

Case Number:	CM14-0108672		
Date Assigned:	08/01/2014	Date of Injury:	12/07/2011
Decision Date:	09/09/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/14/2014

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 Family 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:

This 52-year old correctional officer has a date of injury of 12/07/11, when he experienced an episode of chest pain at work. Current diagnoses include Prinzmetal's angina, coronary artery disease, anxiety and depression. There are no notes from the primary treating provider in the available records, though there are references to them in the UR evaluation. A panel QME exam was done 4/13/13, as well as an AME re-evaluation which was performed by the same physician on 4/24/14. The evaluations describe the patient as having had frequent recurrent episodes of chest pain after the episode on 12/7/11, which resulted in multiple emergency room visits, treadmill tests and cardiac catheterizations. He had an episode of ventricular fibrillation during a stress echocardiogram in March 2012, which resulted in a catheterization that showed coronary artery spasm. A coronary artery stent was placed. He remained symptomatic after the stent placement, with frequent episodes of chest pain. By 4/24/14, The AME noted that the patient had now had a total of 6 coronary angiograms, as well as placement of 2 additional stents on 9/4/13. He was scheduled for a 7th angiogram with probable placement of another stent. The AME cited a pain management consultation performed 1/31/14, which recommended yoga, meditation, psychology consultation, and cardiology consultation. A 12/20/13 psychiatric AME evaluation made a diagnosis of work-related anxiety, and recommended medication changes and supportive psychotherapy, as well as referral for further cardiac evaluation and treatment. The 4/24/14 AME re-evaluation noted that psychiatric and cardiovascular consultations were still pending. He also noted that the patient was requesting referral to a research center where alternative treatments would be available. The Utilization Review report of 6/25/14 refers to a 6/13/14 note from the patient's primary provider, which states that the patient continues to have severe cardiovascular spasms, which occur both with stress and during sleep. The primary provider's plan included a comprehensive multidisciplinary assessment for a functional recovery

program, and a cardiology consultation at a tertiary medical center. The request for assessment for an FRP was denied in UR on 6/25/14 on the grounds that that evidence-based qualifications for the referral had not been met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Comprehensive Multidiscipline Assessment for APM-FRP (Functional Restoration Program) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: The MTUS reference cited above states that functional restoration programs are recommended in situations where there is access to programs with proven success rates. Prior to referral an adequate evaluation must be made which includes baseline function testing. Previous treatment methods must have been unsuccessful, and there must be an absence of other treatment options which are likely to cause clinical improvement. The patient should not be a candidate for surgery or other treatments that would be clearly warranted. The patient must exhibit motivation to change and be willing to forgo secondary gain such as disability payments, and negative predictors of success must have been addressed. (Negative predictors of success include a negative outlook about future employment and high levels of psychosocial distress including higher pre-treatment levels of depression.) In this patient's case, many or all of these criteria have not been met. The patient has not yet had a full trial of psychotherapy and psychiatric medications which has been deemed unsuccessful. The patient is soon to be scheduled for another cardiac catheterization, likely with stent placement. It is not clear that either medical or surgical treatment options have been exhausted. There is no documentation of an evaluation with baseline functional testing, nor is there documentation of any attempt to address the patient's negative risk factors. (These include the patient's conviction that he is unemployable and may not live long, and his high levels of depression and anxiety.) Finally, it is not clear that this patient is interested in participating in an FRP, or that such participation would be a good idea. The patient is on record as stating that he wants a referral to a research center, not to a functional recovery program. Since he has a history of at least two episodes of coronary artery spasm and ventricular arrhythmia that may in part have been provoked by exercise, it is not clear that it would be safe for him to engage in an exercise program such as those often included in FRPs. A cardiac rehabilitation program might be more appropriate. Based on the medical guideline cited and the clinical information provided, a referral to a functional recovery program is medically inadvisable. A referral to a functional recovery program is not medically unnecessary due to lack of documentation that the patient meets evidence-based criteria for enrollment in such a program, or that he is even interested in enrolling.