

Case Number:	CM15-0085227		
Date Assigned:	05/07/2015	Date of Injury:	03/23/2000
Decision Date:	07/22/2015	UR Denial Date:	04/13/2015
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, Indiana, New York
 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 64 year old male who sustained a work related injury May 23, 2000. Past history included s/p right ankle surgery x six, s/p right ankle hardware removal, s/p right ankle fusion with graft, possible cerebral vascular accident without residual September, 2014 and hypertension. A primary treating physician's progress report, dated February 26, 2015, finds the injured worker complaining of right ankle pain, rated 3-4/10, with medication and 7/10 without medication. He reports improvement in increased ability to stand and walk with the use of medication. He ambulates with antalgia, favoring his right lower extremity. There is tenderness about the entire right ankle and foot regions. There was mention of hospitalization for a possible cerebral vascular accident in September 2014, and recently the injured worker had been complaining of chest pain and shortness of breath while pain medication was tapered. A cardiology consultation was ordered and on March 12, 2015, the injured worker presented to cardiology for evaluation. The handwritten notes are difficult to decipher. The injured worker complained of retrosternal chest pain and burning, difficulty walking, loss of balance, and weakness of both legs. He noted a history of a pack a day tobacco use for 30 years and amphetamines, one year ago (consistent with lab in medical record 2013). Examination (handwritten notes are difficult to decipher) revealed mild right carotid bruit, lungs decreased breath sounds at the bases, and electrocardiogram (report not present in medical record) revealed normal sinus rhythm, rate 63, with non-specific ST and T wave changes. Diagnoses are transient ischemic attack; peripheral vascular disease; history of hyperlipidemia. At issue, is the request for authorization for ABI (ankle-brachial index) test and LEXI scan test.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEXI scan- Heart: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/1827166-overview>.

Decision rationale: Pursuant to Medscape, Lexiscan heart is not medically necessary. Exercise testing is a cardiovascular stress test using treadmill bicycle exercise with ECG and blood pressure monitoring. Pharmacologic stress testing, established after exercise testing, is a diagnostic procedure in which cardiovascular stress induced by pharmacologic agents is demonstrated in patients with decreased functional capacity or in patients who cannot exercise. [1] Pharmacologic stress testing is used in combination with imaging modalities such as radionuclide imaging and echocardiography. Regadenoson is a new pharmacologic stress agent approved by the FDA in 2008 as an additional agent for use in stress testing for patients unable to perform the standard exercise stress test. Regadenoson produces maximal hyperemia quickly and maintains it for an optimal duration that is practical for radionuclide myocardial perfusion imaging. Regadenoson's simple rapid bolus administration and short duration of hyperemic effect point to an advantage of enhanced control for the clinician. Regadenoson is an agonist with low affinity (K_i 1.3 M) for the A_{2A} adenosine receptor, and at least a 10-fold lower affinity for the A₁ adenosine receptor ($K_i > 16.5$ M). In addition, it has relatively weak affinity for the A_{2B} and A₃ adenosine receptors. Coronary vasodilation and an increase in coronary blood flow (CBF) results from activation of the A_{2A} adenosine receptor by regadenoson. In this case, the injured worker's working diagnoses (heart related) are hypertension; TIAs; PVD v PUD; history hyperlipidemia; history of Liver abuse. There is a single, handwritten, largely illegible cardiology progress note dated March 12, 2015. There is no clinical indication or rationale stating why the Lexiscan of the heart is clinically indicated. Subjectively, the injured worker complains of chest pain, speech difficulties, difficulty walking and loss of balance. The injured worker has had hypertension for over two years. The injured worker had complaints of retrosternal chest pain burning. The medical record was largely illegible. Objectively, vital signs showed a blood pressure of 148/86 SpO₂ was 94% and the heart rate was 60. The chest was non-tender. PMI was not palpable, S₁ S₂ are normal there was no S₃ or S₄. Breath sounds were decreased. EKG showed a normal sinus rhythm and 63 with nonspecific STT changes. There was no legible clinical indication or rationale in the medical record indicating why a Lexiscan as clinically indicated. Consequently, absent (legible) clinical documentation and a clinical indication and rationale for the Lexiscan heart, Lexiscan heart is not medically necessary.

ABI Test- Heart: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Ankle Brachial Pressure Index (ABI or ABPI) Vascular Health and Risk Management 5: 833-41.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.mayoclinic.org/tests-procedures/ankle-brachial-index/basics/definition/prc-20014625>.

Decision rationale: Pursuant to Mayo Clinic.org, the ankle / brachial index test (ABI) is not medically necessary. The ankle-brachial index test is a quick, noninvasive way to check your risk of peripheral artery disease (PAD). Peripheral artery disease is a condition in which the arteries in your legs or arms are narrowed or blocked. People with peripheral artery disease are at a high risk of heart attack, stroke, poor circulation and leg pain. In this case, the injured worker's working diagnoses (heart related) are hypertension; TIAs; PVD v PUD; history hyperlipidemia; history of Liver abuse. There is a single, handwritten, largely illegible cardiology progress note dated March 12, 2015. There is no clinical indication or rationale stating why the ABI Test of the heart is clinically indicated. Subjectively, the injured worker complains of chest pain, speech difficulties, difficulty walking and loss of balance. The injured worker has had hypertension for over two years. The injured worker had complaints of retrosternal chest pain burning. The medical record was largely illegible. Objectively, vital signs showed a blood pressure of 148/86, SpO2 was 94% and the heart rate was 60. The chest was non-tender. PMI was not palpable, S1 S2 are normal there was no S3 or S4. Breath sounds were decreased. EKG showed a normal sinus rhythm and 63 with nonspecific STT changes. There was no legible clinical indication or rationale in the medical record indicating why an ABI Test is clinically indicated. Consequently, absent legible clinical documentation and a clinical indication and rationale for the ABI Test, ABI Test (ankle-brachial index) is not medically necessary.