

Case Number:	CM14-0059754		
Date Assigned:	07/09/2014	Date of Injury:	08/07/2009
Decision Date:	09/05/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/30/2014

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 53-year old former eligibility worker reported injuries to her neck, both hands and wrists, and both knees after a fall in a parking lot on 8/7/19. Her current diagnoses include cervical strain, lumbar strain, sacroiliac disease, bilateral hand tendonitis, trigger finger of bilateral middle and ring fingers, and bilateral knee sprains. Past medical history is significant for obesity (body mass index of over 50), diabetes, hypertension, increased cholesterol and sleep apnea. Documented treatment to date has included physical therapy, acupuncture, topical compounded medications, and a single lumbar epidural steroid injection performed in June 2012. The LESI resulted in an unacceptable increase in her blood sugar and was not repeated. She has remained at full time work since her injury, though her job title and job tasks have changed with time. An MRI performed 1/7/12 revealed diffuse degenerative changes with an 8 mm disc bulge at L5-S1. There are multiple notes from the primary provider in the record, which do not document any triggering of any finger. They consistently state that she "nonspecific tenderness" of both hands. An AME evaluation performed 1/16/14 noted that she had mild tenderness of the A1 pulleys of her middle and ring fingers bilaterally. It did not document triggering. The AME stated that the patient has mild trigger finger of bilateral middle and ring fingers, and that she might require a referral for injection or surgical release. It also stated that she should be encouraged to participate in a vigorous weight loss program. A request for authorization submitted by the primary treater on 3/20/14 lists the requested items as: a medically supervised weight loss program due to obesity, and a trigger finger release per AME recommendation. The request for the weight loss program was denied in UR on 4/18/14. The request for referral to a hand surgeon for trigger finger release was modified on the same date to a referral to a hand surgeon for evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medically supervised weight loss program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate, an evidence-based review service for medical practitioners (www.uptodate.com), Obesity in Adults: Overview of Management.

Decision rationale: The MTUS does not provide direction for weight loss programs or obesity treatment. Medical necessity for a "weight loss program" is contingent upon more than just the presence of obesity. Per the Up-to-date reference, patients with obesity should be stratified into risk categories based on Body Mass Index. Patients with a Body Mass Index over 40 are at highest risk and should receive lifestyle intervention, pharmacological therapy, and possibly bariatric surgery. Diet, exercise, and behavioral treatment are the most important strategies for weight loss. This Up-to-date guideline lists several obesity management protocols from major national medical organizations. It is clear that this patient has been very overweight for a long time. Beyond measuring her weight, there is no evidence that the treating physician has addressed the issue in any way. The AME did not specifically recommend referral to a medically supervised weight loss program-he simply stated that the patient should be encouraged to participate in a vigorous weight loss program. The treating physician has not provided any information regarding this injured worker's prior treatment for obesity. He has not described the proposed weight loss program in any way, beyond stating that it should be medically supervised. He has not delineated any goals for treatment, or specified duration of any proposed treatment. Without these kinds of specific details and treatment plan, a request for a weight loss program lacks the necessary components to demonstrate medical necessity. A medically supervised weight loss program is not medically necessary due to the lack of information provided about what the program entails and whether or not this patient would meet requirements for it.

Referral to hand specialist for trigger finger release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271 and 273.

Decision rationale: Per the California MTUS, guidelines cited above, one or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are usually sufficient to cure symptoms of trigger finger and restore function. A procedure under local anesthesia may be necessary to permanently correct persistent triggering. Referral to a surgeon should only occur after patient education and conservative treatment, including splinting and injection, have failed. It is completely unclear from the records available

whether this patient has significant triggering of any finger, and whether she is sufficiently troubled by it to want an injection or surgery. There is no objective documentation of any triggering, and the primary provider does not even document tenderness of the associated A1 pulley areas. There is no documentation of what conservative measures have already been tried. Certainly, a referral for surgery is medically contraindicated at this point. Referral to a hand specialist for trigger finger release is not medically necessary, due to the lack of documentation of need for the referral or of trial of appropriate conservative measures. The request is not medically necessary.