

<b>Case Number:</b>	CM15-0127251		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	08/08/2014
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2015

### 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 41-year-old male who sustained an industrial injury on 8/8/14. He had complaints of back pain. Treatments to date include medication, physical therapy, chiropractic, and acupuncture. Orthopedic progress report dated 5/15/15 reports continued complaints of low back pain with radiating pain into both gluteal regions. Previous right leg pain has slowly improved. The pain is aggravated by lifting heavier weight, repetitive lifting and prolonged walking. When pain is aggravated it is rated 9/10 no longer taking medications. Diagnoses include: L4-5 and L5-S1 lumbar disc protrusion with right leg radicular symptoms and persistent mechanical back pain with associated lumbar facet syndrome. Plan of care includes: provided prescriptions for Ultracet 37/32, #60 1 every 6 hours as needed for pain, Flexeril 10 mg #60 one twice per day as needed and celebrex on a trial basis 200 mg 1 every day physical therapy 2 times per week for 6 weeks. Work status: not currently working. Follow up in 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200mg QTY: 30:** Upheld

**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 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) The patient does not have risk factors that would require a COX-2 inhibitor over a traditional NSAID. Therefore, the request is not medically necessary.