

<b>Case Number:</b>	CM14-0031308		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	10/21/2011
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 50-year-old male who reported an injury 10/21/2011. The mechanism of injury was not provided within the medical records. The clinical note dated 01/27/2014 indicated the injured worker reported neck pain and right shoulder and back pain rated 10/10. The injured worker reported wanting to be admitted to the emergency room and have liver test obtained. The injured worker reported nausea, the clinical note is handwritten and hard to decipher. The injured worker's official x-ray dated 01/27/2014 revealed negative exam of the chest. The injured worker reported he had severe intermittent back pain that radiated from neck down to the legs. The injured worker denied any recent trauma. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Vicodin and Motrin. The provider submitted a request for Vicoprofen. A Request for Authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicoprofen 7.5 mg/ 200 quantity #90, 2 Units:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Ibuprofen (Vicoprofen).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

**Decision rationale:** The request for Vicoprofen 7.5 mg/ 200 quantity #90, 2 Units is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of significant evidence of an objective assessment of the injured worker's pain level, functional status and evaluation of risk for aberrant drug use, behaviors and side effects. In addition, there is lack of documentation including an adequate and complete physical exam done on the injured worker. Moreover, it is not indicated how long the injured worker had been utilizing this medication. Furthermore, the request did not indicate a frequency for this medication. Therefore, the request is not medically necessary.