

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jan/20/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Vicoprofen 7.5/200 mg #90

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology and Pain Medicine

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that medical necessity is not established for the requested Vicoprofen 7.5/200 mg #90

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical record 06/12/13  
Clinical record 11/13/13  
Prior utilization reports 11/11/13 and 11/26/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who sustained an injury on xx/xx/xx due to a repetitive use injury. The patient had been diagnosed with reflex sympathetic dystrophy. Prior medication use included hydrocodone 32/712mg, ibuprofen, soma, and Zoloft. The clinical record on 06/12/13 indicated the patient had recent epidural steroid injections which provided approximately 70% pain relief in the right upper extremity. Physical examination was relatively unremarkable. The assessment indicated that there was swelling, allodynia, mottling, discoloration, and temperature change. Overall the findings were reported to have dramatically improved with epidural steroid injections. The patient was seen on 11/13/13. Pain was rated at 9/10 on VAS. Physical examination continued to show decreased sensation in the right shoulder with decreased range of motion. The patient was recommended for additional epidural steroid injections. The use of Vicoprofen was denied by utilization review on 11/11/13 as there were no indications for the medication including rheumatoid arthritis or osteoarthritis. The request was again denied by utilization review on 11/26/13 as there was no specific rationale regarding ongoing use of Vicoprofen. It did not appear that the patient was having successful results with the use of pain medications.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for ongoing complaints of RSD type symptoms in the right upper extremity. This was substantially improved with cervical epidural steroid injections; however, this response was only temporary. The patient reported severe 9/10 pain on VAS as of 11/13/13. The clinical

documentation submitted for review does not establish any functional improvement or pain reduction within the continued use of Vicoprofen. There was also no documentation regarding any recent compliance measures such as toxicology results or long term opioid risk assessments which are recommended by current evidence based guidelines. Given the lack of documentation regarding functional improvement or pain reduction with the continued use of narcotics, it is the opinion of this reviewer that medical necessity is not established for the requested Vicoprofen 7.5/200 mg #90 and the prior denials are upheld.

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

ACOEM-AMERICA 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)