

<b>Case Number:</b>	CM14-0203240		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	12/06/2012
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Practice and is licensed to practice in New Jersey. 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 worker is a 60 year old male who was injured on 12/6/2012 involving twisting of his right knee after slipping on a wet floor. He was diagnosed with meniscus tear of the knee, knee strain/sprain, lumbar sprain/strain, chondromalacia, lumbar radiculitis, lumbosacral intervertebral disc degeneration, and internal derangement of the knee. He was treated with medications, injections, and surgery on the right knee was recommended on 10/1/14. He also has a medical history significant for hypertension and diabetes. However before undergoing any surgery or preoperative clearance testing, he around 10/15/14 began experiencing chest pain on and off. He went to his local ED. X-ray of the chest from 10/16/14 revealed evidence of bibasal subsegmental atelectasis, slightly enlarged heart, but no pleural effusion or pulmonary vascular abnormality. ECG noted normal sinus rhythm, no ST elevations or depressions except for Q-waves inferiorly with approximately 0.5 mm elevation, which was present at least one year prior on ECG. The troponin levels were less than 0.03 and CK levels were also normal. D-dimer was less than 150. Toradol, morphine, and Zofran eventually improved his symptoms. After being admitted, on 10/17/14, his ECG changed to include new anterior T-wave changes. A 2D echocardiogram was ordered, other pertinent labs were drawn, and cardiology was consulted. Follow up troponin levels were normal. He was diagnosed with acute coronary syndrome, placed on the appropriate medications and sent home to follow-up with his cardiologist. Later, a request for echocardiography was submitted by the worker's chiropractor.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Echocardiography:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Zipes: Braunwarld's Heart Disease: A Textbook of Cardiovascular Medicine, 7th ed

**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: Cheitlin MD, et. al. ACC/AHA/ASE 2003 Guideline Update for the Clinical Application of Echocardiography: summary article. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. J Am Soc Echocardiography, 2003 Oct;16(10): 1091-110

**Decision rationale:** The MTUS Guidelines do not address echocardiography specifically. Echocardiogram is used to assess the structure and function of the heart and is typically ordered to diagnose heart failure, valvular disease, or hypertrophy. In the setting of acute coronary syndrome, it would only be considered if there were also signs of one of these. In the case of this worker, he was diagnosed with acute coronary syndrome, based mostly on his clinical presentation and ECG changes during hospitalization. X-ray showed slight enlargement of the heart and echocardiogram confirmed the diagnosis of cardiac hypertrophy. Later, a request for echocardiography was requested by the workers treating physician; however, it is unclear if this was retrospective or for a repeat echocardiogram. Although the echocardiogram was somewhat appropriate in the hospital setting, a follow-up would not be necessary, even for preoperative clearance purposes. Therefore, the echocardiography is considered medically unnecessary.