

Case Number:	CM15-0098014		
Date Assigned:	05/29/2015	Date of Injury:	07/05/2001
Decision Date:	06/29/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/21/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 50 year old male, who sustained an industrial injury on July 5, 2001, incurring head, spine and upper extremity injuries. He was diagnosed with a cervical sprain, blunt head trauma and head contusion. In 2009, a cervical Magnetic Resonance Imaging revealed spondylosis and stenosis. In 2012, the injured worker underwent a rotator cuff repair. Treatment included CPAP for respiratory difficulties at night, pain management, physical therapy and work restrictions. Currently, the injured worker complained persistent neck pain and headaches. He complained of increased weight gain, difficulty sleeping, fatigue, impotence and sleep apnea. The treatment plan that was requested for authorization included a urology consultation, orthopedic consultation and a weight loss program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urology consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), office visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Page(s): 127.

Decision rationale: Technically, ACOEM Chapter 7 is not within the MTUS collection; therefore, it is more appropriately cited under the "Other Guidelines" categorization. This claimant was injured 14 years ago. There was head trauma, a cervical sprain and a head contusion. He uses CPAP. He had increased weight gain, impotence and sleep apnea. There is reported erectile dysfunction, but no urological surgery issues noted. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the urologist consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.

Orthopedic consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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) Chapter 7, page 127.

Decision rationale: Technically, ACOEM Chapter 7 is not within the MTUS collection; therefore, it is more appropriately cited under the "Other Guidelines" categorization. This claimant was injured 14 years ago. There was head trauma, cervical sprain and head contusion. He uses CPAP. He has increased weight gain, impotence and sleep apnea. There is reported erectile dysfunction, but no orthopedic surgery issues are noted. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.

Weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Weight loss program.

Decision rationale: Medical Disability Advisor, under Obesity and weight loss. This claimant was injured 14 years ago. There was head trauma, cervical sprain and head contusion. He uses CPAP. He has increased weight gain, impotence and sleep apnea. Both the MTUS-ACOEM and the ODG-TWC guides are silent on opinions regarding weight loss. The Medical Disability Advisor, notes many ways to lose weight: The five medically accepted treatment modalities are diet modification, exercise, behavior modification, drug therapy, and surgery. All these modalities, alone or in combination, are capable of inducing weight loss sufficient to produce significant health benefits in many obese individuals. Calorie restriction has remained the cornerstone of the treatment of obesity. The standard dietary recommendations for losing weight include reducing total calorie intake to 1,200 to 1,500 calories per day for women, and to 1,500 to 1,800 calories per day for men (Obesity). Saturated fats should be avoided in favor of unsaturated fats, but the low-calorie diet should remain balanced. Keeping a food journal of food and drink intake each day helps individuals to stay on track. The addition of an exercise program to diet modification results in more weight loss than dieting alone and seems especially helpful in maintaining weight loss and preserving lean body mass. Moderate activity (walking, cycling up to 12 miles per hour) should be performed for at least 30 minutes per day, 5 days a week or more. Vigorous activity that increases the heart rate (jogging, cycling faster than 12 miles per hour, and playing sports) should occur for at least 20 minutes, 3 days a week or more. Although vigorous workouts do not immediately burn great numbers of calories, the metabolism remains elevated after exercise. The more strenuous the exercise, the longer the metabolism continues to burn calories before returning to its resting level. Although the calories lost during the post-exercise period are not high, over time they may count significantly for maintaining a healthy weight. Included in any regimen should be resistance or strength training 3 or 4 times a week. Even moderate regular exercise helps improve insulin sensitivity and in turn helps prevent heart disease and diabetes. Exercising regularly is critical because it improves psychological well-being, replaces sedentary habits that usually lead to snacking, and may act as a mild appetite suppressant. Behavior modification for obesity refers to a set of principles and techniques designed to modify eating habits and physical activity. It is most helpful for mildly to moderately obese individuals. One frequently used form of behavior modification called cognitive therapy is very useful in preventing relapse after initial weight loss. None of these MDA measures require a formal program; therefore, it is not possible to say a formal program is a necessary measure to lose weight in this patient. A weight loss program is not necessary to achieve weight loss; there are many no to low cost programs available in the United States to help people in weight loss efforts, such that a formal program would not be medically necessary. Therefore, the weight loss program request is not medically necessary as being an essential program for injury management.