

<b>Case Number:</b>	CM14-0116018		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	03/12/2012
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 Family Medicine 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:

This is a 65 year old female who reported an industrial injury on 3/12/2012, 2 years ago, attributed to the performance of her job tasks reported as falling onto the dashboard and then onto the floor when another bus backed into the bus in which she was standing. The patient was noted to be status post left shoulder open acromioplasty with resection of coracoacromial ligament, open Mumford distal clavicle resection, left shoulder arthrotomy, and open rotator cuff repair on 4/21/2014. The patient was treated with postoperative rehabilitation physical therapy. The patient was currently prescribed atenolol, tramadol, Prilosec, and Neurontin. The MRI of the lumbar spine dated 1/24/2014 documented multilevel degenerative changes within the lumbar spine documented through L3-L4 through L5-S1. The AME report dated 2/13/2014 documented the recommended future medical care as left shoulder arthroscopy with subacromial decompression and resection arthroplasty to the distal clavicle; no further treatment to the neck and low back other than pain medications since the obesity would not allow for surgical intervention; cortisone injection, physical therapy, MRI and possible surgery; no further acupuncture treatment. The AME recommended enrollment in a surgical weight loss program if the examiner felt morbid obesity was going to inhibit recovery from the back and upper extremity injuries.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Weight reduction program:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid Services 40.5 - Treatment of Obesity.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines physical medicine Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) back chapter-physical therapy; exercises Other Medical Treatment Guideline or Medical Evidence: General disciplinary guidelines for the practice of medicine.

**Decision rationale:** The weight loss program requested by the treating physician is not demonstrated to be medically necessary or supported with objective evidence of failure of a self-directed diet. The patient should be in a self-directed weight loss and exercise program. The patient has not been documented to have failed diet and exercise directed to the underlying medical issue of morbid obesity. The treating physician has not documented the BMI; height; or weight of the patient at the present time. There is no provided rationale with a nexus to the cited mechanism of injury for the weight issue. There is no evidence the patient has attempted an appropriate diet. There was no discussion of any attempted diet on the part of the patient. There is no documented exercise program. There was no discussion of the methods of weight loss attempted or the rationale for the failure to follow a diet. There is no provided objective evidence that the patient cannot lose the weight with an appropriate diet and ongoing self-directed home exercise program. There is no demonstrated medical necessity for the [REDACTED] weight loss program on an industrial basis for the treatment of chronic low back pain. The patient should be educated on diet and placed on a strict diet to reduce weight at her own discretion. There is no demonstrated efficacy for the requested [REDACTED] weight loss program to treat the diagnosed morbid obesity and chronic back pain. The weight issues of the patient are not demonstrated to be the effect of the industrial injury; but are an underlying medical comorbidity with the medial diagnosis of Obesity. Psychologists agree that weight loss first of all requires self-motivation and externalizing the process to a facility, a special diet, a weight loss practitioner, etc. simply serves to project the expectations for success to others and provides a rationalization for failure. The New England Journal of Medicine recently studied a wide variety of weight loss programs nationwide and came to the conclusion; none provided a very good long-term track record, except the one that they rated best the [REDACTED] program. Although it does provide an external support mechanism, it also assures that participants understand it is their own responsibility to maintain changes in their eating behaviors and the motivation that keeps them going on with not the program. It also does not require any special dietary foods or supplements but simply applies point values to various foods one normally eats as a simplified manner of counting and controlling calories, which is the way any weight control program ultimately works. The patient should be monitoring her own diet with a restriction on caloric intake and participating in a self-directed home exercise program. The requested weight loss program is not demonstrated to be medically necessary as opposed to a self-directed home exercise program along with a self-directed diet. There is no provided objective medically based evidence provided to demonstrate the medical necessity of a supervised weight loss program such as [REDACTED] as opposed to self-directed exercise and diet. The CA MTUS, ACOEM Guidelines, and the Official Disability Guidelines do not specifically address the use of weight loss for the treatment of the degenerative disc disease, facet arthropathy and chronic lower back pain and state, "Gym

memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatment, and are therefore not covered under these guidelines." The use of gym memberships or advanced exercise equipment without supervision by a health professional is not recommended. The ACOEM Guidelines state, "Aerobic exercise is beneficial as a conservative management technique, and exercising as little as 20 minutes twice a week can be effective in managing low back pain." There is strong scientific evidence that exercise programs, including aerobic conditioning and strengthening, is superior to treatment programs that do not include exercise. There is no sufficient objective evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment rehabilitation. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. The claimant will continue to benefit from an exercise program for her continued conditioning; however, there is no provided objective evidence that this is accomplished with the use of the requested weight loss program. Patients are counseled to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Once the instructions or exercises are learned, the patient may exercise on their own with a self-directed home exercise program. Self-directed home exercises can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Weight loss would be accomplished with the appropriate exercise and a limited caloric diet intake. There is no demonstrated medical necessity for the requested weight loss program for the treatment of chronic low back pain for this patient.