

<b>Case Number:</b>	CM14-0158973		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	01/01/2005
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Family Practice and is licensed to practice in Alabama, Mississippi, and Tennessee. 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:

This injured worker is a 70-year-old female with a reported date of injury 01/01/2005. The mechanism of injury was not included. Her diagnoses include degeneration of the cervical intervertebral disc, disorders of the bursae and tendons in the shoulder region, lumbosacral spondylosis without myelopathy, cervicalgia, degeneration of the lumbar or lumbosacral intervertebral disc, and thoracic or lumbosacral neuritis. Her past treatments include medications, injections, and therapy. No diagnostic studies were included. The injured worker presented on 07/14/2014 with a follow-up to the right greater trochanteric steroid injection. She stated she has had no flare ups and simply needed her medication refilled. She denied arthritis, myositis, numbness, swelling, tingling, pain or migratory pain. Upon physical exam, her musculoskeletal system revealed normal findings and clinical documentation noted her overall pain condition was controlled with the medications. Her medications included Norco, cyclobenzaprine, Gralise, and Celebrex. The treatment plan was to continue the medications due to the injured worker's assessed improvement. The request was for Celebrex 200 mg 1 cap daily and compounding cream and the rationale was to maintain pain control stability. The Request for Authorization was not included in the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200mg 1 cap daily:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

**Decision rationale:** The request for Celebrex 200 mg 1 cap daily is not medically necessary. The California MTUS Guidelines recommend the lowest effective dose be used for all non-steroidal anti-inflammatory drug (NSAIDs) for the shortest duration of time. The injured worker presented stating she needed her medication refilled. She denied arthritis, myositis, numbness, swelling, tingling, pain or migratory pain. The most recent clinical note failed to document evidence of quantifiable pain relief and objective functional improvement with the patient's use of Celebrex. Therefore, it cannot be determined that she would benefit significantly from the ongoing use of this medication. No clinical documentation was submitted to support sufficient improvement in function that would offset the potential gastrointestinal risk of this medication. She has been prescribed this medication in excess of greater than one year. The request did not specify the quantity of the medication. As such, the request for Celebrex 200 mg 1 cap daily is not medically necessary.

**Compounding cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS Guidelines recommend topical compounds as an option primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Its use is largely experimental in use with few randomized control trials to determine efficacy or safety, with few randomized control trials to determine efficacy or safety. The injured worker presented stating she needed her medication refilled. She denied arthritis, myositis, numbness, swelling, tingling, pain or migratory pain. Any compounded product that contains at least one drug that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The request did not specify the ingredients for the compound, dose, the frequency, the amount, or the body part to be applied. Therefore, the request for compounding cream is not medically necessary.