MAXIMUS Federal Services

Case Number:	CM14-0121332		
Date Assigned:	08/06/2014	Date of Injury:	03/18/2009
Decision Date:	10/10/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/30/2014

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 District of Columbia, and Virginia. 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:

This is a 64 year old patient who sustained injury on Mar 18 2009. The patient had ulnar nerve release on May 22 2010. He was diagnosed with impingement syndrome, rotator cuff tear, acromioclavicular joint degenerative joint disease, and biceps tendon subluxation. He had issues with persistent shoulder pain on the right side. [redacted] saw the patient on Sept 4 2013 and noted that the patient had ongoing issues with pain. It was recommended that the patient avoid exacerbating factors and pain triggers. The patient had MRI of the right shoulder on Jan 13 2014 which showed a complete tear of the supraspinatus. [redacted] saw the patient on Jun 18 2014 for headache and diarrhea. He had redness of the right shoulder. He was on multiple medications: Metformin, Benazepril, Doxazosin, Hydrochlorothiazide, Omeprazole, Aspirin, Methocarbamol, Tylenol, Claritin, Nortriptyline, Glucosmae, Multivitamin, Novolog Insulin, Lipitor, and Calcium. The patient was also recommended to have cardiorespiratory testing and a sudoscan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardio-Respiratory testing, Body part: Abdomen and Chest.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, Autonomic Test Battery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) autonomic test battery, pulmonary chapter, Other Medical Treatment Guideline or Medical Evidence: www.cms.gov/MCD/viewlcd.asp?lcd_id=28255&lcd_version=19&show=all.

Decision rationale: Per ODG, autonomic test battery is not recommended as a diagnostic test for CRPS. Per Medicare and Medicaid guidelines, 1. An electrocardiogram (EKG) is a graphic representation of electrical activity within the heart. Electrodes placed on the body in predetermined locations sense this electrical activity, which is then recorded by various means for review and interpretation. EKG recordings are used to diagnose a wide range of heart disease and other conditions that manifest themselves by abnormal cardiac electrical activity. EKG services are covered diagnostic tests when there are documented signs and symptoms or other clinical indications for providing the service. Coverage includes the review and interpretation of EKGs only by a physician. There is no coverage for EKG services when rendered as a screening test or as part of a routine examination unless performed as part of the one-time, "Welcome to Medicare" preventive physical examination under section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Descriptions of Ambulatory EKG Monitoring Technologies1. Dynamic electrocardiography devices that continuously record a real-time EKG, commonly known as HolterTM monitors, typically record over a 24-hour period. The recording is captured either on a magnetic tape or other digital medium. The data is then computer-analyzed at a later time, and a physician interprets the computer-generated report. A 24-hour recording is generally adequate to detect most transient arrhythmias. Documentation of medical necessity is required for monitoring longer than 24 hours. The recording device itself is not covered as durable medical equipment (DME) separate from the total diagnostic service.2. An event monitor, or event recorder, is a patient-activated or event-activated EKG device that intermittently records cardiac arrhythmic events as they occur. The EKG is recorded on magnetic tape or other digital medium.Cardiac event monitor technology varies among different devices. For patient-activated event monitors, the patient initiates recording when symptoms appear or when instructed to do so by a physician (e.g., following exercise). For self-sensing, automatically triggered monitors, an EKG is automatically recorded when the device detects an arrhythmia, without patient intervention. Some devices permit a patient to transmit EKG data transtelephonically (i.e., via telephone) to a receiving center where the data is reviewed. A technician may be available at these centers to review transmitted data 24 hours per day. In some instances, when the EKG is determined to be outside certain pre-set criteria by a technician or other non-physician, a physician is available 24 hours per day to review the transmitted data and to make clinical decisions regarding the patient. These services are known as "24-hour attended monitoring". In other instances, transmitted EKG data is reviewed at a later time and are, therefore, considered "no n-attended."
Per ODG, pulmonary function testing (PFT) is recommended as follows: separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity and provide a variety of airflow rates such as forced expiratory volume in one second and the forced expiratory flow between 25-75% of the total exhale volume. The complete PFT adds tests of the lung volumes and the diffusing lung capacity for carbon monoxide. Lung volumes can be assessed by traditional methods or by using plethysmography, requiring use of a body box. The latter test can also test for airflow resistance and conductance. Other tests of pulmonary function useful in asthma include the spirometry before and after the use of a bronchodilator or after use of a bronchoconstrictor, generally followed by a bronchodilator. The use of a bronchoconstricting agent is termed bronchoprovocation and commonly used agents include chemical agents, physical agents and exercise (Birnbaum 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. PFT is utilized and, on occasions, incorporates pulmonary exercise stress testing. The following is 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).