

<b>Case Number:</b>	CM14-0116280		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	05/13/2010
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in Maryland. 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/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 employee was a 63 year old female who was being treated for shoulder pain, right upper extremity pain, neck, upper and lower back pain. The date of injury was 05/13/10 when she fell down at work. She was diagnosed with fracture of right wrist. Subsequent to that she had injection of the right shoulder, patches, topical creams, Naprosyn and Tramadol. Her history was significant for arthroscopic rotator cuff repair right shoulder, decompression and distal clavicle resection. Her diagnoses included myoligamentous strain of the cervical spine with radicular symptoms of the right upper extremity, myoligamentous strain of the right trapezius musculature, inflammatory process of the right shoulder with stiff shoulder syndrome, lateral epicondylitis of right elbow, status post open reduction and internal fixation of right distal radius, sprain of lumbar spine and De Quervain's synovitis. She also had history of anxiety, hypertension, depression and irritability and GI issues for which she had been taking Omeprazole since January 2014. She was seen by an internal medicine consultant on 05/20/14. A History of presenting illness notes that she had been referred for stomach complaints secondary to medications. There was no history of GI illness prior to the injury. She had stopped taking Naprosyn 5 months prior to presentation but she continued to have epigastric pain, not related to food, burning in character with radiation to the chest and the right upper quadrant. There was also nausea without vomiting. She also had choking spells and had to vomit to feel better and was following up with psychiatrist for stress and depression. The current medications included Alprazolam, Zolpidem, Fluoxetine, Terocin Patches, Tramadol, Omeprazole, Naprosyn, Lisinopril and Simvastatin. On examination, she was found to have a blood pressure of 148/90 mm of Hg, with tenderness in epigastric region. Electrocardiogram revealed normal sinus rhythm within normal limits. The diagnoses included gastritis, history of NSAID use and obesity. The request was for electrocardiogram.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Electrocardiogram for date of service 5/20/14 #1:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Differential diagnosis of abdominal pain in adults. Uptodate.

**Decision rationale:** The employee was being treated for shoulder pain, neck and back pain, anxiety and depression as well as epigastric abdominal pain. She was seen by the internal medicine consultant and was found to have epigastric pain radiating to chest. She was noted to have ongoing symptoms despite discontinuing NSAIDs. She also had underlying hypertension. The request was for retro electrocardiogram. According to the above article, upper abdominal pain can be the presenting symptom of an acute myocardial infarction and hence any patient with cardiac risk factors should have an electrocardiogram. Given the epigastric pain with radiation to chest, underlying hypertension with uncontrolled blood pressure and age, an Electrocardiogram to evaluate for cardiac etiology of epigastric pain is medically necessary.