

Case Number:	CM15-0198672		
Date Assigned:	10/14/2015	Date of Injury:	09/08/1979
Decision Date:	11/23/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/09/2015

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:

This is a 79 year old male who sustained an industrial injury on 9-8-1979. A review of the medical records indicates that the injured worker is undergoing treatment for status post lumbar fusion L1-S1, lumbar radiculopathy, adjacent segment disease, right L5-S1 radiculopathy and thoracic disc herniations with neural foraminal narrowing. Medical records (5-14-2015 to 9-10-2015) indicate ongoing low back pain. On 8-12-2015, the injured worker reported that pain had gotten progressively worse since 5-2015. He also complained of back spasms and intermittent burning in his feet. He rated his pain 6-7 out of 10. He reported that medications provided about 40% of temporary relief. On 7-23-2015, the injured worker reported that Promolaxin was helping to decrease his narcotic induced constipation. Per the treating physician (8-12-2015), the disability status was permanent and stationary. The physical exam (8-12-2015 to 9-10-2015) revealed an antalgic gait. He had tenderness to palpation of the thoracic and lumbar spine with severe spasms noted. Range of motion of the thoracic and lumbar spine was limited. There was decreased sensation of the right L4 dermatome. Treatment has included surgery, chiropractic treatment, physical therapy, acupuncture and medications. Current medications (9-10-2015) included Flexeril, Senna, Celebrex (since at least 3-19-2015), Norco (since at least 3-19-2015), Diazepam, Prilosec, Terocin patches and Capsaicin cream. The injured worker reported that Celebrex did not work as well as Naproxen. The treating physician indicates (8-12-2015) that an oral swab collected on 5-14-2015 was consistent for current medications. The request for authorization was dated 9-10-2015. The original Utilization Review (UR) (9-14-2015) modified a request for Norco from quantity 120 to quantity 60 and denied a request for Celebrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120, unspecified refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Celebrex 200mg #30, unspecified refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

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 ug 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. 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. In terms of the actual cardioprotective effect of aspirin: Traditional NSAIDs (both Ibuprofen and Naproxen) appear to attenuate the antiplatelet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before Cox-2 NSAIDs and Diclofenac (a traditional NSAID) do not decrease anti-platelet effect. 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.