

Case Number:	CM14-0042891		
Date Assigned:	08/08/2014	Date of Injury:	01/18/2010
Decision Date:	09/12/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/09/2014

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 Occupational 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:

Patient is a 34-year-old female who has submitted a claim for morbid obesity, diabetes, rotator cuff syndrome, and stress urinary incontinence associated with an industrial injury date of 01/18/2010. Medical records from 2013 to 2014 were reviewed. Patient had been overweight for 15 years and previously attempted non-surgical weight loss via protein and conventional diet without long-lasting success. Patient previously was a smoker and quit smoking on November 2013. She denied symptoms of chest pain, palpitations, syncope, dyspnea, orthopnea, edema, cyanosis and claudication. She likewise denied shortness of breath, pleuritic pain, wheezing, cough, and hemoptysis. Patient did not report anxiety or depression. There was no history of DVT, PE, and coagulopathy. Patient denied nausea, vomiting, dysphagia, heartburn, abdominal pain, jaundice, hematemesis, constipation or diarrhea. Vital signs were recorded as: blood pressure 131/74 mmHg and pulse rate 83 beats per minute. Anthropometric measurements were height of 69 inches, weight of 351 pounds, and body mass index of 51.8 kg/m². Cardiovascular exam showed regular heart rate and rhythm, no murmur, no bruit, and normal pulses. Respiratory examination showed clear to auscultation, no wheezing and no respiratory effort. Abdomen was soft, non-tender, non-distended, without any appreciable organomegaly. Judgment and insight appeared normal. Orientation and remote memory were intact. Treatment to date has included diet, right shoulder cortisone injection, medications such as glyburide, ibuprofen, metformin, and tramadol. Utilization review from 03/21/2014 denied the request for chest x-ray because patient was already cleared medically to undergo weight reduction surgery; denied abdominal ultrasound because there was no documentation of any specific abdominal pain issues or GI problems; denied Cardiac stress test/ Myocardial perfusion imaging and ECG because there was no documentation of any particular cardiac problem; denied Nutritional Classes QTY 12.00 because there was no clear detail provided whether the patient had any other

previous education or nutrition classes with regard to obesity issues including outcomes; denied Psychological testing QTY 1.00 because it was unclear if patient underwent psychological evaluation in the past and what recommendations were made; denied Blood work QTY 1.00 because of unspecified type of planned bariatric surgery; and denied Esophagogastroduodenoscopy because it was unclear whether this had been performed in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nutritional Classes QTY 12.00: Overturned

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 Non-MTUS Other Medical Treatment Guideline, Nutritional Course of Patients Submitted to Bariatric Surgery, *Obes Surg.* 2010 Jun;20(6):716-21. doi: 10.1007/s11695-008-9721-6. Epub 2008 Oct 17, SAGES Guidelines for Laparoscopic and Conventional Surgical Treatment of Morbid Obesity, Society of American Gastrointestinal Endoscopic Surgeons, <http://www.lapsurgery.com/BARIATRIC%20SURGERY/SAGES.htm> American Society of Bariatric Surgeons.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, an online article from The Society of American Gastrointestinal Endoscopic Surgeons and the American Society of Bariatric Surgeons was used instead. It states that bariatric surgery should be considered for individuals who: have a body mass index (BMI) of greater than 40 kg/m², OR have a BMI greater than 35 kg/m² with significant co-morbidities AND can show that dietary attempts at weight control have been ineffective. The overall care of patients undergoing bariatric surgery (weight reduction surgery) requires programs, which address both perioperative care and long-term management. Patients require appropriate lifelong follow-up with nutritional counseling and biochemical surveillance. Furthermore, an article published from the *Obesity Surgery* journal states that metabolic and nutritional deficiencies may occur during the late postoperative period. The diet of these patients, who frequently present inadequate intake of macronutrients and micronutrients, should receive special attention. Patient follow-up and assessment at short intervals are necessary for an early correction of nutritional deficiencies. In this case, patient is a known morbid obesity with a body mass index of 51.8 kg/m². Patient previously attempted non-surgical weight loss via protein and conventional diet without long-lasting success; hence, current treatment plan includes bariatric surgery. Recent studies recommend enrollment to nutrition counseling to prevent dietary deficiencies, as stated above. The medical necessity has been established. Therefore, the request for nutritional classes x 12 sessions is medically necessary.

Blood work QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The American Academy of Orthopedic Surgeons.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Preoperative testing, General.

Decision rationale: ODG states that pre-operative testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patient likewise has concomitant diabetes; hence, pre-operative blood test is reasonable at this time. However, the present request as submitted failed to specify blood examination appropriate for this case. The request is incomplete; therefore, the request for blood work is not medically necessary.

