

<b>Case Number:</b>	CM14-0205092		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	07/26/2014
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 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 (IW) is a 29-year-old man with a date of injury of July 26, 2014. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are cervical spine sprain/strain; thoracic spine sprain/strain; bilateral elbow sprain/strain. The remainder of the diagnoses are illegible. Pursuant to the handwritten, largely illegible progress reports dated November 10, 2014, the IW reports he completed 12 sessions of acupuncture with decreased pain, increased range of motion (ROM), and increased activities of daily living. The IW complains of low back pain radiating to the upper mid back. The IW complains of triggering of the bilateral long fingers (illegible) left thumb. (Illegible) pain with popping and clicking. Examination of the lumbar spine reveals tenderness to the paraspinals. Right shoulder examination reveals positive crepitus and positive compression. The remainder of the objective findings are illegible. Treatment plan includes chiropractic treatment, and continue home exercises. The IW is taking Norco 5mg, and Zanaflex 2mg. The current request is for and electrocardiogram. There is no clinical indication or rationale the medical record to perform an electrocardiogram. The utilization review contains information about chemical exposure and respiratory symptoms for this IW. There was no evidence of subjective or objective findings regarding respiratory symptoms or chemical exposure in the medical records submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electrocardiogram Qty:1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines, EKG is not medically necessary. History and Physical Examination; Assessment Approaches. Thorough history taking is important in the clinical assessment and treatment planning for the patient chronic pain and includes a review of medical records. A thorough physical examination is important to establish/confirm diagnoses and to observe/understand pain behavior. Diagnostic studies should be ordered in this context and not simply for screening purposes. In this case, a progress note dated November 10, 2014 is largely illegible. The note contains the injured worker's working diagnoses. They are cervical spine-trapezius sprain/strain; the thoracic spine - lumbar spine strain sprain; bilateral elbow sprain/strain. The remainder of the diagnoses is illegible. The documentation does not contain any references to chest pain, shortness of breath. There is no clinical indication or rationale the medical record to perform an electrocardiogram. Diagnostic studies should not be ordered simply for screening purposes. The utilization review contains information about chemical exposure and respiratory symptoms for this patient. There is no documentation in the medical record to support these symptoms and signs. Consequently, absent the appropriate clinical documentation, indication and rationale to perform an EKG, and EKG is not medically necessary.