

Case Number:	CM15-0140481		
Date Assigned:	07/30/2015	Date of Injury:	01/26/2014
Decision Date:	08/31/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 36 year old male who sustained a work related injury January 26, 2014. While cleaning gym bleachers, he twisted his left ankle and fell forward down the bleachers, striking his left hip, leg, and left shoulder on the wood gym floor. He was treated with medication, x-rays were obtained with negative findings, and six sessions of physical therapy to the left ankle, which exacerbated his symptoms. Past history included hypertension and diabetes and a fractured right ankle in 2000 with fusion surgery. An MRI of the left ankle performed October 10, 2014 revealed arthritic changes about the talonavicular joint, calcaneocuboid joint and mid tarsus. According to a primary treating physician's progress report, dated May 19, 2015, the injured worker presented with complaints of constant pain and swelling of the left foot. He also reports left shoulder pain with popping and grinding, and pain radiating down his arm and into the hand and wrist. Low back pain is present with cramps and pain into both legs, bilateral hip pain, worse on the left side, abdominal cramping, and depression with bouts of anxiety attacks that come and go. Examination of the left ankle revealed slight swelling, ankle extension is 0 degrees on the left versus 15 degrees on the right, plantar flexion 25 degrees left-40 degrees right, inversion 0 degrees left-25 degrees right, eversion 0 degrees on the left and 15 degrees on the right. A previous office visit in April, 2015, the injured worker stated he was 6'4" and 560 pounds. Diagnosis is documented as left ankle sprain with probable severe degeneration. Non-accepted diagnoses are lumbar, bilateral hips, bilateral shoulder sprain and strain. At issue, is the request for authorization for bariatric consultation, weight loss surgery unspecified, and an MRI of the left foot without dye.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bariatric consultation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational Medicine Practice Guidelines, 2nd Edition, 2004 page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: With regard to the request for specialty consultation, the ACOEM Practice Guidelines recommend expert consultation "when the plan or course of care may benefit from additional expertise." Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. The patient has morbid obesity as evidenced by the height and weight documented in the progress notes. Therefore, from a medical necessity standpoint, the patient can benefit from a bariatric consultation. The bariatric consultant can then review this patient's case and determine whether non-surgical interventions have been exhausted. Although this request is medically necessary. The IMR process does not comment upon the industrially related nature of morbid obesity. If the claims administrator disputes the causation of morbid obesity and IME can be carried out to determine whether this diagnosis is industrially related or not.

Weight loss surgery, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Bariatric surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aetna.com/cpb/medical/data/100_199/0157.htmlClinical Policy Bulletin: Obesity Surgery.

Decision rationale: Clinical Policy Bulletin: Obesity Surgery Roux-en-Y Gastric Bypass (RYGB), Laparoscopic Adjustable Silicone Gastric Banding (LASGB), Biliopancreatic Diversion (BPD) and Duodenal Switch (DS) Procedures: Aetna considers open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) medically necessary when the selection criteria listed below are met. Selection criteria: Presence of severe obesity that has persisted for at least the last 2 years (24 months), defined as any of the following: Body mass index (BMI)* exceeding 40; or BMI* greater than 35 in conjunction with any of the following severe comorbidities: Coronary heart disease; or Type 2 diabetes mellitus; or Clinically significant obstructive sleep apnea (i.e., patient meets the criteria

for treatment of obstructive sleep apnea set forth in Aetna CPB 004 - Obstructive Sleep Apnea in Adults); or Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); and Member has completed growth (18 years of age or documentation of completion of bone growth); and Member has attempted weight loss in the past without successful long-term weight reduction; and Member must meet either criterion 1 (physician-supervised nutrition and exercise program) or criterion 2 (multidisciplinary surgical preparatory regimen):

Physician-supervised nutrition and exercise program: Member has participated in physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. This physician-supervised nutrition and exercise program must meet all of the following criteria: Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote); and Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within 2 years prior to surgery, with participation in one program of at least three consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program(s) will be completed prior to the date of surgery.); and Member's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program. For members who participate in a physician administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the member's participation and progress may substitute for physician medical records; or

