

Case Number:	CM15-0202667		
Date Assigned:	10/19/2015	Date of Injury:	02/15/2005
Decision Date:	12/01/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/14/2015

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: 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 68 year old male with an industrial injury dated 02-15-2005. A review of the medical records indicates that the injured worker is undergoing treatment for hypertension, left atrial enlargement and right atrial enlargement, new onset atrial fibrillation and status post knee surgery. According to the progress note dated 09-03-2015, the injured worker reported low blood pressure and a decrease in his Atenolol and Diltiazem. The injured worker also reported that he was awaiting ablation treatment for his Afib. Objective findings (09-03-2015) revealed elevated blood pressure. In a progress report dated 09-21-2015, documentation noted that the injured worker was scheduled for Computed tomography angiogram and ablation treatment. Some documents within the submitted medical records are difficult to decipher. The injured worker blood pressure was "now stable". Objective findings revealed 115 over 75 blood pressure and irregular heart rhythm. Treatment has included prescribed medications and periodic follow up visits. The utilization review dated 09-29-2015, non-certified the request for cardiac ablation treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardiac ablation treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Cardiology Foundation; <http://www.nlm.nih.gov/medlineplus/ency/article/003419.htm>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape On Line Version, updated Jul 06, 2015 Catheter Ablation.

Decision rationale: Both MTUS and ODG are silent on the use of cardiac ablation treatment. Based on the Online Version of Medscape regarding catheter ablation, the indications are as follows: There are three class I indications for catheter ablation. The first is symptomatic supraventricular tachycardia (SVT) due to atrioventricular (AV) nodal reentrant tachycardia (AVNRT), Wolff-Parkinson-White (WPW) syndrome, unifocal atrial tachycardia, or atrial flutter (especially common right atrial forms). For these conditions, catheter ablation is first-line therapy if that is the patient's preference. The second indication is AF with lifestyle-impairing symptoms and inefficacy or intolerance of at least one antiarrhythmic agent. [6, 3] Both left atrial ablation for restoration of sinus rhythm and AV junction ablation for rate control are class I indications, depending on the circumstance. The third indication is symptomatic VT. [7] Catheter ablation is first-line therapy in idiopathic VT if that is the patient's preference. In structural heart disease, catheter ablation is generally performed for drug inefficacy or intolerance or as adjunctive therapy in patients with an implantable cardioverter-defibrillator (ICD) who are experiencing frequent ICD discharges. Uncommon indications for catheter ablation include the following: Symptomatic drug-refractory (inefficacy or intolerance) idiopathic sinus tachycardia; Lifestyle-impairing ectopic beats; Symptomatic junctional ectopic tachycardia; RFCA has been applied to most clinical tachycardias, even to polymorphic VT and VF in preliminary studies. Success rates are highest in patients with common forms of SVT, namely AVNRT and orthodromic reciprocating tachycardia (ORT). In this case, there is not good documentation of lifestyle-impairing symptoms. There are no reports of chest pain, shortness of breath or dyspnea on exertion to name just a few. Also, there is no evaluation from a cardiologist. Lastly, it is not clear whether the patient did not tolerate the antiarrhythmic agents he was placed on. Therefore, based on current guidelines and the evidence in this case, the request for cardiac ablation treatment is not medically necessary.