

<b>Case Number:</b>	CM15-0034034		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	08/27/2012
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: California

Certification(s)/Specialty: Emergency Medicine

### 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 68-year-old male, who sustained an industrial injury reported on 8/27/2012. He reported occasional shortness of breath with lightheadedness. The diagnoses were noted to include paroxysmal atrial fibrillation - rate controlled (since 2011); dyspnea and respiratory abnormalities; dizziness, lightheadedness and giddiness; and right bundle branch block (RBBB) on electrocardiogram. Examination findings, of 10/13/2014, note symptomatic atrial fibrillation with bruits', dyspnea, and shortness of breath, x 3 episodes since 2011. Treatments to date have included consultations; diagnostic imaging studies; and medication management. The work status classification for this injured worker (IW) was noted to be retired. Noted on the cardiology letter, post-this Utilization Review and dated 2/13/2015, this IW is symptomatic with dyspnea and dizziness, with an abnormal baseline and physical findings, and requires this testing to work-up for structural heart disease. The cardiology notes of 10/13/2014, note that this IW father had a myocardial infarction (MI) at the age of 50. On 2/6/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 2/4/2015, for a stress echocardiogram for dyspnea, to rule out ischemia; echocardiogram to rule out structural heart disease; and carotid ultrasound study due to the noted bruit, all tests were requested to be done either in the cardiologist office, or at the Hospital. The National Guidelines Clearinghouse, cardiovascular disease and risk factors screening, imaging considerations; and the Singapore Ministry of Health, screening for cardiovascular disease and risk factors, major recommendations, atrial fibrillation, screening protocols, were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Stress Echo:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA Guidelines for the Clinical Application of Echocardiography *Circulation*.1997; 95: 1686-1744.

**Decision rationale:** Due to the recurring symptomatic dysrhythmia the patient is having, a stress echocardiogram is indicated to rule out an ischemic etiology which could be inciting the dysrhythmia and could potentially be life threatening. "In the setting of arrhythmias, the utility of echocardiography lies primarily in the identification of associated heart disease, the knowledge of which will influence treatment of the arrhythmia or provide prognostic information. In this regard, echocardiographic examination is frequently performed to assess patients with atrial fibrillation or flutter, reentrant tachycardias, ventricular tachycardia, or ventricular fibrillation. Echocardiography detects an underlying cardiac disorder in approximately 10% of patients with atrial fibrillation who have no other clinically suspected cardiac disease 319 320 and in 60% of those with equivocal indicators of other heart disease. 319 Ventricular arrhythmias of RV origin should alert the physician to a diagnosis of RV abnormalities, including RV dysplasia, 321 322 323 while ventricular tachycardias of LV origin are frequently associated with reduced LV function."

**Echocardiogram:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA Guidelines for the Clinical Application of Echocardiography *Circulation*.1997; 95: 1686-1744doi: 10.1161/01.CIR.95.6.1686.

**Decision rationale:** It is important to rule out a structural cause for the patient's recurrent atrial fibrillation, especially in light of the fact that the patient has had multiple symptomatic episodes which included lightheadedness and well as dyspna. These symptoms could be a warning sign. "Arrhythmias can occur as primary electrophysiological abnormalities or as a complication of or in association with structural heart disease. The spectrum of heart disease associated with arrhythmias is broad, including congenital abnormalities as well as acquired diseases of the myocardium, valves, pericardium, and coronary arteries. While some arrhythmias may be life-threatening or carry significant morbidity, others are considered benign." "Dyspnea, either at rest or with exertion, is one of the cardinal symptoms of heart disease. When present in patients with heart failure, dyspnea usually denotes pulmonary venous hypertension. It can be difficult to distinguish among the various etiologies of dyspnea, which include primary cardiac or

respiratory abnormalities, deconditioning, anemia, difficulties with peripheral circulation, or anxiety. Certain features of the history help establish that dyspnea is of cardiac origin, such as a progressive decrease in the intensity of exertion necessary to produce symptoms. Certainly dyspnea accompanying obvious signs of heart disease strongly suggests a cardiac etiology. When the etiology is in doubt, echocardiography can elucidate the origin of dyspnea by documenting or ruling out the common cardiac causes of pulmonary congestion: left-sided valvular disease, depressed systolic function, diastolic function, and cardiomyopathy. In this regard, echocardiography may be the preferred initial diagnostic test when the history, physical examination, and routine laboratory tests suggest or cannot eliminate cardiac disease."

**Cortid ultrasound:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACCF/AHA Pocket Guideline Based on the 2011 ASA/ACCF/AHA/AANN/AANS/ACR/ CNS/SAIP/SCAI/SIR/SNIS/SVM/SVS.

**Decision rationale:** Due to the physical finding of a carotid bruit, an ultrasound would be the preferred imaging study of choice to aid in determining his risk for high grade stenosis. "Class I 1. In asymptomatic patients with known or suspected carotid stenosis, duplex ultrasonography, performed by a qualified technologist in a certified laboratory, is recommended as the initial test to detect hemodynamically significant carotid stenosis. (Level of Evidence: C) Class IIa 1. It is reasonable to perform duplex ultrasonography to detect hemodynamically significant carotid stenosis in asymptomatic patients with carotid bruit. (Level of Evidence: C)."