

<b>Case Number:</b>	CM14-0200122		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	03/18/2014
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Physical Medicine Rehab 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 55 year-old patient sustained a low back injury on 3/18/14 from falling from walking backwards pulling on tarp while employed by [REDACTED]. Request(s) under consideration include [REDACTED]. Diagnoses include cervical and thoracolumbar myoligamentous injury; lumbosacral radiculopathy. EMG/NCV of bilateral lower extremities dated 6/2/14 was negative and unremarkable. Conservative care has included medications, aquatic therapy, HEP (home exercise program), trigger point injections, and modified activities/rest. Medications list Tramadol and Cyclobenzaprine. The patient continues to treat for chronic ongoing symptom complaints. Report of 10/20/14 from the provider noted constant upper/lower back pain relieved with trigger point injections and medications with increased ADLs (activities of daily living). Pain was rated at 8/10 without and 3-4/10 with medications. Exam showed restricted thoracic and lumbar range in all planes; myofascial trigger points and taut bands throughout paraspinal musculature; decreased sensation in right buttock and posterior lateral right thigh with positive compression test. Diagnoses include chronic myofascial pain syndrome, cervical and thoracolumbar spine, and lumbosacral radiculopathy. The request(s) for [REDACTED] Program was non-certified on 11/24/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS 40.5 - Treatment of Obesity (Rev 54, Issued: 04-29-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Obesity, page 320 and on Other Medical Treatment Guideline or Medical Evidence: The Washington State guidelines state: Obesity does not meet the definition of an industrial injury or occupational disease. There is no published literature on the [REDACTED] weight loss program that indicates consistent success

**Decision rationale:** Although MTUS/ACOEM are silent on weight loss program, the ODG does state high BMI in obese patient with osteoarthritis does not hinder surgical intervention if the patient is sufficiently fit to undergo the short-term rigors of surgery. There is no peer-reviewed, literature-based evidence that a weight reduction program is superior to what can be conducted with a nutritionally sound diet and a home exercise program. There is, in fact, considerable evidence-based literature that the less dependent an individual is on external services, supplies, appliances, or equipment, the more likely they are to develop an internal locus of control and self-efficacy mechanisms resulting in more appropriate knowledge, attitudes, beliefs, and behaviors. The fewer symptoms are ceremonialized and the sick role is reinforced as some sort of currency for positive gain, the greater the quality of life is expected to be. A search on the [REDACTED] for "Weight Loss Program" produced no treatment guidelines that support or endorse a Weight Loss Program for any medical condition. While it may be logical for injured workers with disorders to lose weight, so that there is less stress on the body, there are no treatment guidelines that support a formal Weight Loss Program in a patient with chronic pain. The long term effectiveness of weight loss programs, as far as maintained weight loss, is very suspect. There are many published studies that show that prevention of obesity is a much better strategy to decrease the adverse musculoskeletal effects of obesity because there are no specific weight loss programs that produce long term maintained weight loss. Additionally, the patient's symptoms, clinical findings, and diagnoses remain unchanged for this injury without acute flare, new injury, or specific surgical treatment plan hindered by the patient's chronic obesity that would require a weight loss program. There is no specific BMI or weight gain documented in comparison to initial weight at date of injury. The provider has not identified what program or any specifics of supervision or treatment planned. Other guidelines state that although obesity does not meet the definition of an industrial injury or occupational disease, a weight loss program may be an option for individuals who meet the criteria to undergo needed surgery; participate in physical rehabilitation with plan to return to work, not demonstrated here as the patient has remained functionally unchanged for this injury. The request for [REDACTED] [REDACTED] Program is not medically necessary and appropriate.