

<b>Case Number:</b>	CM15-0124257		
<b>Date Assigned:</b>	07/08/2015	<b>Date of Injury:</b>	06/06/2008
<b>Decision Date:</b>	08/05/2015	<b>UR Denial Date:</b>	05/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 62-year-old male with an industrial injury dated 06/06/2008. The injured worker's diagnoses include status post anterior fusion at L4-S1 and instability at L3-4, lesser degree at L2-3. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 04/15/2015, the treating physician reported pain and spasms throughout back with intermittent radiating pain of significant severity on the injured worker's left leg. Objective findings revealed guarded movement with left antalgic gait, severely limited range of motion of the thoracolumbar spine, and moderately positive straight leg raises test on the left. The treating physician prescribed Vicoprofen 200/7.5 mg, sixty count now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicoprofen 200/7.5 mg, sixty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Pain, Opioids.

**Decision rationale:** ODG states concerning Vicprofren (Hydrocodone/Ibuprofen). Recommended for short term use only (generally less than 10 days). The patient has exceeded the 10 day recommended treatment length for usage. MTUS does not discourage use of opioids past 2 weeks, but does state that 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. The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Vicoprofen 200/7.5 mg, sixty count is not medically necessary.