

Case Number:	CM14-0092442		
Date Assigned:	07/25/2014	Date of Injury:	07/10/2010
Decision Date:	09/12/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/18/2014

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 & Rehabilitation and 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 53-year-old male who reported an injury on 07/10/2010. The mechanism of injury was noted to be a slip and fall. Prior surgeries were noted to be unspecified left knee surgery. The injured worker had prior treatments of physical therapy and medications. A Request for Authorization was provided and dated 02/06/2014. The injured worker had a clinical evaluation on 05/02/2014. The injured worker's subjective complaints were noted to be pain located in the head, neck, low back, and left knee. Current medications were noted to be Cyclobenzaprine, Ibuprofen, Simvastatin and Topamax. The objective physical exam findings include tenderness over the paracentral musculature and suprascapular trapezius. In addition, there were muscle spasms and trigger points. His diagnoses were noted to be neck pain/myofascial pain syndrome, lumbar myofascial pain, left knee derangement of medial meniscus/arthroscopic partial medial meniscectomy patellofemoral symptoms/syndrome, and headache/myofascial pain syndrome. The recommendations include physical therapy and medication management. The provider's rationale for the request was not noted within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 99070: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Naproxen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
NONSELECTIVE NSAIDS Page(s): 73.

Decision rationale: The request for Anaprox DS 99070 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend Anaprox at 275 to 550 mg by mouth twice daily. It is noted by the guidelines that the maximum dose on day 1 should not exceed 1375 mg and 1100 mg on subsequent days. The provider's request fails to indicate a dose and frequency and quantity. As such, the request for Anaprox DS 99070 is not medically necessary.