

<b>Case Number:</b>	CM14-0162996		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	04/20/2008
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Medicine and is licensed to practice in North Carolina. 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 patient is a 62-year-old with a reported date of injury of 04/20/2008. The patient has the diagnoses of status post lumbar fusion at L5-S1, revision of fusion, chronic pain syndrome and lumbar radiculopathy. Per the progress reports provided for review by the treating physician dated 08/01/2014, the patient had complaints of lumbar spine pain radiating to the bilateral lower extremities that was rated a 8/10. The physical exam noted moderate tenderness over the lumbar paraspinal muscles, moderate facet tenderness at the levels of L4-S1 and positive sacroiliac tenderness, Fabere's test, sacroiliac thrust test, Kemp's test and Patrick's test. There was decreased sensation at L4-S1 dermatomes bilaterally. The treatment recommendations included prescriptions for Celebrex, Elavil and Xanax.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 Celebrex 10mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, Page(s): 68-70.

**Decision rationale:** The California chronic pain medical treatment guidelines section on Celebrex states: Selective COX-2 NSAIDs: Celecoxib (Celebrex) is the only available COX-2 in the United States. No generic is available. Mechanism of Action: Inhibits prostaglandin synthesis by decreasing cyclooxygenase-2 (COX-2). At therapeutic concentrations, cyclooxygenase-1 (COX-1) is not inhibited. In animal models it works as an anti-inflammatory, analgesic, and antipyretic. It does not have an anti-platelet effect and is not a substitute for aspirin for cardiac prophylaxis. Use: Relief of the signs and symptoms of osteoarthritis, rheumatoid arthritis, [and] ankylosing spondylitis. Side Effects: See NSAIDs, hypertension and renal function; & NSAIDs, GI Symptoms and Cardiovascular Risks. Cardiovascular: Hypertension (13%) CNS: headache (15.8%), dizziness (1% - 2%), insomnia (2.3%); GI: diarrhea (4% to 11%), dyspepsia (8.8% vs. 12.8% for ibuprofen and 6.2% for placebo), diarrhea (5.6%), abdominal pain (4.1% vs. 9% for ibuprofen and 2.8% for placebo), N/V (3.5%), gastroesophageal reflux (5%), flatulence (2.2%); Neuromuscular/ skeletal: arthralgia (7%), back pain (3%); Respiratory: upper respiratory tract infection (8%), cough (7%), sinusitis (5%), rhinitis (2%), pharyngitis (2%); Skin Rash (2%) - discontinue if rash develops; Peripheral Edema (2.1%). Recommended Dose: 200 mg a day (single dose or 100 mg twice a day). (Celebrex package insert) This patient is not at high risk for gastrointestinal events. The patient reportedly has hypertension but does not have major risk factors for cardiovascular disease per the California MTUS. The California MTUS recommends Naproxen as the first line choice in patients with mild to moderate risk factors for cardiovascular disease. There is no documented evidence of failure of Naproxen or gastrointestinal events, which would make the use of a COX-2 inhibitor necessary. Therefore criteria for its use has not been met per the California MTUS guidelines and the request are not certified.

**Elavil 25mg:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants, Page(s): 131-4.

**Decision rationale:** The California chronic pain medical treatment guidelines section on antidepressants states: Antidepressants for chronic pain Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. Amitriptyline: Neuropathic pain: The starting dose may be as low as 10-25 mg at night, with increases of 10-25 mg once or twice a week up to 100 mg/day. (ICSI, 2007) The lowest effective dose should be used (Dworkin, 2007). Fibromyalgia: One review recommended the following dosing regimen: Start with low doses, such as 5-10 mg

1-3 hours before bedtime. Dose may be increased by 5 mg at two-week intervals; final dose is dependent upon efficacy and patient tolerability to side effects. Doses that have been studied range from 25 to 50 mg at bedtime. (Goldenberg, 2007) This patient has the diagnoses of lumbar radiculopathy and neuropathic pain. The requested medication is a first line treatment option per the California MTUS. The patient has no contraindications to take the medication. Therefore the request is certified.

**Xanax 0.5mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Chronic low back pain: Tricyclic antidepressants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
benzodiazepines Page(s): 24.

**Decision rationale:** The California chronic pain medical treatment guidelines section on benzodiazepines states: Benzodiazepines Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) The requested medication is not recommended for long-term use and is the treatment of choice in very few conditions in the setting of chronic use. Per the progress notes, the patient was prescribed the medication to assist with sleep. There is no evidence of failure of other first line choices for insomnia or anxiety. Therefore the request is not certified.