

Case Number:	CM15-0217059		
Date Assigned:	11/09/2015	Date of Injury:	05/13/2002
Decision Date:	12/28/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	11/04/2015

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

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 56 year old male, who sustained an industrial injury on 5-13-2002. Diagnoses include postlaminectomy back pain syndrome with radiculitis, chronic pain due to trauma, nausea, complicated headache syndrome, and status post cervical fusions in 2002 and 2004. Treatments to date include activity modification, medication therapy, and cervical epidural steroid injections. The records indicated evaluation and treatment for diagnoses of Gastroesophageal reflux disease, constipation, uncontrolled hypertension, hyperlipidemia, and sleep disorder, elevated uric acid, Vitamin D deficiency, and fatty liver, in addition to chronic pain and orthopedic diagnoses. On 5-7-15, he reported no change in symptoms of acid reflux and quality of sleep. Blood pressure documented as 158-98 mmHg prior to medication and 148-80 with medication. Weight was 244 pounds. The provider documented he instructed the injured worker to avoid NSAIDs and continue to follow a low cholesterol, low sodium, low back, and low acid diet, and increase fluid intake. Recent BMI noted to be 36, Renal ultrasound obtained 2-3-15 was normal. The plan of care included laboratory evaluations. The records indicated a review of a Body Composition Study was obtained on 5-7-15 and on 8-13-15. On 9-23-15, he complained of ongoing neck pain with radiation to upper extremities, rated 6 out of 10 VAS with medications. The physical examination documented a height of 70 inches, weight of 241 pounds, and Body Mass Index (BMI) of 35. The plan of care included ongoing medication therapy and consideration for a spinal nerve stimulator trial. The appeal requested authorization for a body composition study. The Utilization Review dated 10-16-15, denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Body composition study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/22179169>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.aetna.com/cpb/medical/data/1_99/0039.html.

Decision rationale: The patient was injured on 05/13/12 and presents with neck pain and headaches. The request is for a body composition study. There is no RFA provided and the patient's current work status is not provided. Guidelines do not address body composition studies. For keeping track of weight loss, AETNA guidelines (www.aetna.com/cpb/medical/data/1_99/0039.html) use Body Mass Index and does not reference body composition. The patient is diagnosed with postlaminectomy back pain syndrome with radiculitis, chronic pain due to trauma, nausea, complicated headache syndrome, status post cervical fusions in 2002 and 2004, gastroesophageal reflux disease, constipation, uncontrolled hypertension, hyperlipidemia, and sleep disorder, elevated uric acid, Vitamin D deficiency, and fatty liver. Treatment to date includes activity modification, medication therapy, and cervical epidural steroid injections. The patient had a prior body composition study on 08/13/15 which revealed that he was 70 inches in height, 254 pounds, and had a BMI of 38.4. The reason for the request is not provided. There is no discussion as to why a simple BMI taken from weight and height is insufficient if the treater is trying to keep track of the patient's weight. The request is not medically necessary.