

Case Number:	CM14-0067523		
Date Assigned:	07/11/2014	Date of Injury:	08/20/2008
Decision Date:	09/19/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/12/2014

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 and Pain Medicine and is licensed to practice in Texas and Ohio. 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 52-year-old male who reported an injury on 08/20/2008. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar intervertebral disc disorder, lumbar radiculitis/radiculopathy, symptoms of anxiety and depression. Previous treatments included medication, home exercise and aqua therapy. Diagnostic testing included an MRI and EMG/NCV. Within the clinical note dated 04/15/2014, it was reported the injured worker complained of pain and stiffness in the lower back. He reported radiating pain in his right lower extremity. He complained of persistent numbness and tingling in the right lower extremity. On the physical examination, the provider noted tenderness of the mild paravertebral muscles in the lower lumbar region. The injured worker had tenderness on palpation of the right sciatic notch and right gluteal muscle. The range of motion of the lumbar spine was decreased in all planes with forward flexion at 40 degrees and extension at 14 degrees. The provider requested Naprosyn. However, the rationale was not provided for clinical review. The request for authorization was submitted and dated on 04/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium tablets, 550 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66, 67.

Decision rationale: The request for Naproxen Sodium tablets 550 mg is not medically necessary. The California MTUS Guidelines note Naproxen is a nonsteroidal anti-inflammatory drug for the relief of symptoms of osteoarthritis. The guidelines recommend the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the quantity of the medication. Therefore, the request is not medically necessary.