Case Number:	CM15-0146169		
Date Assigned:	08/07/2015	**Date of Injury:**	08/03/2013
Decision Date:	09/09/2015	**UR Denial Date:**	07/20/2015
Priority:	Standard	**Application Received:**	07/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, California
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62-year-old male patient who sustained an industrial injury on 08-03-2013. Diagnoses include unspecified chest pain. He sustained the injury when his left hand caught in the hook of a crane. Per the doctor's note dated 5/11/15, he had complaints of left wrist/hand pain. The physical examination revealed diffuse left hand and wrist tenderness, Dupuytren's contracture at the 4th metacarpal on the left side. According to the Doctor's First Report of Occupational Injury or Illness dated 4-8-2015, he reported left hand pain and chest pain. On examination, all systems were within normal limits. The current medications list is not specified in the records provided. The records reviewed included blood pressure readings taken from 13:04 on 4-30-2015 to 10:31 on 5-1-2015, an exercise stress test report dated 4-21-2015 and a pulmonary treadmill test result dated 4-21-2015. He has had EMG/NCS upper extremities dated 10/8/13 with normal findings; left wrist and hand MRIs dated 10/15/2013. He has had physical therapy visits for this injury. A request was made for cardiac treadmill, pulmonary treadmill and 24-hour blood pressure monitor to assess the IW's cardiopulmonary status.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pulmonary treadmill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines, 19th Edition, Chest Painm ORG M-89(ISC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pulmonary (updated 05/27/15) Pulmonary function testing.

Decision rationale: Per the ODG guidelines, pulmonary function test is "Recommended in asthma. (NHLBI, 2007) In other lung diseases, it can be used to determine the diagnosis and provide estimates of prognosis. In these diseases, the complete PFT is utilized and, on occasions, incorporates pulmonary exercise stress testing. Recommended for the diagnosis and management of chronic lung diseases. (NHLBI/WHO, 2007) Lastly, it is recommended in the pre-operative evaluation of individuals who may have some degree of pulmonary compromise and require pulmonary resection or in the pre-operative assessment of the pulmonary patient. (Colice, 2007) (Brunelli, 2007)" The rationale for pulmonary treadmill or pulmonary exercise stress testing was not specified in the records provided. Evidence of asthma is not specified in the records provided. Diagnostic studies demonstrating chronic lung disease are not specified in the records provided. Evidence of a plan for surgical intervention is also not specified in the records provided. A recent detailed clinical evaluation note with cardio-respiratory examination was not specified in the records provided. The medical necessity of Pulmonary treadmill is not fully established for this patient at this juncture. Therefore, the request is not medically necessary.

24hour BP monitor: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines, 19th Edition, Chest Painm ORG M-89(ISC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Diabetes (updated 05/06/15) Hypertension treatment.

Decision rationale: Per the cited guidelines "The US Preventive Services Task Force (USPSTF) concluded that ambulatory blood pressure monitoring should be the reference standard for confirming office-based diagnosis, since it can rule out white coat hypertension. The harms associated with ambulatory blood pressure monitoring are minor (eg, disturbed sleep, discomfort, and restricted movements), but failure to confirm a diagnosis can lead to unnecessary use of anti- hypertensives. The recommendations conclude that the benefits of screening for high blood pressure in adults to prevent cardiovascular morbidity and mortality are substantial, and the harms of screening are small. (USPSTF, 2015)." A basic cardiac evaluation including BP measurement and ECG is not specified in the records provided. Evidence of abnormal blood pressure before ordering 24 hours BP monitoring is not specified in the records provided. Rationale for the request of 24 hours BP monitoring is not specified in the records provided. The medical necessity of 24-hour BP monitor is not fully established for this patient. Therefore, the request is not medically necessary.

Cardiac treadmill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines , 19th Edition, Chest Painm ORG M-89(ISC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed ACC/AHA 2002 guideline update for exercise testing: summary article. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1997 Exercise Testing Guidelines). Gibbons RJ, Balady GJ, Bricker JT, Chaitman BR, Fletcher GF, Froelicher VF, Mark DB, McCallister BD, Mooss AN, O'Reilly MG, Winters WL, Gibbons RJ, Antman EM, Alpert JS, Faxon DP, Fuster V, Gregoratos G, Hiratzka LF, Jacobs AK, Russell RO, Smith SC, American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Committee to Update the 1997 Exercise Testing Guidelines J Am Coll Cardiol. 2002; 40(8):1531. PubMed The rational clinical examination. Is this patient having a myocardial infarction Panju AA, Hemmelgarn BR, Guyatt GH, Simel DLJAMA. 1998; 280(14):1256.

Decision rationale: When faced with a patient with acute chest pain, clinicians must distinguish myocardial infarction (MI) from all other causes of acute chest pain. If MI is suspected, current therapeutic practice includes deciding whether to administer thrombolysis or primary percutaneous transluminal coronary angioplasty and whether to admit patients to a coronary care unit. The former decision is based on electrocardiographic (ECG) changes, including ST-segment elevation or left bundle-branch block, the latter on the likelihood of the patient's having unstable high-risk ischemia or MI without ECG changes. Despite advances in investigative modalities, a focused history and physical examination followed by an ECG remain the key tools for the diagnosis of MI. The most powerful features that increase the probability of MI, and their associated likelihood ratios (LRs), are new ST-segment elevation (LR range, 5.7-53.9); new Q wave (LR range, 5.3-24.8); chest pain radiating to both the left and right arm simultaneously (LR, 7.1); presence of a third heart sound (LR, 3.2); and hypotension (LR, 3.1). The most powerful features that decrease the probability of MI are a normal ECG result (LR range, 0.1-0.3), pleuritic chest pain (LR, 0.2), chest pain reproduced by palpation (LR range, 0.2-0.4), sharp or stabbing chest pain (LR, 0.3), and positional chest pain (LR, 0.3). Computer-derived algorithms that depend on clinical examination and ECG findings might improve the classification of patients according to the probability that an MI is causing their chest pain. AD Department of Medicine, McMaster University, Hamilton, Ontario, Canada. panjuaa@fhs.csu.mcmaster.ca. Per the records provided patient had left wrist/hand pain and chest pain. Cardiac treadmill test was requested as a part of evaluation of chest pain. Any prior lab tests including a CBC or basic ECG, chest X-ray report before requesting a treadmill are not specified in the records provided. The medical necessity of cardiac treadmill is not fully established for this patient.