MAXIMUS Federal Services

Case Number:	CM14-0022362		
Date Assigned:	03/05/2014	Date of Injury:	09/01/2011
Decision Date:	08/27/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/22/2014

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 Physical Medicine and Rehabilitation 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 is a 59-year-old male who reported an injury on 09/01/2011. The mechanism of injury was not provided in the medical records submitted for review. The injured worker's diagnoses included status post work related injury, orthopedic diagnosia, hypertension triggered by industrial industry, hyperlipidemia, psychiatric diagnosis, history of traumatic brain injury, secondary to motor vehicle accident in 1982, cephalgia/vertigo, hearing loss/tinnitus, and sleep disorder. Previous treatments included a lumbar epidural steroid injection on 09/09/2013 and on 10/21/2013. Diagnostic studies included an MRI of the cervical spine on 03/07/2013 and MRI of the lumbar spine on 07/08/2013 and ultrasound echocardiogram on 01/16/2014. Previous surgeries included cervical spine surgery for cervical myelopathy on 05/06/2013. It was noted within the clinical note dated 01/08/2014 the patient reported continued anxiety and depression, as well as hearing loss, and headaches. There was no elevation in the jugular venous pressures and there was 2+ carotid upstrokes. There were no systolic or diastolic bruits noted. The injured worker's heart rate was noted as a regular rate and rhythm, audible S1 and S2. The examination further noted no clubbing, cyanosis, or edema was present. There was no calf tenderness and Hoffman's sign was negative. The cranial nerves 2 through 7 were grossly intact and deep tendon reflexes were 2+ and brisk in the bilateral lower extremities. There was no focal neurologic deficits appreciated, and motor strength examination revealed 5/5 strength in all extremities. Medications included gabapentin 800 mg 3 times a day, a compound analgesic cream, amlodipine 2.5 mg daily, Norco 7.5/325mg 3 times a day, and tizanidine 4mg twice a day. The specific compound analgesic cream, dosage and frequency were not provided in the medical records submitted for review. The provider requested a 2D echocardiogram. The rationale for the requested treatment was to rule out any end organ damage. The request for authorization form was not provided 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:

2D ECHOCARDIOGRAM: Upheld

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

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:ACC/AHA Guidelines for the Clinical Application of Echocardiography. A Report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (Committee on Clinical Application of Echocardiography) Developed in Collaboration With the American Society of Echocardiography. Circulation. 1997; 95: 1686-1744.

Decision rationale: The request for 2 D Echocardiogram is non-certified. In an article from the American College of Cardiology (ACC)/American Heart Association (AHA) it was noted, as a general rule, all patients with congenital heart disease must be followed indefinitely, even those who have had "corrective" procedures to return them to physiologically normal status. Adult patients with congenital heart disease are seen by the cardiologist because they have been undiagnosed in the past, have recognized congenital heart disease that is presently inoperable, e.g., hypoplastic pulmonary arteries or systemic level pulmonary hypertension and severe pulmonary vascular disease or have progressive clinical deterioration, such as ventricular dysfunction or arrhythmias due to the natural history of the disease. Additionally, patients with congenital heart disease are seen by the cardiologist because they have other stresses such as non-cardiac surgery or infection, including infective endocarditis, have residual defects after a palliative or corrective operation, develop arrhythmias (including ventricular tachycardia, atrial flutter, or atrial fibrillation) that may result in syncope or sudden death, have progressive deterioration of ventricular function with congestive heart failure, have progressive hypoxemia because of inadequacy of palliative shunt or development of pulmonary vascular disease or require monitoring and prospective management to maintain ventricular or valvar function and/or to prevent arrhythmic or thrombotic complications. The documentation provided noted the injured worker denied any chest pains, shortness of breath, palpitations, syncope or peripheral edema. The documentation further noted that the injured worker was tolerating the current medication regimentation. However the documentation provided did not indicate a diagnosis of congenital heart disease or provide a physical assessment notating objective signs and symptoms to support a diagnosis of congenital heart disease. The documentation provided did not indicate any arrhythmias including ventricular tachycardia, atrial flutter, or atrial fibrillation. The documentation provided noted there was no clubbing, cyanosis, or edema present. An ultrasound echocardiogram was performed on 01/16/2014; however, the results were not provided within the medical records. There is a lack of documentation to indicate the injured worker required monitoring and prospective management to maintain ventricular or valvar function and/or to prevent arrhythmic or thrombotic complications. The requesting physician's rationale for the request is not indicated within the provided documentation. Overall, there is a

lack of documentation to indicate the medical necessity for 2D echocardiogram. As such, the request for 2D echocardiogram is not medically necessary.