

<b>Case Number:</b>	CM14-0146586		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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 Internal Medicine and is licensed to practice in California. 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 patient is a 49 year old male who was injured on 02/01/2013 when he was assaulted. Prior medication history included Norco and Anaprox. There are no urine drug screenings available for review. Office note dated 11/19/2013 states the patient complained of neck, back, and right knee pain. He reported his activities of daily living are affected such as self-care, hand function, and sensory function. On exam, he has pain that radiates to bilateral knees, right greater than left, with associated numbness and tingling to the knees intermittently. The lumbar spine range of motion revealed extension is decreased at 50%; left lateral flexion is decreased at 50%. The patient is diagnosed with chronic lumbar sprain/strain with nonverifiable radiculopathy; chronic left wrist sprain; and thoracic sprain/strain. There were no other progress notes available for review. Prior utilization review dated 08/15/2014 states the request for Anaprox DS 550mg (one tablet twice daily), #60 is not certified as there is a lack of documented evidence to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS 550mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Anaprox DS(r)).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs) Page(s): 67-73.

**Decision rationale:** The guidelines recommend NSAID therapy for acute or acute on chronic pain for short-term treatment. Generally treatment should not exceed 4-6 weeks. It is unclear from the documents how long the patient has been taking NSAIDs but it appears to be longer than the recommended duration. It is unclear from the documents provided how significant the benefit from NSAID therapy has been. From the documents provided the indication for ongoing NSAID therapy is unclear. Based on the guidelines and criteria as well as the clinical documentation stated above, the request of Anaprox DS 550mg, #60 is not medically necessary and appropriate.