

Case Number:	CM15-0143497		
Date Assigned:	08/04/2015	Date of Injury:	08/17/2009
Decision Date:	09/24/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/23/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 42-year-old male, who sustained an industrial injury on 8-17-2009. The mechanism of injury occurred while pushing and moving a trailer. The injured worker was diagnosed as having lumbosacral spondylosis, lumbar radiculopathy, lumbar degenerative disc disease, bilateral shoulder pain and chronic pain syndrome. Lumbar magnetic resonance imaging showed multilevel disc bulging. Treatment to date has included therapy and medication management. In a progress note dated 7-1-2015, the injured worker complains of pain in the neck, mid back, low back, buttock and shoulder rated 9 out of 10 without medication and 6 out of 10 with medications. Physical examination showed left flank pain with myofascial restrictions, sacroiliac tenderness, and lumbar paraspinal tenderness and decreased left shoulder range of motion. The treating physician is requesting Anaprox DS tablet 550 mg #60 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS tab 550mg #60 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, p68-73 Page(s): 68-73.

Decision rationale: The claimant sustained a work-related injury in August 2009 and is being treated for pain throughout his spine and bilateral shoulders. When seen, medications were providing pain relief and facilitating activities of daily living. Physical examination findings included a BMI of nearly 45. There was pain with lumbar range of motion. There was sacroiliac joint and lumbar tenderness. There was back pain with straight leg raising. Left shoulder range of motion was decreased with positive drop arm test. Oral NSAIDs (non-steroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain and for control of inflammation. Dosing of naproxen (Anaprox-DS) is 275-550 mg twice daily and the maximum daily dose should not exceed 1100 mg. In this case, the requested dosing is within guideline recommendations and medically necessary.