MAXIMUS Federal Services

Case Number:	CM14-0157554		
Date Assigned:	09/30/2014	Date of Injury:	01/27/2014
Decision Date:	10/28/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/25/2014

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 Ohio. 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 injured worker is a 56 year old male with a date of entry of January 27, 2014. He sustained a low back injury as result of a fall at work. He was diagnosed initially with a lumbar strain and treated with physical therapy and medication. An MRI scan of the lumbar spine revealed facet arthropathy at L4, L5 and L5, S1. During the course of his physical therapy the injured worker developed left knee pain. Evidently the injured worker has had previous left knee surgery. X-rays of the left knee revealed hardware in the region of the medial tibia consistent with a high tibial osteotomy. He was given a cortisone injection and a CT arthrogram has been ordered. The physical exam reveals diminish lumbar range of motion of the lumbar spine, tenderness to palpation of the mid-and lower lumbar spine regions, diminished left L5 dermatome sensation, and tenderness to the lateral aspect of the tibia. Diagnoses include lumbar strain, lumbar disc degeneration, cervical strain, cervical disc degeneration, hypertension, dyslipidemia, and obesity. The injured worker has claimed a 50 pound weight gain since his injury. A note from a utilization review physician documents a 10 pound weight gain in this timeframe. There is one solitary note regarding the patient's weight which was a self-report, that being 350 pounds. At issue is a request for a supervised weight loss program. There is no indication from the documentation that there are any plans for surgery that may require substantial weight loss prior.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised Weight Loss Program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS.gov, Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N

Decision rationale: The reviewed records reflect that the injured worker has a body weight of 350 pounds but an actual body mass index determination has not been done and no height has been provided. The issue of supervised weight loss programs is not addressed by ODG or the Chronic Pain Medical Treatment Guidelines. Some guidance is available from CMS Medicare: Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N) The evidence is adequate to conclude that intensive behavioral therapy for obesity, defined as a body mass index (BMI) 30 kg/m2, is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B and is recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF). Intensive behavioral therapy for obesity consists of the following:1.Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m2); 2.Dietary (nutritional) assessment; and3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.The intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been highlighted by the USPSTF:1. Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.2.Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.3.Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.4. Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate. 5. Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment. For Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS covers: -One face-to-face visit every week for the first month; -One face-to-face visit every other week for months 2-6; -One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement as discussed below. At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six-month period. For the purposes of this decision memorandum, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this

definition. For the purposes of this decision memorandum a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (6) Physician Defined. For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist. Primary care practitioner-The term "primary care practitioner" means an individual (i) who (I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)). While this benefit is limited to primary care practitioners and primary care settings, it does not preclude primary care practitioners from screening beneficiaries for obesity and referring those who screen positive with a BMI 30 kg/m2 to other practitioners and/or settings for intensive multicomponent counseling; however coverage remains only in the primary care setting. In this instance, no possible means of obtaining a body mass index can be found within the available record and therefore it is not possible to determine eligibility for such a program under Medicare guidelines. Additionally, the record does not reflect previous attempts at weight loss. There is no indication that weight loss is necessary for any upcoming surgeries connected with a Workmen's Compensation claim. The documentation does not reflect that weight loss efforts have been undertaken in partnership with the injured worker's primary care physician. Therefore, a supervised weight loss program is not medically necessary under the above guidelines.