

<b>Case Number:</b>	CM15-0087641		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	01/03/2009
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: California

Certification(s)/Specialty: Internal 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 31-year-old male who sustained an industrial motor vehicle accident injury on 01/03/2009. The injured worker suffered facial and dental injuries, cervical spine injuries, spinal cord contusion and right lower extremity fracture. On the date of injury, the injured worker was stabilized with an external fixator to the right tibia-fibula fracture, repair of the posterior tibial artery with thrombectomy and vein graft and a four compartment fasciotomy of the right lower extremity and evacuation of a right thigh hematoma. On January 5, 2009, a Steinmann pin was applied and the right knee dislocation was reduced. Multiple surgical interventions followed for the right lower extremity, facial reconstructions, and cervical spine with external fixator and collar for 3-month duration for a lateral mass fracture of C1 and transverse process fracture at C2. He was discharged in May 2009 from in-patient rehabilitation. According to the primary treating physician's progress report on April 14, 2015, the injured worker continues to experience right lower extremity pain. The injured worker rates his pain level at 3/10 with medications and 9/10 without medications. Examination demonstrated a right Trendelenburg gait with right foot laterally rotated during stance and right patella deviated laterally. The cervical spine demonstrated decreased range of motion in all field and tenderness to palpation at the paracervical and trapezius muscles. Examination of the lumbar spine noted full range of motion without tenderness and negative straight leg raise. No motor weakness was evident. Right lower extremity edema was evident with anatomic deformity and decreased range of motion of the right knee and ankle secondary to pain. Current medications are listed as, Norco, Topamax, Celebrex, Colace and Levitra x. Treatment plan consists of continuing medication regimen, use Jobe stockings with compression machine, increase Celebrex for

swelling and the current request for a multidisciplinary evaluation for a functional restoration program (FRP) candidacy determination, Celebrex and Norco medication renewal.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **1 Referral for a Multidisciplinary Evaluation for FRP: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75, Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page 30-34. Functional restoration programs (FRPs) Page 49. Biopsychosocial model of chronic pain Page 25. Decision based on Non-MTUS Citation ACOEM 2nd Edition (2004) Chapter 7 Independent Medical Examiner Page 127. Official Disability Guidelines (ODG) Pain (Chronic) Office visits.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses multidisciplinary programs. Chronic pain programs are also called multidisciplinary pain programs, interdisciplinary rehabilitation programs, or functional restoration programs (FRP). These pain rehabilitation programs combine multiple treatments. Chronic pain programs (functional restoration programs) are recommended for patients with conditions that put them at risk of delayed recovery. An adequate and thorough evaluation has been made including baseline functional testing is a criterion for the general use of multidisciplinary pain management programs. MTUS addresses occupational physicians and other health professionals. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 5 Cornerstones of Disability Prevention and Management (Page 75) indicates that occupational physicians and other health professionals who treat work-related injuries and illness can make an important contribution to the appropriate management of work-related symptoms, illnesses, or injuries by managing disability and time lost from work as well as medical care. ACOEM Chapter 7 Independent Medical Examiner (Page 127) indicates that the health practitioner may refer to other specialists when the plan or course of care may benefit from additional expertise. The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss, or fitness for return to work. A consultant may act in an advisory capacity, or may take full responsibility for investigation and treatment of a patient. Official Disability Guidelines (ODG) indicate that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The orthopedic agreed medical evaluation dated 2/7/11 documented that patient was injured on 1/3/09. The patient was summoned to the roadside to help a disabled vehicle. As the patient was hooking up the vehicle to be towed, he was struck by another vehicle and sustained facial injuries, cervical spine injuries, dental injury, an injury to his right lower extremity and a spinal cord contusion. On January 3, 2009 he had a closed reduction and external fixator applied to his open right tibia-fibula fracture and repair of the posterior tibial artery with a thrombectomy and vein graft and a four compartment fasciotomy of the right lower extremity and a right thigh hematoma evacuation. On January 5,

