

<b>Case Number:</b>	CM14-0194792		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	08/06/2007
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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: 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:

On 6/17/14 the patient was noted to be on the following meds: Effexor, Zantac, Flexeril, Trazadone, and Welbutrin. On 8/11/14 she saw her MD who noted that she had had a complicated history of neck injury. She was noted to have bilateral paraspinal neck spasm and good range of motion of her neck. He diagnosed a flare up of her neck pain and his diagnosis was cervicalgia spasm acute on chronic and DJD of her neck. He treated with symptomatic measures and Lodine, Soma, Vicodin, and PT. On 10/6/14 she reapointed with her MD and was noted to have notable improvement of her chronic cervicalgia and her spasm. The patient noted that PT was beneficial. On exam she had some right side paraspinal muscle spasm but good ROM was observed. His diagnosis was chronic intermittent cervicalgia and spasm. He discussed with the patient the fact that UR had refused to allow anti-inflammatory muscle relaxants or more PT. The MD noted that the patient was not a surgical candidate and wanted to refer to pain management for continued treatment. We note that UR denied the request for Lodine and Vicodin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lodaine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Chronic Pain Treatment Guidelines Page(s): 67, 69. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Up to date topic 9682 and version 145.0

**Decision rationale:** The guidelines state that non-steroidal anti-inflammatory drugs (NSAIDs) in general are indicated for acute exacerbation of pain and should be avoided in the treatment of chronic pain and should be a second line drug after the use of acetaminophen because of less side effects. Lodine is a medication in the NSAID class. NSAIDs have been implicated in cardiac, gastrointestinal (GI), renal side effects and high blood pressure. A Cochrane study confirmed the above and a Maroon study stated that NSAID's may actually delay healing of all soft tissue if given on a chronic basis. In a review in the shoulder section of the AECOM it states that invasive techniques have limited proven value. If pain with elevation causes significant limitation in activity then sub acromial injection with a local anesthetic and steroid preparation may be attempted after 2 to 3 weeks of conservative treatment with shoulder strengthening exercises and NSAID treatment. Treatment indications for NSAID's include such entities as ankylosing spondylitis, osteoarthritis, rheumatoid arthritis, acute gout, dysmenorrhea, acute tendinitis and bursitis, and acute migraine. In the above patient, we note that she was not on Lodine prior to her exacerbation of pain and that this medicine was started in the summer of 2014. In October, we note that the acute exacerbation had ended and she had intermittent neck pain. Therefore, the request is not medically necessary.

**Vicodin:** 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 Page(s): 75, 91.

**Decision rationale:** Vicodin is noted to be a short acting opioid effective in controlling chronic pain and often used intermittently and for breakthrough pain. It is noted that it is used for moderate to moderately severe pain. The dose is limited by the Tylenol component and officially should not exceed 4 grams per day of this medicine. The most feared side effects are circulatory and respiratory depression. The most common side effects include dizziness, sedation, nausea, sweating, dry mouth, and itching. In general, opioid effectiveness is noted to be augmented with 1- education as to its benefits and limitations, 2- the employment of non-opioid treatments such as relaxation techniques and mindfulness techniques, 3- the establishment of realistic goals, and 4- encouragement of self-regulation to avoid the misuse of the medication. The MTUS notes that opioid medicines should be not the first line treatment for neuropathic pain because of the need for higher doses in this type of pain. It is also recommended that dosing in excess of the equivalent of 120 mg QD of morphine sulfate should be avoided unless there are unusual circumstances and pain management consultation has been made. It is also stated that the use of

opioids in chronic back pain is effective in short term relief of pain and that long term relief of pain appears to be limited. However, the MTUS does state that these meds should be continued if the patient was noted to return to work and if there was noted to be an improvement in pain and functionality. Also, it is noted that if the medicine is effective in maintenance treatment that dose reduction should not be done. We note that in the above patient that she had had an exacerbation of her neck pain that was treated with Vicodin. However, on the visit in October we note that the patient was back to baseline and that PT had been very helpful. At this point, the Vicodin should be D/Cd and possibly reinstated for a short course of treatment if exacerbation of pain reoccurred in the future. Therefore, the request is not medically necessary.