MAXIMUS Federal Services

Case Number:	CM13-0066806		
Date Assigned:	01/03/2014	Date of Injury:	01/07/2013
Decision Date:	05/20/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/17/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55 year old male who was injured on 01/07/2013. He was on a metal scaffold installing tile when the scaffold collapsed. The patient fell approximately 20 feet. He immediately had head pain, neck and back pain, as well as radiating arm and leg pain. He was promptly sent to [redacted] for medical treatment the following day. From [redacted] he was sent to [redacted] and was admitted to the hospital for several days. Prior treatment history has included medications, six sessions of physical therapy, and received treatment for his internal injuries. Neurosurgical Evaluation Report dated 10/15/2013 indicated the patient stated since the injury, he has developed increased blood pressure. He continued to complain of neck pain that radiated down the left arm and lower back pain. He also admitted to swelling and numbness in the left leg from the knee down to the foot. He stated his pain was constant in nature and he rated his pain on average at 8/10 in severity. The patient was taking medications such as Corig 6.25 mg twice a day ., Lisinopril 40 mg q day, Lasik 25 mg twice a day., Vicodin 750 mg as needed, Keflex twice a day., and Xanax 1 mg q. day. The physical exam revealed a well-developed, well-nourished male. The patient was diagnosed with 1) Cervical radiculopathy; 2) T1-2 disc degeneration; 3) Prior C2-C6 anterior and posterior decompression and fusion; 4) L1-2 disc degeneration; 5) L1-2 lumbar stenosis; 6) Prior L3 to S1 posterior lumbar decompression and fusion; 9) Severe left ulnar neuropathy at the wrist and elbow; 10) Left median neuropathy; 11) Morbid obesity; and 12) Hypertension. Options were discussed with the patient that included a trial of epidural steroid injections versus a surgical decompression and posterior lumbar interbody fusion at this level. Given the patient's weight and hypertension, he is a high risk for either the lumbar or cervical spinal surgical procedures discussed. The patient had been advised to see a weight loss program and meet with a nutritionist. He has used Weight Watchers in the past with success. Evaluation

note dated 05/10/2013 documented the patient is 6 ft 1 inch tall and weighs 290 lbs with a BMI of 38.

IMR ISSUES, DECISIONS AND RATIONALES

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

WEIGHT LOSS PROGRAM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Annals of Internal Medicine, Volume 142, page 1-42

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline Or Medical Evidence: Medical Evidence: Clinical Policy Bulletin: Weight Reduction Medications And Programs online version

Decision rationale: An evaluation note dated 05/10/2013 documented the patient was 6 ft 1 inch tall, weighed 290 lbs. with a BMI of 38. The medical records do not document the patient's current weight, height and BMI. In addition the medical records do not detail attempts made by the patient to manage his weight or decrease weight on his own. The references suggest a clinician supervised weight loss program may be considered when certain criteria have been met. However, the medical records also do not establish failure to lose at least one pound per week after at least 6 months on a weight loss regimen that includes a low calorie diet, increased physical activity, and behavioral changes. The medical records do not establish this patient is unable to adopt a low-calorie diet and exercise program on his own, which would be equally efficacious. The request for weight loss program is not medically necessary and appropriate.