

<b>Case Number:</b>	CM14-0206528		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	08/02/2002
<b>Decision Date:</b>	02/12/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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 Internal Medicine, has a subspecialty in Rheumatology, Allergy & Immunology and is licensed to practice in Texas. 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 43 year old female with a date of injury of 08/02/02. The patient is being treated for lumbar sprain/strain, labral tear-hip and sacroiliac pain. Subjective findings on 10/27/14 include lower backache, left hip and left knee pain. Right knee pain is burning and also in right hip. Objective findings include weight of 283 pounds, height 5'3" and BMI of 53, right knee with restricted flexion at 90 degrees, tenderness on palpation on right medial joint line, 1+ effusion. Right knee MRI on 6/17/14 reveals status post subtotal meniscectomy of the medial meniscus body and posterior horn, grade chondral fissuring on medial femoral condyle and tibia, tibial cartilage defect increased in size from prior study, mild associated peripheral bone marrow edema, intact anterior cruciate ligament graft, small joint effusion. Treatment thus far has consisted of medication (omeprazole, oxycodone, OxyContin, trazadone, gabapentin, Zanaflex, Percocet, Lidoderm), physical therapy, outpatient 7 week rehabilitation/functional restoration program and a gym program. The Utilization Review on 11/07/14 found the request for Weight Loss Program as denied given no documentation of other failed attempts at weight loss (formal exercise program and no evidence that she has failed caloric restrictions).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Weight Loss Program:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Disability Advisor

**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: Reed, P, Medical Disability Advisor, Obesity 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society, Circulation 2014 S139-40.

**Decision rationale:** This is a request for Weight Loss Program. The MTUS and ODG are silent when it comes to obesity and its management. The resources used in this review are the Medical Disability Advisor by Reed and the 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults. 2013 AHA/ACC/TOS guidelines state that the initial approach to weight loss should include an energy deficit through caloric restriction and increased exercise. The most important strategy to reduce weight is to combine diet, exercise and behavior treatments. This includes regular self-monitoring of food intake, physical activity and body weight. Although a comprehensive program may be necessary, it is emphasized that the provider make the above interventions (caloric restricted diet and prescription exercise program) and follow up on the patient's progress. Reed's Medical Disability Advisor section on Obesity states that there are five medically acceptable treatments for obesity. Below is a summary of his recommendations. The five treatments include diet modifications, exercise, behavioral modifications, drug therapy and surgery. All these approaches together or in combination may produce weight loss and health benefits but weight regain with result in loss of these benefits. Most patients have difficulty maintaining weight loss. The cornerstone of therapy is caloric restriction with the standard recommendation for weight loss being a reduction by 500 to 1,000 calories daily. The addition of exercise will help by increasing metabolism and help replace unhealthy habits of snacking. Behavioral therapy with help with looking for cues about eating habits and ways to increase physical activity. Medications may be used but typically as adjuvants. Surgery may also be helpful in those with less severe obesity (BMI 35-40) and have co-morbid conditions (disabling joint disease, pulmonary insufficiency, hypertension or diabetes). In this case, the requesting physician states that this patient has severe right knee joint disease but is not a surgical candidate due to her morbid obesity. The medical records fail to demonstrate that she has tried and failed with the conservative recommendations of caloric restriction and exercise. She has a gym membership but there is no documentation of what if any exercise plan and how this was being administered or monitored. There is no documentation that she is on a caloric restricted diet or consultation with dietician. Given that the records do not demonstrate a failure of the cornerstone treatments for obesity (caloric restriction and exercise). The request for weight loss program is not medically necessary.