

<b>Case Number:</b>	CM15-0142300		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	10/24/2008
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 66 year old female, who sustained an industrial injury on October 24, 2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having unspecified spinal backache and cervical strain. Treatment and diagnostic studies to date has included laboratory studies, electromyogram with nerve conduction study, sleep study, medication regimen, and trigger point injections. In a progress note dated May 21, 2015 the treating physician reports complaints of pain at work. Examination reveals a slow, antalgic, stooped gait, decreased range of motion to the cervical spine with pain, tenderness, tightness, and trigger points to the bilateral cervical paravertebral muscles, decreased range of motion to the lumbar spine with pain, hypertonicity, tightness, and trigger points to the bilateral lumbar paravertebral muscles, positive pelvic compression testing, tenderness to the right wrist, and swelling to the right wrist joint, and decreased sensation to the medial foot on the right and to the medial thigh on the left. The injured worker's current medication regimen included Nucynta, Celebrex, Flector Patch, Zanaflex, and Omeprazole. The injured worker's pain level was rated a 6 on a scale of 1 to 10 with the use of her medication regimen and the pain level was rated an 8 on a scale of 1 to 10 without the use of her medication regimen. The treating physician requested Celebrex 100mg capsules with a quantity of 30 with the treating physician noting that the injured worker's medication regimen alleviates her pain along with noted functional improvement. The treating physician also indicated that the injured worker will adjust the spacing of her medications to assist with the pain that occurs while at work.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 100mg cap #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID use and proton pump inhibitors (PPI) states: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxen plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxen is ineffective, the suggested treatment is (1) the addition of aspirin to naproxen plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine, 2007) Use with Aspirin for cardio-protective effect: In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007) In terms of the actual cardio-protective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the anti-platelet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before. (Antman, 2007) Cox-2 NSAIDs and diclofenac (a traditional NSAID) do not decrease anti-platelet effect. (Laine, 2007) Per the California MTUS guidelines, Cox-2 agents like Celebrex are indicated for patients at intermediate or high gastrointestinal risk. While the patient has had non-specific GI complaints, there are no documented risk factors that place the patient at intermediate or high risk as set forth above. Therefore the medication does not meet criteria and is not medically necessary.