2009, he had application of a Steinmann pin and reduction of the right knee dislocation. Cervical spine X-rays and CT scans revealed a lateral mass fracture of C1 and transverse process fracture at C2 and what appeared to be a transverse process fracture on the right at L2. The patient wore a cervical collar and had the external fixator applied for approximately. On May 20, 2009, a physician removed the external fixator and applied a short-leg cast. On December 9, 2009, osteotomy of the right fibula and intramedullary rodding of the right tibia with a locked intramedullary rod was performed. The patient had facial reconstructive procedures performed. The patient is status post C1 lateral mass fracture with residual left paracervical and trapezial strain, status post right knee fracture-dislocation, status post right open tibia fibula fracture requiring external fixation and intramedullary rodding, status post posterior tibial artery disruption with reconstruction and vein graft with residual weakness of the right lower extremity. The treating physician's progress report dated 4/14/15 documented that the patient completed a one-time consultation with a psychologist specializing in chronic pain patients to address current coping skills and depressed mood related to chronic pain and decreased function. Now that surgery will not imminently occur, the treating physician will request for a functional restoration program evaluation to determine if he is a candidate for this program to elevate his function. Per patient, no surgery is currently recommended. Patient is permanent and stationary. The patient is currently not working. The patient has a current presentation of chronic pain, impaired functional capacity, and delayed recovery. The patient's pain is attributable to a physical cause, previous methods of treating chronic pain have been unsuccessful, a multidisciplinary approach would likely be beneficial, and the patient has a significant loss of ability to function independently from the chronic pain. The treating physician is requesting authorization for referral to the program director a functional restoration for multidisciplinary evaluation. For now, treating physician is only making a request for an evaluation to determine if this patient is appropriate for functional restoration. The request was for a multidisciplinary evaluation to see if patient is a candidate for a functional restoration program. MTUS, ACOEM, and ODG guidelines support the request for a multidisciplinary evaluation to assess the candidacy for a functional restoration program. Therefore, the request for a multidisciplinary evaluation is medically necessary.

**Norco 10/325mg, #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96. Hydrocodone / Acetaminophen Page 91.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. Do not attempt to lower the dose if it is working. Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled

drugs. Hydrocodone/Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The orthopedic agreed medical evaluation dated 2/7/11 documented that patient was injured on 1/3/09. The patient was summoned to the roadside to help a disabled vehicle. As the patient was hooking up the vehicle to be towed, he was struck by another vehicle and sustained facial injuries, cervical spine injuries, dental injury, an injury to his right lower extremity and a spinal cord contusion. On January 3, 2009 he had a closed reduction and external fixator applied to his open right tibia-fibula fracture and repair of the posterior tibial artery with a thrombectomy and vein graft and a four compartment fasciotomy of the right lower extremity and a right thigh hematoma evacuation. On January 5, 2009, he had application of a Steinmann pin and reduction of the right knee dislocation. Cervical spine X-rays and CT scans revealed a lateral mass fracture of C1 and transverse process fracture at C2 and what appeared to be a transverse process fracture on the right at L2. The patient wore a cervical collar and had the external fixator applied for approximately. On May 20, 2009, a physician removed the external fixator and applied a short-leg cast. On December 9, 2009, osteotomy of the right fibula and intramedullary rodding of the right tibia with a locked intramedullary rod was performed. The patient had facial reconstructive procedures performed. The patient is status post C1 lateral mass fracture with residual left paracervical and trapezial strain, status post right knee fracture-dislocation, status post right open tibia fibula fracture requiring external fixation and intramedullary rodding, status post posterior tibial artery disruption with reconstruction and vein graft with residual weakness of the right lower extremity. The treating physician's progress report dated 4/14/15 documented right lower extremity pain. Analgesia, activities of daily living, adverse side effects, and aberrant behaviors were addressed. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. Per MTUS, Hydrocodone / Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The request for Norco (Hydrocodone/Acetaminophen) is supported by the MTUS guidelines. Therefore, the request for Norco 10/325 mg is medically necessary.

**Celebrex 200mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Anti-inflammatory medications Page 22. Celebrex Page 30. NSAIDs (non-steroidal anti-inflammatory drugs) Page 67-73. NSAIDs, specific drug list & adverse effects Page 70.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC complete blood count and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. All NSAIDs have the potential to raise blood pressure in susceptible patients. COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) indicates that nonsteroidal anti-inflammatory drugs (NSAID) can

cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. Therefore, they should be used only acutely. The treating physician's progress report dated 4/14/15 documented right lower extremity pain. Ibuprofen was effective for anti-inflammatory pain relief. The patient reports Celebrex was helpful for swelling in the past but not as effective at this time. MTUS Chronic Pain Medical Treatment Guidelines indicate that Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. The treating physician's progress report dated 4/14/15 does not document that the patient has a risk of GI gastrointestinal complications. Medical records document the long-term use of NSAIDs. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. Long-term NSAID use is not recommended by MTUS. The use of an NSAID is not supported by MTUS guidelines. Therefore, the request for Celebrex is not medically necessary.