

Case Number:	CM15-0107657		
Date Assigned:	06/12/2015	Date of Injury:	11/15/2000
Decision Date:	07/14/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/04/2015

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 75-year-old female, who sustained an industrial/work injury on 11/15/00. She reported initial complaints of back pain. The injured worker was diagnosed as having lumbosacral disc degeneration, spondylosis of the lumbar spine with myelopathy, lumbago, and chronic pain syndrome. Treatment to date has included medication, steroid epidural injections, and facet block injections. Currently, the injured worker complains of chronic back pain with sciatica. Pain levels range from 3-7/10 that improved after steroid injection several months earlier. Per the primary physician's progress report (PR-2) on 12/17/14, there was mild tenderness over the right per lumbar muscles without spasm or asymmetry, able to bend forward well, but has pain on hyperextending the back, no sciatic notch tenderness or distal weakness. Current plan of care included continuing current medication. The requested treatments include Celecoxib 200mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celecoxib 200mg quantity 60 with five refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celecoxib; Non Steroidal Anti Inflammatory Drugs.

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

Decision rationale: Regarding the request for Celebrex, 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. Celebrex is recommended for patients at intermediate to high risk for gastrointestinal events with no cardiovascular disease. Within the documentation available for review, there is indication that Celebrex is reducing the pain by 50% without known side effects. Additionally, the patient has taken other NSAIDs such as ibuprofen and Naproxen with documented treatment failure. As such, the currently requested Celebrex is medically necessary.