Esophagogastroduodenoscopy QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Role of Endoscopy in the Bariatric Surgery Patient, The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy (ASGE).

Decision rationale: The rationale for performing an Esophagogastroduodenoscopy(EGD) before bariatric surgery is to detect and/or treat lesions that might potentially affect the type of surgery performed, cause complications in the immediate postoperative period, or result in symptoms after surgery. An upper endoscopy should be performed in all patients with upper GI tract symptoms who are to undergo bariatric surgery. Upper endoscopy should be considered in all patients who are to undergo an RYGB, regardless of the presence of symptoms. In patients without symptoms and who were undergoing gastric banding, a preoperative upper endoscopy should be considered to exclude large hernias that may change the surgical approach. However, there was no documentation concerning presence of gastrointestinal symptoms or the specific type of surgery to warrant an EGD. The medical necessity cannot be established due to insufficient information. Therefore, the request for esophagogastroduodenoscopy is not medically necessary.

Psychological testing QTY 1.00: Overturned

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 Role of Endoscopy in the Bariatric Surgery Patient, The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy (ASGE) and Rationale for the Surgical Treatment of Morbid Obesity, American Society of Bariatric Surgery.

Decision rationale: Per The Society of American Gastrointestinal Endoscopic Surgeons and the American Society of Bariatric Surgeons online article, It states that surgeons need to be aware of the needs of severely obese patients in terms of facilities, supplies, equipment, staff and procedures, and should plan the personal time, specialized staff and/or multi-disciplinary referral system as required. This multi-disciplinary approach includes medical management of comorbidities, dietary instruction, exercise training, specialized nursing care and psychological assistance as needed. Another article from the American Society of Bariatric Surgery go on to state that some patients with manifest psychopathology that jeopardizes an informed consent and cooperation with long term follow up may need to be excluded. The documented rationale for testing is to assess psychological fitness for surgery. Guidelines criteria were met, Therefore, the request for psychological testing is medically necessary.

Electrocardiogram QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Preoperative testing, General; and Preoperative electrocardiogram (ECG).

Decision rationale: Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. The documented rationale for ECG is to assess heart rhythm and evidence of myocardial ischemia. Per the cardiovascular exam, likewise showed; regular heart rate and rhythm, no murmur, no bruit, and normal pulses. The medical necessity for pre-operative ECG testing was not established. Guideline criteria were not met, Therefore, the request for Electrocardiogram is not medically necessary.

Chest X-Ray QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Preoperative testing, General; and Preoperative Chest X-ray.

Decision rationale: ODG states that pre-operative testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The documented rationale for Chest X-Ray is to assess presence of intrathoracic pathology. Pulmonary examination showed clear to auscultation, no wheezing and no respiratory effort. The medical necessity for pre-operative CXR testing was not established. Guideline criteria were not met, Therefore, the request for chest x-ray is not medically necessary.

Abdominal Ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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: ACR-SPR-SRU Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations.

Decision rationale: The ACR-SPR-SRU Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations was used instead. It states that there should be documentation regarding signs, symptoms, and relevant history (including known diagnoses) that will satisfy the medical necessity of an abdominal ultrasound. In this case, the documented rationale for an ultrasound is to assess for gallstones. Abdominal examination was soft, non-tender, non-distended, without any appreciable organomegaly. There is no evidence presented to support the diagnostic procedure. Guideline criteria were not met, Therefore, the request for abdominal ultrasound is not medically necessary.

Cardiac stress test/ Myocardial perfusion imaging QTY1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

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: ACC/AHA/ASNC Guidelines for the Clinical Use of Cardiac Radionuclide Imaging: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/ASNC Committee to revise the 1995 guidelines for the clinical use of cardiac radionuclide imaging).

Decision rationale: Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the ACC/AHA/ASNC Guidelines for the Clinical Use of Cardiac Radionuclide Imaging was used instead. The AHA

states that cardiac PET scans are recommended for diagnosis of patients with an intermediate likelihood of CAD and/or risk stratification of patients with an intermediate or high likelihood of CAD; patients with heart failure, to assess myocardial viability (for predicting improvement in regional and global LV function after revascularization, for predicting improvement in heart failure symptoms after revascularization and for predicting improvement in natural history after revascularization. The documented rationale for myocardial perfusion imaging is to assess evidence of myocardial ischemia. However, medical records submitted for review showed that patient is a 34-year-old female who denied symptoms of chest pain, palpitations, syncope, dyspnea, orthopnea, edema, cyanosis and claudication. Cardiovascular exam likewise showed regular heart rate and rhythm, no murmur, no bruit, and normal pulses. The medical necessity for pre-operative cardiac testing was not established. Guideline criteria were not met, Therefore, the request for Cardiac stress test/ Myocardial perfusion imaging QTY1.00 is not medically necessary.