

Case Number:	CM15-0084709		
Date Assigned:	05/07/2015	Date of Injury:	04/04/2003
Decision Date:	07/01/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	05/04/2015

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 58 year old male, who sustained an industrial injury on 4/4/2003. Diagnoses have included thoracic facet arthropathy, lumbar radiculitis, coronary artery disease with history of myocardial infarction, severe peripheral vascular disease and severe ischemic pain of the bilateral lower extremities. Treatment to date has included diagnostic testing and medication. According to the office note dated 3/20/2015, the injured worker had severe, lifestyle limiting claudication. He was only able to walk around 25-50 feet with a significant amount of pain. It was noted that he had an ankle-brachial index (ABI) study with ABI on the right 0.4 and on the left 0.58. He had severe monophasic flow down in the DPs and PT bilaterally. He appeared to have an occluded PT on the right side. The injured worker was taking Xarelto. Authorization was requested for aortogram with runoff and possible percutaneous transluminal angioplasty/stent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aortogram with runoff, possible PTA/Stent: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACCF/AHA Practice Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2005 Practice Guidelines for the Management of Patients With Peripheral Arterial Disease <http://www.ncbi.nlm.nih.gov/pubmed/16549646>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address contrast angiography. American College of Cardiology / American Heart Association 2005 Practice Guidelines for the Management of Patients With Peripheral Arterial Disease (Lower Extremity, Renal, Mesenteric, and Abdominal Aortic) indicates that contrast angiography provides detailed information about arterial anatomy and is recommended for evaluation of patients with lower extremity PAD peripheral arterial disease when revascularization is contemplated. Endovascular procedures are indicated for individuals with a vocational or lifestyle-limiting disability due to intermittent claudication when clinical features suggest a reasonable likelihood of symptomatic improvement with endovascular intervention and (a) there has been an inadequate response to exercise or pharmacological therapy and/or (b) there is a very favorable risk-benefit ratio (e.g., focal aortoiliac occlusive disease). Endovascular procedure is the treatment of choice for type A lesions. TransAtlantic Inter-Society Consensus TASC type A femoropopliteal lesion is a single stenosis less than 3 cm of the superficial femoral artery or popliteal artery. TransAtlantic Inter-Society Consensus TASC type A iliac lesion is a single stenosis less than 3 cm of the CIA common femoral artery or EIA external iliac artery (unilateral/bilateral). Endovascular intervention is recommended as the preferred revascularization technique for TASC type A iliac and femoropopliteal arterial lesions. Vascular lab bilateral lower extremity Arterial Duplex report dated 2/19/15 documented monophasic inflow seen to the right and left lower extremity. On the right, there appears to be occlusion of the above knee popliteal artery. There appears to be flow in the anterior tibial artery. The distal posterior tibial artery appears to be occluded. On the left, there appears to be a high-grade stenosis greater than 75% in the mid superficial femoral artery as well as an above knee popliteal artery occlusion. Monophasic flow is seen in the tibial vessels. Vascular lab ankle brachial indices report dated 2/19/15 documented moderate to severe decrease in pressures are seen in the right and left ankle with monophasic waveforms. Moderate severe arterial insufficiency at rest in the right and left lower extremity was documented. The vascular surgery treating physician's report dated 3/20/15 documented that the patient is a 57 year old man with severe lifestyle limiting claudication. He can only walk around 25 to 50 feet with significant amount of pain. Ankle-brachial index ABI study was performed. ABI on the right is 0.4. ABI on the left is 0.58. He has severe monophasic flow down in the dorsalis pedis DP and posterior tibial PT arteries bilaterally. He appears to have an occluded PT posterior tibial on the right side. His arterial duplex on the right side has his above-knee popliteal artery and all the way down to the below-knee popliteal to the PT posterior tibial is occluded. He has anterior tibial AT reconstitution. He has monophasic inflow bilaterally. He has significant stenosis on the left SFA superficial femoral artery with an 8 to 1 step-up in the proximal SFA superficial femoral artery and mid SFA with an occluded BK below-knee popliteal on the left side and flow with PT posterior tibial and the AT anterior tibial. He has 1-2+ bilateral femoral pulses with nonpalpable popliteal, DP dorsalis pedis, and PT posterior tibial pulse. The treatment plan was to perform an abdominal aortogram with possible angioplasty, stenting. The patient likely has iliac disease which can be treated. The physician will treat and evaluate the left lower extremity at the same time. ACC/AHA Practice Guidelines indicates that contrast angiography is recommended for evaluation of patients with lower extremity peripheral arterial disease when

revascularization is contemplated. The medical records document that the revascularization is being considered for the patient with peripheral arterial disease. ACC/AHA Practice Guidelines supports the request for aortogram with runoff with possible percutaneous transluminal angioplasty PTA/stent. Therefore, the request for an aortogram is medically necessary.