

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0141957 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 05/18/2013 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 08/04/2014 |
| Priority: | Standard | Application Received: | 09/02/2014 |

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, has a subspecialty in 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 43-year-old male who reported an injury on 05/18/2013. The mechanism of injury was a fall. The diagnoses included lateral epicondylitis, contusion of the elbow, elbow/forearm sprain, shoulder/arm sprain. The previous treatments included medication. Within the clinical note dated 07/09/2014 it was reported the injured worker complained of right shoulder pain. He complained of right elbow pain. He rated his pain 7/10 in severity. Medication regimen included Anaprox and Norco. Upon the physical examination the provider noted the injured worker had tenderness at the subacromial space. The provider noted the injured worker had tenderness at the bicipital groove, pain with resisted abduction and pain with biceps flexion. The range of motion was decreased with abduction and flexion. The provider requested Anaprox. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated 07/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, Page(s): 66-67.

Decision rationale: The request for Anaprox 550mg #60 is not medically necessary. The California MTUS Guidelines note naproxen is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend naproxen at 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 evidence by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.