MAXIMUS Federal Services

Case Number:	CM13-0049048		
Date Assigned:	12/27/2013	Date of Injury:	10/02/2011
Decision Date:	02/19/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/07/2013

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, has a subspecialty in Pulmonology and is licensed to practice in New York. 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 38 year old female food processor with a slip and fall injury when she walked into the freezer section; the date of injury of 10/02/2011. On10/22/2013 a request for a cardiopulmonary autonomic function assessment was requested and this was denied a week later. This was appealed. She complained of back pain and neck pain from the injury. On 04/02/2012 she had a MRI of the lumbar spine that revealed disc protrusions. Also on 04/02/2012 she had a normal thoracic spine MRI and a normal cervical spine MRI. She had at least 45 physical therapy visits and was also treated with Vicodin and Relafen. On 09/10/2013 she had an office visit and complained of occipital pain, neck pain radiating to her upper extremities, bilateral knee pain and back pain radiating to her lower extremities. She had a positive straight leg raising, mild decrease in cervical range of motion and more severe decrease in lumbar range of motion. She had a decreased knee range of motion. There was no focal weakness and no abnormal reflex. Most important to this review is that there was no documentation of any cardiopulmonary disease before or after the injury. On 01/22/2013 she had no shortness of breath, chest pain, palpitations, wheezing or cough. The blood pressure was 124/72 and the pulse was 83/min. She was 5'1" tall and weighed 179 pounds. BMI was 33.85. Chest was clear. Heart sounds were regular and there was no murmur. On 08/16/2013 her chest was clear. Heart sounds were normal. Blood pressure was 131/80 and the pulse was 78/min. On 08/23/2013 the HbA1c was 6.4. On 09/10/2013 she denied any cardiac or pulmonary disease in her past medical history.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardio-respiratory autonomic function assessment: 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 Jones, NL. Clinical Exercise Testing, 4th Edition. 1997.

Decision rationale: During a cardiopulmonary stress test the following is measured: The peak O2 consumption, CO2 production, heart rate, O2 pulse, and maximum minute ventilation are measured. EKG monitoring is done. The test measures exercise capacity during a progressively increased exercise test. It documents if the exercise capacity is normal, if there is a cardiac limitation to perform exercise (normal) and if there is a respiratory limitation to perform exercise. It can also document if the patient is malingering (stating that they cannot do more exercise when in fact they can). The most important clinical use is in the situation where it is important to differentiate a cardiac from a pulmonary limitation to perform exercise in a patient with decreased exercise capacity who has both cardiac disease and pulmonary disease and an important management decision has to be made. For example, if the patient has mitral valve disease and COPD an exercise cardiopulmonary stress test can help decide if a mitral valve replacement might improve the patient's dyspnea. If the patient has a pulmonary limitation to perform exercise from COPD, the mitral valve replacement will not improve the patient's symptoms. Again, for the cardiopulmonary stress test to have clinical usefulness, the patient must have both severe cardiac disease and severe pulmonary disease and an important management decision must be made. Cardiopulmonary stress testing is also used in disability cases for malingering and for documentation of a pulmonary limitation to perform exercise. Patients with a pulmonary occupational condition may still have a cardiac limitation to perform exercise and thus symptoms of dyspnea may not be from the pulmonary condition. Usually at peak exercise there is a 30% or more pulmonary reserve and a cardiac limitation to perform exercise is normal. This patient has no documentation of any pulmonary or cardiac condition or any pulmonary or cardiac symptoms and cardiopulmonary testing is not medically necessary.