

<b>Case Number:</b>	CM15-0050049		
<b>Date Assigned:</b>	03/23/2015	<b>Date of Injury:</b>	12/15/2004
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 49 year old male, who sustained an industrial injury on December 15, 2004. The injured worker reported back pain radiating down left leg. The injured worker was diagnosed as having post lumbar laminectomy syndrome, sacroiliac pain, lumbar radiculopathy and lumbar degenerative disc disease (DDD). Treatment and diagnostic studies to date have included medication, injections, H-wave therapy and surgery. A progress note dated February 4, 2015 provides the injured worker complains of low backache rated 1/10 with medication and 5/10 without medication. He reports his activity has increased since last visit and that medication works well. Physical exam notes the injured worker appears to be in mild pain, have decreased lumbar range of motion (ROM) with tenderness and have normal lower extremity strength. The plan includes surgery, H-wave therapy and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200 mg capsule Qty 30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti inflammatory medications Page(s): 27-30.

**Decision rationale:** According to MTUS guidelines, Celebrex is indicated in case of back , neck and shoulder pain especially in case of failure or contraindication of NSAIDs. There is no clear documentation that the patient failed previous use of NSAIDs. There is no documentation of contra indication of other NSAIDs. There is no documentation that Celebrex was used for the shortest period and the lowest dose. The patient continued to report back pain. Therefore, the prescription of Celebrex 200mg #30, with 3 refills is not medically necessary.