

Case Number:	CM15-0041413		
Date Assigned:	03/11/2015	Date of Injury:	10/15/2013
Decision Date:	04/15/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	03/04/2015

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: 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 10/15/2013. On provider visit dated 12/22/2014 the injured worker has reported increased low back pain. On examination was noted to have tenderness to palpation of lumbar spine. The diagnoses have included cervical strain with degenerative disc disease, lumbar strain with degenerative disc disease, anxiety and insomnia. Treatment to date has included medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

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

Decision rationale: 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 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 antiplatelet 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 does not have risk factors that would require a COX-2 inhibitor over a traditional NSAID. Therefore the request is not certified.