MAXIMUS Federal Services

Case Number:	CM15-0165145		
Date Assigned:	09/02/2015	Date of Injury:	08/26/2013
Decision Date:	10/06/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/24/2015

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 55 year old female, who sustained an industrial injury on 8-26-2013. The mechanism of injury was not described. The injured worker was diagnosed as having rule out internal derangement right knee, right knee patellar tendinitis, edema around right gluteus minimus tendon, right lumbar radiculopathy, cervical pain with right upper extremity symptoms, thoracic myofascial pain, and right hip pain. Treatment to date has included diagnostics, chiropractic, acupuncture, transcutaneous electrical nerve stimulation unit, and medications. A progress report (3-09-2015) noted gastrointestinal (GI) upset with nonsteroidal anti- inflammatory drug use without proton pump inhibitor (PPI). Her medication included Naproxen three times daily. It was documented that she failed other first line nonsteroidal anti-inflammatory drugs and Cox-2 drug trials were non-efficacious, as afforded no relief. She denied GI upset with PPI at current dosing (three times daily). It was documented that recent labs, inclusive of complete blood count and comprehensive metabolic panel, were normal. Currently (8-10-2015), the injured worker complains of right hip and left knee pain (rated 6 out of 10), increasing right knee pain (rated 8 out of 10), and thoracic pain (rated 5 out of 10). Medications included Hydrocodone, Cyclobenzaprine, Pantoprazole, and Celebrex. The use of Celebrex was referenced in the progress report dated 7-27-2015. Consistent pain levels were documented. The treatment plan included continued medications, including Celebrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200 mg, sixty count: Overturned

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

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 gastro-intestinal 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 naproxyn 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 naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn 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 cardioprotective 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 cardioprotective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the antiplatlet 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) The patient has documented failure of NSAID therapy with PPI. Therefore, the request is medically necessary.