Case Number:	CM15-0110991		
Date Assigned:	06/17/2015	**Date of Injury:**	04/19/2010
Decision Date:	07/16/2015	**UR Denial Date:**	06/03/2015
Priority:	Standard	**Application Received:**	06/09/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 43 year old female, who sustained an industrial injury on 4/19/10. The injured worker has complaints of left lower extremity radicular pain, which radiates from the posterlateral aspect of the left buttock to the anterolateral aspect of the right, leg and to the dorsum of the foot including the first and second dorsal web space. The documentation noted decreased lumbar spine range of motion and significant tenderness over the L4-5 and L5-S1 (sacroiliac) facets, bilaterally. The documentation noted on 5/8/15 the injured worker has gained approximately 15-20 pounds since the time of the last examination. The documentation noted on 5/18/15, the injured worker stands 5 feet and 1 inch tall and weighs 120 pounds. The diagnoses have included L4-5 and L5-S1 (sacroiliac) lumbar spinal stenosis; lumbosacral sprain superimposed on lumbar degenerative disc disease, preexisting and non-industrial; intermittent left lower extremity radiculopathy and morbid obesity. Treatment to date has included magnetic resonance imaging (MRI) of the lumbar spine on 4/1/15 showed the L5-S1 (sacroiliac) level reveals moderate degenerative changes of the facet joints and ligamentum flavum hypertrophy resulting in mild bilateral foraminal stenosis; celebrex; excedrin and prilosec and injections. The request was for [redacted] Weight Loss Program x 10 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

[redacted] **Weight Loss Program x 10 Weeks:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate.com, Obesity in adults: Overview of management.

Decision rationale: MTUS is silent specifically regarding medical weight loss programs. Uptodate states, "Overweight is defined as a BMI of 25 to 29.9 kg/m2; obesity is defined as a BMI of 30 kg/m2. Severe obesity is defined as a BMI 40 kg/m2 (or 35 kg/m2 in the presence of comorbidities)." Additionally, "Assessment of an individual's overall risk status includes determining the degree of overweight (body mass index [BMI]), the presence of abdominal obesity (waist circumference), and the presence of cardiovascular risk factors (eg, hypertension, diabetes, dyslipidemia) or comorbidities (eg, sleep apnea, nonalcoholic fatty liver disease). The relationship between BMI and risk allows identification of patients to target for weight loss intervention (algorithm 1). There are few data to support specific targets, and the approach described below is based upon clinical experience." "All patients who would benefit from weight loss should receive counseling on diet, exercise, and goals for weight loss. For individuals with a BMI 30 kg/m2 or a BMI of 27 to 29.9 kg/m2 with comorbidities, who have failed to achieve weight loss goals through diet and exercise alone, we suggest pharmacologic therapy be added to lifestyle intervention. For patients with BMI 40 kg/m2 who have failed diet, exercise, and drug therapy, we suggest bariatric surgery. Individuals with BMI >35 kg/m2 with obesity-related comorbidities (hypertension, impaired glucose tolerance, diabetes mellitus, dyslipidemia, sleep apnea) who have failed diet, exercise, and drug therapy are also potential surgical candidates, assuming that the anticipated benefits outweigh the costs, risks, and side effects of the procedure." The most recent medical documentation indicates this patient is 5'1" and weighs 120 pounds, which would not indicate a BMI greater than 25. The treating physician does not detail what weight loss (diet, exercise, and counseling) has been tried and failed. There is no rationale behind the request for this specific weight loss program or explanation of anticipated benefits over traditional diet and exercise. Additionally, no goals for weight loss or expected length of program have been detailed. As such, the request for [redacted] Weight Loss Program x 10 Weeks is not medically necessary.