

Case Number:	CM13-0021652		
Date Assigned:	11/13/2013	Date of Injury:	01/29/2009
Decision Date:	01/13/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/09/2013

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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 56-year-old male who reported a work-related injury on 01/29/2009, with the specific mechanism of injury noted as a fall. The clinical note dated 07/05/2013 reports the patient was seen under the care of [REDACTED] for his pain complaints. The provider documents the patient presents with no change to complaints of acid reflux, hypertension, sleep quality, or low back pain. The patient's average blood pressure was noted to be at 110/80 per the patient. Vital signs at this visit were 144/72 and heart rate 55. The provider documented the lungs were clear to auscultation. There were no rales or wheezes appreciated and there was no dullness to percussion. The patient's heart rate was regular with rhythm at S1-S2 and there were no rubs or gallops appreciated. The provider documented he was requesting a copy of the patient's sleep study results to confirm diagnosis obstructive sleep apnea in addition the provider documented an EKG and 2D echo with Doppler were performed at the clinic visit. The provider documented the patient was administered the following medications, Prilosec, ranitidine, Colace, and simethicone. The provider documented the patient was to avoid NSAIDs as the patient receives Coumadin 10 mg from his private physician. The patient was advised to follow a low sodium, low fat, and low acid diet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrocardiography (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.guideline.gov/content.aspx?id+39338&search=electrocardiography=hypertension>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Suzuki, Takeki, et al. "Echocardiographic predictors of frequency of paroxysmal atrial fibrillation (AF) and its progression to persistent AF in hypertensive patients with paroxysmal AF: Results from the Japanese Rhythm Management Trial II for Atrial Fibrillation

Decision rationale: The clinical documentation submitted for review fails to indicate significant objective findings of symptomatology to support the requested diagnostic study at this point in the patient's treatment. The clinical notes did not evidence the patient's cardiac history, as the provider did document that the patient presents with atrial fibrillation; however, it is unclear when the patient last underwent cardiac test, or if the patient's symptomatology had increased, therefore, precipitating the patient having undergone an EKG on 07/05/2013. The clinical notes do not support the requested intervention. As the patient presents with a date of injury of over 4 years, it is unclear what the patient's course of treatment has been as far as from a cardiac aspect. The provider documented that the patient had stated his blood pressure was generally 110/80 at home. Given the lack of documentation evidencing when the patient last underwent a cardiac workup, and the patient's objective symptomatology, the current request is not supported. The request for an EKG is not medically necessary and appropriate.