

Case Number:	CM15-0079718		
Date Assigned:	04/30/2015	Date of Injury:	07/15/2012
Decision Date:	05/29/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/27/2015

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: New York

Certification(s)/Specialty: Internal 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 35 year old male, who sustained an industrial injury on 7/15/12. He reported back pain, right elbow pain, and right shoulder pain. The injured worker was diagnosed as having obesity, gastroesophageal reflux disease with dyspepsia and irritable bowel, intermittent sinus tachycardia related to anxiety, pre-existing mild hypertension, obstructive sleep apnea, and hypertriglyceridemia. Treatment to date has included medications. A physician's report dated 12/16/14 noted that after the injury the injured worker developed hypertension and had a 50 pound weight gain. An echocardiogram revealed left ventricular hypertrophy. The injured worker complained of difficulty breathing and chest pain. Laboratory tests revealed high triglycerides. An electrocardiogram revealed sinus tachycardia with nonspecific T-wave changes. A stress test was performed and revealed non-specific ST elevation. The stress test was negative for ischemia but was consistent with hypertensive heart disease and deconditioning. A comprehensive echocardiogram including Doppler and color flow was performed but was noted to be suboptimal due to obesity. The results revealed normal contractility, probable septal hypertrophy, left atrium slight dilation, diastolic dysfunction, and trace mitral and tricuspid valve insufficiency. Currently, the injured worker complains of lumbar spine pain, thoracic spine pain, cervical spine pain, and right shoulder pain. The treating physician requested authorization for a 2D echo stress test

IMR ISSUES, DECISIONS AND RATIONALES

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

2 D echo stress test: 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 Medscape Internal Medicine 2014: 2D Stress Electrocardiography.

Decision rationale: Stress echocardiography is the combination of 2D echocardiography with a physical, pharmacological or electrical stress. The diagnostic end point for the detection of myocardial ischemia is the induction of a transient worsening in regional function during stress. Stress echocardiography provides similar diagnostic and prognostic accuracy as radionuclide stress perfusion imaging, but at a substantially lower cost, without environmental impact, and with no biohazards for the patient and the physician. Among different stresses of comparable diagnostic and prognostic accuracy, semisupine exercise is the most used, dobutamine the best test for viability, and dipyridamole the safest and simplest pharmacological stress and the most suitable for combined wall motion coronary flow reserve assessment. The additional clinical benefit of myocardial perfusion contrast echocardiography and myocardial velocity imaging has been inconsistent to date, whereas the potential of adding coronary flow reserve evaluation of left anterior descending coronary artery by transthoracic Doppler echocardiography adds another potentially important dimension to stress echocardiography. In this case, the claimant has no new cardiac findings or specific EKG changes that warrant further evaluation for ischemia. Medical necessity for the requested study is not established. The requested study is not medically necessary.