Multidisciplinary surgical preparatory regimen: Proximate to the time of surgery (within 6 months prior to surgery), member must participate in organized multidisciplinary surgical preparatory regimen of at least three consecutive months duration meeting all of the following criteria, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the member's ability to comply with post-operative medical care and dietary restrictions: Consultation with a dietician or nutritionist; and Reduced-calorie diet program supervised by dietician or nutritionist; and Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional; and Behavior modification program supervised by qualified professional; and Program must have a substantial face-to-face component (must not be entirely delivered remotely); and Documentation in the medical record of the member's participation in the multidisciplinary surgical preparatory regimen at each visit. (A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the member, and the physician's assessment of the member's progress at the completion of the multidisciplinary surgical preparatory regimen.) and For members who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic

medications, pre-operative psychological clearance is necessary in order to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and postoperative regimen. Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery. In the case of this injured worker, a bariatric surgery should not be authorized prior to a bariatric consult taking place. The bariatric surgeon should make a determination based on past medical history, previous non-surgical interventions tried thus far, and various other factors. Given this, this request is not medically necessary.

MRI of left foot without dye: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372-373. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot Chapter, Magnetic resonance imaging (MRI).

Decision rationale: OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, Ankle and Foot Complaints, Pages 372-374: For most cases presenting with true foot and ankle disorders, special studies are usually not needed until after a period of conservative care and observation. Most ankle and foot problems improve quickly once any red-flag issues are ruled out. Routine testing, i.e., laboratory tests, plain-film radiographs of the foot or ankle, and special imaging studies are not recommended during the first month of activity limitation, except when a red flag noted on history or examination raises suspicion of a dangerous foot or ankle condition or of referred pain. In particular, patients who have suffered ankle injuries caused by a mechanism that could result in fracture can have radiographs if the Ottawa Criteria are met. This will markedly increase the diagnostic yield for plain radiography. The Ottawa Criteria are rules for foot and ankle radiographic series. An ankle radiographic series is indicated if the patient is experiencing any pain in the: Malleolar area, and any of the following findings apply: a) tenderness at the posterior edge or tip of the lateral malleolus; b) tenderness at the posterior edge or tip of the medial malleolus; or c) inability to bear weight both immediately and in the emergency department. Midfoot area, and any of the following findings apply: a) tenderness at the base of the fifth metatarsal; b) tenderness at the navicular bone; or c) inability to bear weight both immediately and in the emergency department. Radiographic evaluation may also be performed if there is rapid onset of swelling and bruising; if patient's age exceeds 55 years; if the injury is high-velocity; in the case of multiple injury or obvious dislocation/subluxation; or if the patient cannot bear weight for more than four steps. For patients with continued limitations of activity after four weeks of symptoms and unexplained physical findings such as effusion or localized pain, especially following exercise, imaging may be indicated to clarify the diagnosis and assist reconditioning. Stress fractures may have a benign appearance, but point tenderness over the bone is indicative of the diagnosis and a radiograph or a bone scan may be ordered. Imaging findings should be correlated with physical findings. Disorders of soft tissue (such as tendinitis, metatarsalgia, fasciitis, and neuroma) yield negative radiographs and do not warrant other studies, e.g., magnetic resonance imaging (MRI). Magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis dissecans in cases of delayed recovery. _Cases of hallux valgus that fail conservative treatment merit standing plain films to plan surgery, and consultation with the potential surgeon is recommended. Sprains are frequently

seen after emergency room treatment in which radiographs are obtained to rule out fractures. Minimal sprains can be treated symptomatically without films. Table 14-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. Official Disability Guidelines (ODG), Ankle & Foot Chapter, Magnetic resonance imaging (MRI): Indications for imaging MRI (magnetic resonance imaging): Chronic ankle pain, suspected osteochondral injury, plain films normal; Chronic ankle pain, suspected tendinopathy, plain films normal; Chronic ankle pain, pain of uncertain etiology, plain films normal; Chronic foot pain, pain and tenderness over navicular tuberosity unresponsive to conservative therapy, plain radiographs showed accessory navicular; Chronic foot pain, athlete with pain and tenderness over tarsal navicular, plain radiographs are unremarkable; Chronic foot pain, burning pain and paresthesias along the plantar surface of the foot and toes, suspected of having tarsal tunnel syndrome; Chronic foot pain, pain in the 3-4 web space with radiation to the toes, Morton's neuroma is clinically suspected; Chronic foot pain, young athlete presenting with localized pain at the plantar aspect of the heel, plantar fasciitis is suspected clinically; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) Within the documentation available for review, there is documentation of red flag symptoms, no indication of failed conservative treatments, and no plan for future surgical intervention of the left foot. As such, the currently requested left foot MRI is not medically necessary.