

<b>Case Number:</b>	CM14-0117431		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/16/1992
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/26/2014

### 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 Family 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 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 injured worker is a 76-year old aircraft maintenance worker with multiple accepted injuries including injuries of the heart, lungs, neck, psyche and "multiple body parts". There is no information in the available records regarding how he was injured. A request for a preoperative echocardiogram was received in UR on 7/13/14 and denied on 7/20/14 on the grounds that the patient is not sufficiently obese to require preoperative echocardiography. There is no note in the records from the requesting cardiologist which delineates what surgery is to be performed and why an echocardiogram is needed. However, there is sufficient information available to ascertain that the patient has several serious cardiac conditions. He has had an inferior myocardial infarction with bypass grafting in 1995 and 1997. He has diagnoses of Ishchemic cardiomyopathy and of "'at least moderate to severe" mitral valve regurgitation per an echocardiogram performed in May of 2012, which also revealed an ejection fraction of 39%. Several of the available notes from the cardiologist over 2012 and 2013 document that the patient was fatigued and had dyspnea on exertion. The UR report makes reference to a note from the cardiologist dated 5/16/14. The note itself is not available, but apparently states that the patient has no dyspnea at present but does not exercise by choice, and has a relatively normal exam with no overt signs of heart failure.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One echocardiogram:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gualandro DM, YU PC, Caideraro D, Marques AC, Pinho C, Caramelli B, et al. Assessment of comorbidities In: II guidelines for perioperative evaluation. Arq Bras Cardiol 2011;96(3 Suppl 1):43-54.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2007 ACC/AHA Guidelines on Perioperative Cardiovascular Evaluation UptoDate (www.uptodate.com), an on-line evidence-based review service for clinicians, "Noncardiac Surgery in Patients with Mitral or Aortic Regurgitation".

**Decision rationale:** The ACC/AHA Guidelines cited above state that when one or more specific clinical risk factors are present, they justify careful assessment of the patient's current status, which may necessitate non-invasive testing. These risk factors include prior myocardial infarction and history of compensated or prior heart failure. Advanced age (over 70) is also recognized as a minor risk factor. Per the Up-to-date citation listed above, there are limited data which show markedly increased rates of intraoperative adverse events and postoperative morbidity and mortality (mortality up to 12%) in patients with advanced mitral regurgitation, particularly with ejection fractions of less than or equal to 44%. It also states that echocardiography is essential for assessing the severity and hemodynamic consequences of mitral regurgitation. This patient is known to have had moderate to severe mitral regurgitation with a low ejection fraction as of May 2012. He also has had a myocardial infarction, has a history of congestive heart failure and he is 76 years old, all of which are risk factors for increased morbidity and mortality with surgery. Prior to any sort of surgery, it would be medically prudent to assess his current mitral valve function, ejection fraction and hemodynamic status. Per the Guidelines cited above and the available clinical information, an echocardiogram is medically necessary in this case.