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| Case Number: | CM15-0190502 | | |
| Date Assigned: | 10/02/2015 | Date of Injury: | 12/01/2011 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/09/2015 |
| Priority: | Standard | Application Received: | 09/28/2015 |

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: Arizona, Texas

Certification(s)/Specialty: Internal 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 42 year old female who sustained an industrial injury on 12-01-2011. A review of the medical records indicated that the injured worker is undergoing treatment for unstable angina, coronary artery disease, hypertension and obesity. The injured worker is status post triple coronary artery bypass graft on 05-11-2015. According to the treating physician's progress report on 08-27-2015, the injured worker was evaluated for a 3 month post-operative follow-up. The injured worker continues to experience fatigue and soreness in the anterior rib cage. She denies shortness of breath, palpitations, diaphoresis and chest pain. Blood pressure was 152 systolic and 91 diastolic with heart rate at 76 beats per minute. Height was 59 inches; weight 186 pounds with a body mass index of 37.36. Electrocardiogram (EKG) on 05-27-2015 noted sinus rhythm, non-specific ST-T abnormalities, probable ischemia. Recent diagnostic testing included echocardiogram and treadmill on 04-22-2015. Echocardiogram noted trace tricuspid regurgitation, mild left ventricular dysfunction and ejection fraction of 55%. Prior treatments have included cardiac diagnostic work-up, cardiac catheterization, revascularization, home health physical therapy and occupational therapy and medications. Current medications were listed as Aspirin 325mg DR, Atorvastatin and Carvedilol. Treatment plan consists of nuclear myocardial perfusion study, life style and weight counseling and management; decrease Aspirin to 81mg, discontinued Famotidine and Lisinopril and the current request for an echocardiogram. On 09-09-2015 the Utilization Review determined the request for echocardiogram was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Echocardiogram, quantity: 1: 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 UptoDate.com. Late recurrent angina pectoris after coronary artery bypass graft surgery.

Decision rationale: The MTUS and ODG are silent regarding the use of echocardiogram. According to UptoDate.com regarding recurrent chest pain occurring in a patient several months post-CABG, although the history may be strongly suspicious for recurrent angina, confirming the suspicion with diagnostic testing is recommended. As these patients have a high pretest probability of obstructive coronary artery disease, a positive test will likely confirm the diagnosis. Such testing will also provide prognostic information, which should be used to help formulate a reasonable management strategy. Obtaining a 12-lead electrocardiogram (ECG) in all patients as soon as recurrent angina is suspected is recommended; it should be compared to prior ECGs. New findings of ST-segment or T wave changes representing ischemia, Q waves, bundle branch block, or arrhythmias should raise the possibility of an acute coronary syndrome (ACS). For patients who have a stable presentation, including a stable ECG, we recommend stress testing with imaging (either nuclear or echocardiographic). In this case, both nuclear and echocardiographic imaging was requested. During the utilization review a stress test with nuclear imaging was approved therefore an echocardiogram is not medically necessary.