

<b>Case Number:</b>	CM13-0008074		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	11/14/2003
<b>Decision Date:</b>	01/06/2014	<b>UR Denial Date:</b>	07/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in internal medicine and is licensed to practice in California. 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 physician 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/services.

### 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 patient is a widowed registered nurse, who was assaulted by a homeless woman in a rest room at the patient's work place on November 14, 2003. As result of this incident, the patient sustained head trauma which was complicated by seizure attack. In May 2004, the patient fell into the bathtub and suffered an aggravation of existing injury. The patient subsequently developed impairments in her cognitive function. The patient has had multiple diagnosis related to these injuries, including post traumatic headaches, potential post traumatic epilepsy vs post traumatic epilepsy associated with pseudo-seizure, vs generalized anxiety disorder with panic episodes/hyperventilation and syncopal spells, Diabetes Mellitus-non-industrial on regular insulin regimen since 2005. On may 28, 2013, the patient had an Echo-cardiogram which revealed : Left Ventricular Enlargement with estimated ejection fraction of 65%, trivial Mitral regurgitation. At issue are whether the 24 hour Holter Monitor is/are medically necessary and appropriate, and whether the EKG Ansar study is/are medically necessary and appropriate.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Halter monitor:** 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 American College of Cardiology/American Heart

Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography) developed in collaboration with the North American Society for Pacing and Electrophysiology" from

**Decision rationale:** The 24 hour Holter monitor is a type of electrocardiogram (ECG or EKG) used to monitor the ECG tracing continuously for a period of 24 hours or longer. A standard or "resting" ECG is one of the simplest and fastest procedures used to evaluate the heart. Electrodes (small, plastic patches) are placed at certain locations on the chest and abdomen. When the electrodes are connected to an ECG machine by lead wires, the electrical activity of the heart is measured, interpreted, and printed out for the doctor's information and further interpretation. When symptoms, such as dizziness, fainting, low blood pressure, prolonged fatigue, and palpitations, continue to occur without a definitive diagnosis obtained with a resting ECG, a 24 hour Holter monitoring study could be requested. Certain dysrhythmias and arrhythmias (abnormal heart rhythms), which can cause the symptoms noted above, may occur only intermittently, or may occur only under certain conditions, such as stress. Dysrhythmias of this type are difficult to obtain on an ECG tracing that only runs for a few minutes. Thus, the doctor will request a Holter monitor to allow a better opportunity to capture any abnormal heartbeats or rhythms that may be causing the symptoms. The Holter monitor records continuously for the entire period of 24 to 48 hours. Some Holter monitors may record continuously but also have an event monitor feature that you activate when symptoms begin to occur. One of the primary and most widely accepted uses of Holter Monitor also known as Ambulatory ECG (AECG) is the determination of the relation of a patient's transient symptoms to cardiac arrhythmias. Some symptoms are commonly caused by transient arrhythmias: syncope, near syncope, dizziness, and palpitation. However, other transient symptoms are less commonly related to rhythm abnormalities: shortness of breath, chest discomfort, weakness, diaphoresis, or neurological symptoms such as a transient ischemic attack. Vertigo, which is usually not caused by an arrhythmia, must be distinguished from dizziness. More permanent symptoms such as those seen with a cerebrovascular accident can be associated less commonly with an arrhythmia, such as embolic events that occur with atrial fibrillation. A careful history is essential to determine if AECG is indicated. When reviewed alongside the provided medical records, the criteria for a 24-hour halter monitor is not met. The request for a 24 hour halter monitor is not medically necessary and appropriate.

**EKG - Ansar study:** 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 A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography) developed in collaboration with the North American Society for Pacing and Electroph

**Decision rationale:** Autonomic nervous system (ANS) testing is considered investigational for all other indications that do not meet the above criteria, including but not limited to: Screening or

routine testing of patients without signs or symptoms of autonomic dysfunction, including patients with diabetes, hepatic or renal disease; Testing for the sole purpose of monitoring disease intensity or treatment efficacy in diabetes, hepatic or renal disease; Patients with a clearly diagnosed somatic neuropathy, especially demyelinating neuropathies; Patients with uncomplicated vasovagal syncope; General diagnosis of conditions including, but not limited to: - Asthma - Anxiety and/or stress - General wellness - Obesity - Psychological conditions - Post-partum dysfunctions - Sleep apnea. The autonomic nervous system (ANS) regulates physiologic processes, such as blood pressure, heart rate, body temperature, digestion, metabolism, fluid and electrolyte balance, sweating, urination, defecation, sexual response, and other processes. Regulation occurs without conscious control, i.e., autonomously. The ANS has two major divisions: the sympathetic and parasympathetic systems. Many organs are controlled primarily by either the sympathetic or parasympathetic system, although they may receive input from both; occasionally, functions are reciprocal (e.g., sympathetic input increases heart rate; parasympathetic decreases it). The sympathetic nervous system is catabolic and activates fight-or-flight responses. Thus, sympathetic output increases heart rate and contractility, bronchodilation, hepatic glycogenolysis and glucose release, BMR (basal metabolism rate), and muscular strength; it also causes sweaty palms. Less immediately-life-preserving functions (e.g., digestion, renal filtration) are decreased. The parasympathetic nervous system is anabolic; it conserves and restores. Gastrointestinal secretions and motility (including evacuation) are stimulated, heart rate is slowed, and blood pressure decreases. Disorders of the ANS can affect any system of the body; they can originate in the peripheral or central nervous system and may be primary or secondary to other disorders. Symptoms suggesting autonomic dysfunction include orthostatic hypotension, heat intolerance, nausea, constipation, urinary retention or incontinence, nocturia, impotence, and dry mucous membranes. If a patient has symptoms suggesting autonomic dysfunction, cardiovagal, adrenergic, and sudomotor tests are usually done to help determine severity and distribution of the dysfunction. Cardiovagal innervation testing evaluates heart rate response to deep breathing and to the Valsalva maneuver, via electrocardiogram rhythm strip. If the ANS is intact, heart rate varies with these maneuvers; the ratio of longest to shortest R-R interval (Valsalva ratio) should be 1.4 or greater. Vasomotor adrenergic innervation testing evaluates response of beat-to-beat blood pressure to the head-up tilt and