

Case Number:	CM15-0094686		
Date Assigned:	05/20/2015	Date of Injury:	06/25/2012
Decision Date:	06/25/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/15/2015

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 (IW) is a 61-year-old male who sustained an industrial injury on 06/25/2012. Diagnoses include lumbar sprain/strain with degenerative disc disease (DDD)/facet osteoarthropathy/stenosis with bilateral lower extremity radiculitis, cervical/trapezius sprain/strain and bilateral hip sprain with osteoarthritis/possible avascular necrosis. A Supplemental Medical-Legal Report dated 3/6/15 included lumbar spine MRI results from 8/14/12, which showed DDD with neural foraminal stenosis most prominent at L3-4 and L4-5 and an electrodiagnostic study result dated 9/21/12, which indicated evidence of chronic bilateral L4, L5 and S1 radiculopathy. Treatment to date has included medications, epidural steroid injections, medial branch nerve blocks, acupuncture and physical therapy. According to the PR2 dated 4/17/15, the IW reported constant moderate to severe low back pain with left lower extremity numbness and tingling, sharp, shooting electrical pain with difficulty walking/sitting. On examination, the lumbar spine was tender to palpation with guarding and spasms; straight leg raise was positive on the left and deep tendon reflexes were 1+ bilaterally. The IW's weight was recorded as 314 pounds with height 6'2". A request was made for [REDACTED] Weight Loss Program for weight reduction for possible lumbar spine surgery and to reduce pressure on the lumbar spine, increase range of motion, increase activities of daily living and to decrease pain and inflammation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown sessions for [REDACTED] weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of physicians.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation Lindora weight program website <http://www.lindora.com/lhc-riteaid.aspx> AETNA website (aetna.com/cpb/medical/data/1_99/0039.html).

Decision rationale: The patient presents on 04/17/15 with worsening lumbar spine pain which radiates into the left lower extremity, rated 9-10/10. The patient's date of injury is 06/25/12. Patient is status post lumbar epidural steroid injections at dates and levels unspecified, and status post medial branch block on 10/17/14. The request is for UNKNOWN SESSIONS FOR [REDACTED] WEIGHT LOSS PROGRAM. The RFA was not provided. Physical examination dated 04/17/15 reveals tenderness to palpation of the lumbar paraspinal muscles with spasms noted, positive straight leg raise on the left, and reduced sensation along the L5 and S1 dermatomes bilaterally. The patient is currently prescribed Tylenol 3, Anaprox, Norflex, Neurontin, and Fexmid. Diagnostic imaging included lumbar MRI dated 08/14/12, significant findings include: "... neuroforaminal stenosis, most prominent at L3-L4 and L4-L5..." Electrodiagnostic stud dated 09/21/12 was also provided, significant findings include: "evidence of chronic bilateral L4, L5, and S1 radiculopathy." Per 04/17/15 progress note, patient is classified as temporarily totally disabled for 6-8 weeks. MTUS Guidelines page 46 and 47 recommends exercise, but states that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The [REDACTED] weight program is a medically supervised program (<http://www.lindora.com/lhc-riteaid.aspx>) MTUS, ODG, and ACOEM are silent on this particular weight loss program. AETNA website (aetna.com/cpb/medical/data/1_99/0039.html) was referred. AETNA allows "medically supervised" weight loss program only if the patient has failed caloric restriction and physical activity modifications. In this case, the provider is requesting a medically supervised [REDACTED] weight loss program to resolve this patient's obesity. Per 04/17/15 progress note, patient is 314 pounds and is 74 inches tall; a calculated BMI of 40.3 meeting obesity criteria. The progress reports do not reveal any steps taken by the patient to achieve weight loss goals; such as caloric restriction or increased physical activity. There is no stated number of sessions to be attended, as the note only specifies program attendance from 04/17/15 through 08/02/15 and there is no stated end-point or goal weight set. Without evidence that this patient has attempted and failed self-directed weight loss, or a specific number of weight loss sessions to be undertaken with a clearly stated end-point or goal, the request as written cannot be substantiated. Therefore, the request IS NOT medically necessary.