

Case Number:	CM15-0037207		
Date Assigned:	03/05/2015	Date of Injury:	01/01/2004
Decision Date:	05/14/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	02/27/2015

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 45 year old female, who sustained an industrial injury on 1/1/2004. She has reported work related stress subsequently resulting in work related medical conditions. The diagnoses have included neurocardiogenic syncope, tachycardia, non-specific chest pain, with pacemaker inserted, atrial fibrillation, mitral valve prolapse, chronic orthostatic hypotension, vestibular vertigo, and acute post traumatic headache, reflex sympathetic dystrophy of right arm, nerve stimulator insert, and depression and anxiety. Treatment to date has included anti-depressant, anti-anxiety, cardiology care and assessments, implanted pacemaker and nerve stimulator, analgesic and psychotherapy. Currently, the Injured Worker complains of frequent chest pain episodes associated with rapid heartbeat. The cardiology evaluation dated 2/19/15 documented a recent history of frequent chest pain and tachycardia resulting in several recent Emergency Room visits. The electrocardiogram (EKG) from the same date revealed minor ST and T wave changes, sinus rhythm. The pacemaker was interrogated confirming frequent tachycardia events identified as sinus tachycardia. The provider documented clinical difficulty due to comorbidities including panic attacks with tachycardia and chest pain requiring a cardiac catheterization with possible stenting. The plan of care included initiation of beta blocker therapy and continuation of nitroglycerin. On 2/27/2015, the injured worker submitted an application for IMR for review of left heart catheterization with possible stenting.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left heart catheterization/possible stenting: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.ncbi.nlm.nih.gov/pubmedheart/PMH0004322>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to date topic 1470, version 14.0, topic 46 and version 23.0 and lastly topic 1534 and version 14.0.

Decision rationale: Stress testing is useful for the evaluation of suspected CHD. Pharmacologic stress testing is used for patients who cannot exercise and exercise stress testing for those who can exercise. Specific clinical assessment of pretest probability should be made prior to testing. In the patient with a high pretest probability of CHD, noninvasive testing is generally not necessary because a negative result is likely a false negative. On the other hand, patients with a low pretest probability of CHD stress testing is not recommended because positive results are likely to be false positives. Cardiac catheterization is a procedure in which the native coronaries are visualized to allow for diagnosis and treatment of coronary artery disease. The risk of major complications such as death, MI, or major embolization during or after cardiac catheterization is well below 1 percent. Mortality is under .1percent. The risk of MI is .1 percent and the risk of stroke is .2 to .4 percent. Local complications at the site of catheter insertion are among the most common problems. These problems may include acute thrombosis, distal embolization, dissection, poorly controlled bleeding, hematoma, retroperitoneal hemorrhage, pseudoaneurysm, or arteriovenous fistula. Cardiac cath is often used in cases of non ST elevation MI and unstable angina. Immediate cath is recommended if there is hemodynamic instability, heart failure, recurrent or persistent rest angina, new or worsening mitral regurgitation, or new VSD, or sustained ventricular arrhythmias. However, patients that are at low risk for further cardiac problems may be treated conservatively without cardiac catheterization. In the above patient, we have a very difficult presentation. Noninvasive procedures have failed to confirm coronary disease. Her presentation is classical in the sense that it is associated with chest pain and tachycardia. However, she has depression and anxiety which can present with the same clinical picture secondary to panic attacks. A negative stress test can still be misleading and result in false reassurance. In a patient such as this, definitive clarification is needed in order to appropriately treat her. The only test that can do this with certainty would be a cardiac cath and the risk of major side effects is low. It is deemed in the patients best interests to have the procedure for definitive diagnosis and the decision is reversed. Therefore the request is medically necessary.