

Case Number:	CM14-0154450		
Date Assigned:	09/24/2014	Date of Injury:	02/19/2013
Decision Date:	10/24/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/22/2014

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 Occupational 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:

The claimant injured her low back on 02/19/13. Aquatic therapy, a [REDACTED] weight loss program, and Celebrex are under review. She was evaluated on 02/27/14 and was status post 2 epidural steroid injections and had a second neurosurgery opinion. A third epidural steroid injection was approved and was pending. Her exam was unchanged. She had a positive right straight leg raise test at 50 and a positive SLR on the left causing low back pain. She had benefited from epidural steroid injections but the benefit was waning. On 03/25/14, she reportedly lost 12 pounds. She was too young for surgery and epidurals were recommended by another doctor. She stated gabapentin helped. She was about the same from her previous visit. She had right lower extremity radicular symptoms that were increased with prolonged sitting. She had a positive straight leg raise on the right side and was diagnosed with an HNP at L4-5 and sciatica of the right lower extremity. She underwent an epidural steroid injection at level L4-5 on 04/22/14. On 04/29/14, she stated she felt better within the last 2 weeks after her third lumbar ESI. She still had tightness of her back with occasional radicular pain down her right leg. She had lost 15 pounds. There was no spasm. SLR caused low back pain at 90. She was to continue weight reduction. She was placed on modified work on 06/10/14. Chiropractic visits were requested. She was feeling better but still had mainly right side burning low back pain with occasional radicular pain down the leg. She was overweight. ROM was decreased by at least 30% and she had low back pain. She was to continue weight reduction and gabapentin. On 07/22/14, she stated Biofreeze was helpful. She was minimally improved and had started chiropractic. She had decreased sensation and positive straight leg raise on the right. On 08/25/14, she had gained weight and was 262 pounds. She was taking gabapentin and ibuprofen. She had recurrent pain in the low back with radiation to her right leg down to the foot and toes with numbness and tingling in the right foot and behind her leg. She said activity restrictions.

She complained of pain in the right hip region and had an uneven gait on occasion. She complained of recurrent pain in the right knee and ankle. She was morbidly obese. Straight leg raise was limited bilaterally at 45 for low back pain. She still had decreased flexion and diffuse lumbar tenderness. She was diagnosed with plantar fasciitis. She had limited benefit from 3 epidural steroid injections. A water therapy program, [REDACTED] weight loss program, and Celebrex were recommended. She had tried Motrin but had stomach upset. X-rays of the right hip showed mild diffuse degenerative changes in the tibiofemoral and patellofemoral compartments; x-rays of the hip showed mild osteoarthritic changes; x-rays of the lumbar spine showed disc degenerative changes. She had bilateral calcaneal spurs in the feet. On 08/26/14, she appeared more comfortable than previously. She had reached maximum medical improvement. She received future medical.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Fitch A, Everling L, Fox C, Goldberg J, Heim C, Johnson K, Kaufman T, Kennedy E, Kestenbaum C, Lano M, Leslie D, Newell T, O'Connor P, Slusarek B, Spaniol A, Stovitz S, Webb B. Prevention and management of obesity for adults. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 May.

Decision rationale: The history and documentation do not objectively support the request for a [REDACTED] weight loss program. The ICSI state that weight loss can be managed by clinicians and the 5 A's should be addressed during initial phases of counseling and guidance. They include the following: The clinician should follow the 5 A's (Ask, Advise, Assess, Assist, Arrange). Clinician intervention can be effective and influential, and successful management is possible. ASK about weight, measure height and weight and calculate BMI. ADVISE to lose weight. In a clear, strong, but sensitive and personalized manner, urge every overweight or obese patient to lose weight. ASSESS readiness to lose weight. Ask every overweight or obese patient if he or she is ready to make a weight loss attempt at the time (e.g., within the next 30 days). ASSIST in weight-loss attempt. Help the patient with a weight loss plan. Refer to appropriate resources. ARRANGE follow-up. Schedule follow-up contact, either in person or via telephone. There is no evidence that these criteria have been addressed and monitored and the claimant failed to lose weight and needs a more intensive program with a dietary counselor other than the provider on this case. Typically, patients are advised on dietary guidelines, exercise, etc. and can make an attempt to lose weight. There is no evidence that the claimant has received basic counseling about weight loss. There is evidence, however, that she lost weight and then gained it but the history of weight loss trial and the reason she gained the weight again are not explained as would be expected prior to consideration of a formal program. There is no evidence that the claimant has been evaluated for this type of program and has been determined to be highly

motivated and unable to lose weight independently with diet and exercise. The request for a [REDACTED] weight loss program is not medically necessary.

Aqua therapy lower for back area (inc. lumb./lumb-sac.): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 53.

Decision rationale: The history and documentation do not objectively support the request for aquatic therapy for the back area for unknown frequency and duration/number of visits. The MTUS state "Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity." There is no evidence that the claimant is unable to continue her rehab with a land-based rehab program. She has few findings that would support a request for aquatic therapy. It is not clear what significant benefit is anticipated from this type of therapy for chronic complaints. There is no evidence that the claimant has attempted and failed or remains unable to complete his rehab with an independent HEP. The request is not medically necessary.

Medications - Celebrex 200mg #45: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex,NSAIDs Page(s): 61; 101.

Decision rationale: The history and documentation do not objectively support the request for Celebrex 200mg #45 with unknown frequency and duration. The MTUS state "Celebrex is the brand name for celecoxib [which] is a non-steroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, celecoxib does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures." There is no evidence that the claimant was prescribed Celebrex because surgery was being planned although surgery was discussed later in the file. The MTUS also state regarding "NSAIDs (non-steroidal anti-inflammatory drugs) - Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there

appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain -Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. (Van Tulder, 2006) (Hancock, 2007)" In this case, there is no indication that the claimant has tried acetaminophen instead of Celebrex when the ibuprofen was discontinued due to gastrointestinal symptoms. There is no clear evidence of increased gastrointestinal risk although she reported side effects from ibuprofen. There is no documentation that she failed trials of local modalities such as ice and heat and exercise. The request for Celebrex 200 mg #45, frequency and duration unknown, is not medically necessary.