related to the claimant's work injury and was being prescribed by an outside doctor initially, then taken over. However, the claimant has no objective findings regarding the anxiety, and this is not part of her compensable injury. There is no documentation supporting the need for Xanax. There is also no documentation of a neuropathic pain condition. The claimant's EMG studies were normal, and therefore Elavil would not be supported. There is also evidence of MRI of nerve root compression supporting a diagnosis of radiculopathy. Elavil and Xanax can be weaned slowly as well as the Vicodin, over a 1-month to 60 day interval.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The previous adverse determinations are agreed upon/upheld. Deny permanent use of medications, particularly Vicodin, Xanax and Elavil since there is lack of clinical information. There is no information as to how the medications are actually taken (not just how they are prescribed), their effectiveness (such as change in pain scale level, examples of and objective evidence of improved function, change in psychological parameters), adverse side effects, urine drug screens, red flags such as escalated use of opioids, abuse or diversion, no documentation of neuropathic pain for the Elavil, no psychological testing regarding anxiety regarding Xanax, and Anxiolytics are not recommended for long term use given potential of physical and psychological dependence. Therefore, the request for continued use of Vicodin, Xanax, and Elavil is denied.

## PER ODG:

Medications for subacute & chronic pain

Recommended as indicated below. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to [improvements in function](#) and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. ([Mens, 2005](#)) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others. ([Chou, 2006](#)) There are multiple medication choices listed separately (not all recommended). See [Anticonvulsants for chronic pain](#); [Antidepressants for chronic pain](#); [Antidepressants for neuropathic pain](#); [Antidepressants for non-neuropathic pain](#); [Antiemetics](#) (for opioid nausea); [Anxiety medications in chronic pain](#); [Anti-epilepsy drugs](#) (AEDs); [Anti-Inflammatories](#); [Benzodiazepines](#); [Boswellia Serrata Resin](#) (Frankincense); [Buprenorphine](#); [Cannabinoids](#); [Capsaicin](#); [Cod liver oil](#); [Compound drugs](#); [Curcumin](#) (Turmeric); [Cyclobenzaprine](#) (Flexeril®); [Duloxetine](#) (Cymbalta®); [Gabapentin](#) (Neurontin®); [Glucosamine](#) (and Chondroitin Sulfate); [Green tea](#); [Herbal medicines](#); [Implantable drug-delivery systems](#) (IDDSs); [Injection with anaesthetics and/or steroids](#); [Insomnia treatment](#); [Intrathecal drug delivery systems, medications](#); [Intravenous regional sympathetic blocks](#) (for RSD, nerve blocks); [Ketamine](#); [Medical food](#); [Methadone](#); [Milnacipran](#) (Ixel®); [Muscle relaxants](#); [Nonprescription medications](#); [NSAIDs](#) (non-steroidal anti-inflammatory drugs); [NSAIDs, GI symptoms & cardiovascular risk](#); [Opioids](#) (with links to multiple topics on opioids); [Opioid-induced constipation treatment](#); [Proton pump inhibitors](#) (PPIs); [Pycnogenol](#) (maritime pine bark); [Salicylate topicals](#); [Tapentadol](#); [Topical analgesics](#); [Uncaria Tomentosa](#) (Cat's Claw); [Venlafaxine](#) (Effexor®); [White willow bark](#); & [Ziconotide](#) (Prialt®).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**