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| Case Number: | CM15-0117866 | | |
| Date Assigned: | 06/26/2015 | Date of Injury: | 03/24/2010 |
| Decision Date: | 07/27/2015 | UR Denial Date: | 06/10/2015 |
| Priority: | Standard | Application Received: | 06/18/2015 |

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, Florida, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This is a 61 year old male with a March 24, 2010 date of injury. A progress note dated June 4, 2015 documents subjective complaints (feels okay; not short of breath). The medical record indicates that the injured worker had a history of dilated cardiomyopathy and a left bundle branch block. An echocardiogram performed on April 3, 2014 showed an ejection fraction of 40% with enlargement and diffuse hypocontractility of the left ventricle, no significant valvular disease, and normal pulmonary artery systolic pressure. The record notes that there were no significant changes in the findings since a previous echocardiogram performed on May 9, 2013. Portions of the progress notes were difficult to decipher. The treating physician requested authorization for a resting echocardiograph.

IMR ISSUES, DECISIONS AND RATIONALES

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

Resting echocardiograph: Upheld

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 Per the Medical Disability Advisor:
<http://www.mdguidelines.com/echocardiography>.

Decision rationale: This claimant was injured in 2010. As of June 4, 2015, there is no shortness of breath or cardiac symptoms, but there is a history of dilated cardiomyopathy and left bundle branch block. An echocardiogram performed on April 3, 2014 showed an ejection fraction of 40% (which is very low), with enlargement and diffuse hypocontractility of the left ventricle, no significant valvular disease, and normal pulmonary artery systolic pressure. The record notes that there were no significant changes in the findings since a previous echocardiogram performed on May 9, 2013. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. ODG is also silent. Per the Medical Disability

Advisor:
<http://www.mdguidelines.com/echocardiography>
Echocardiography is a noninvasive technique that uses high frequency sound waves to produce images of the heart's internal anatomy. A beam of ultrasonic waves is directed at the heart and partially reflected back by each tissue in its path. These reflected waves (echoes) are converted into electronic signals. The signals are displayed on a video screen, producing an image of the heart walls, chambers, and valves in motion. Echocardiography is widely used in hospital and diagnostic laboratory settings in evaluating individuals of all ages suspected of having heart problems. Repeat clinical tests such as this one should be driven by changes in physical exam or symptoms. On this review such changes are not evident. The request for a repeat resting echocardiogram is appropriately not medically necessary.