

Case Number:	CM15-0089548		
Date Assigned:	05/13/2015	Date of Injury:	05/23/2013
Decision Date:	06/18/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/11/2015

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: California

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 55 year old male, who sustained an industrial injury to the neck, low back and right knee on 05/23/2013. Documented treatments and diagnostic testing to date has included conservative care, medications, x-rays, MRIs, electrodiagnostic testing, conservative therapies, injections, and left knee surgery. Currently, the injured worker complains of axial low back pain with numbness and tingling radiating into the lower extremities, lower extremity weakness, shooting pain into the back of both legs, and left knee pain. Pertinent objective findings include tenderness to palpation of the posterior lumbar musculature bilaterally with increased muscle rigidity, tenderness to numerous trigger points throughout the lumbar paraspinal musculature, decreased range of motion with guarding of the lumbar spine, antalgic gait favoring the left lower extremity, decreased sensation in the lower extremities, positive straight leg raise bilaterally at 60°, and tenderness along the medial and lateral joint lines of the left knee. No current medications were listed. Relevant diagnoses include lumbar degenerative disc disease with central and bilateral foraminal stenosis resulting in neurogenic claudication and bilateral lower extremity radiculopathy, left knee internal derangement status post arthroscopy (11/2013), and medication induced gastritis. The treatment plan consisted of anaprox DS 550 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550mg, twice a day, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Naprosyn, delayed release).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Anaprox (Naproxen), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, the patient is undergoing conservative management with over the counter Advil and therapy sessions. There is no clear rationale provided for the need of prescription naproxen. In the absence of such documentation, the currently requested Anaprox (Naproxen) is not medically necessary.