Case Number:	CM17-0013587		
Date Assigned:	01/25/2017	**Date of Injury:**	10/10/2016
Decision Date:	02/22/2017	**UR Denial Date:**	01/08/2017
Priority:	Standard	**Application Received:**	01/20/2017

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: Pennsylvania
Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 45 year old male, who sustained an industrial injury on 10-10-2016. The injured worker is undergoing treatment for palpitations. Mechanism of injury is unclear. Current work status is unclear. The treatment and diagnostic testing to date has included: 24 hour Holter monitor, Echocardiogram (11-2016) reveals all cardiac chambers appear to be within normal limits, left ventricle posterior wall and interventricular septal thickness are normal, no intra cardiac tumors, thrombi or vegetations are seen, no pericardial effusion is observed, overall global systolic function is normal and left ventricular ejection fraction is approximately 58 percent, a ratio is reversed suggestive diastolic dysfunction, color doppler images revealed mild mitral and tricuspids valvular regurgitations, Electrocardiogram revealed normal sinus rhythm, adenosine cardiolite stress test, medications and evaluations. Medications have included: Atenolol 25mg and Atenolol 50mg. Physician progress notes dated 11-16-16, reported the injured worker complains of palpitations with the most recent episodes was yesterday with no apparent triggers. The injured worker reported having shortness of breath, dizziness, vertigo, and lightheadedness that is moderate in severity. The injured worker reported the episode happens a few weeks ago while sitting and they felt dizzy like they were going to pass out, this episode only lasted a few seconds. The injured worker reported no history of COPD or asthma, sputum clear, no wheezing, hemoptysis, recurrent respiratory tract infections, no orthopnea, paroxysmal nocturnal dyspnea, peripheral edema, no varicosities, thrombophlebitis or claudication, no Raynaud's phenomenon, and no syncope or near syncope. There is no history of TIA, CVA or seizure disorder, no amaurosis, no diplopia, paralysis, paresis, muscle weakness, tremors, ataxia

or dysesthesia. Objective findings: height 75inches, oxygen saturation 98 percent, respiratory rate 17, pulse 85 bpm, weight 250 pounds, BMI 31.25 and blood pressure 143 over 103 mmHg. Cardiovascular exam revealed: no abnormal pulsation, bulging, or heaving over precordial area is seen, apical impulse if at the left fifth intercostal space with midclavicular line, on palpation no shocks, thrills, and rubs are noted, heart size seems within normal limits and there is a grade 2 out of 6 systolic murmur head over mitral areas, no clicks, pericardial rub or added sounds are heard, bilaterally carotid exam does not reveal any bruit, no abdominal aortic bruit is heard, femoral pulses are symmetrical without bruit and pedal pulses are felt and are of normal amplitude. The physician documented the plan is for EKG, Echocardiogram, aorta abdominal scan, adenosine cardiolite stress test, follow up after stress test for results, 24 hour Holter monitor to assess palpitations and follow up after Holter for results. The request for authorization is for Electrocardiogram QTY: 3 and follow up office visit QTY: 3.The UR dated 1-8-17 non-certified the request for Electrocardiogram QTY: 3 and modified the request for follow up office visit QTY: 3 to follow up office visit QTY: 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up office visit times 3 was the original request. Follow up office visit times 1 was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, Follow up office visit times 2 is: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Office visits. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Introduction.

Decision rationale: The MTUS Guidelines generally encourage follow up care when needed to maximize the worker's function. The submitted and reviewed records indicated the worker was experiencing chest palpitations, problems breathing, and lightheadedness. There was no discussion detailing the reason additional specialist follow up care for unspecified treatment would be helpful in improving the worker's function or was known at the time of the request to be medically needed. In addition, the request was for a large number of visits with an unspecified type of specialist, which does not allow for changes in the worker's care needs or for a determination of medical need or Guideline support. For these reasons, the current request for two additional follow up office visits with an unspecified type of specialist is not medically appropriate.

Electrocardiogram times 3: Upheld

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

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation What is an electrocardiogram? National Heart, Lung, and Blood Institute, Department of Health and Human Services. http://www.nhlbi.nih.gov/health/health-topics/topics/ekg, accessed 02/18/2017, Benditt D, et al. Syncope in adults: Clinical manifestations and diagnostic evaluation. Topic 969, version 21.0. UpToDate, accessed 02/18/2017.

Decision rationale: Electrocardiograms (ECG or EKG) look at the flow of electricity through the heart and create a graph tracing or image that reflects this flow. The flow of electricity through the heart is related to its rhythm and rate. An ECG is often done to evaluate chest pain; high blood pressure; signs or symptoms of an abnormal heart rate or rhythm; or a concern that the flow of electricity through the heart may be abnormal, such as can occur with certain medications. All people who have passed out from an uncertain cause should also have an ECG. The MTUS Guidelines are silent on these issues. Preoperative tests for otherwise healthy people generally should not routinely include an ECG because the general risk of surgery is quite low. An ECG should therefore not be done before surgery unless there are clinical findings that clearly indicate the test is needed. The submitted and reviewed documentation indicated the worker was experiencing chest palpitations, problems breathing, and lightheadedness. There was no describing the reason an additional electrocardiogram was needed or detailing special circumstances that sufficiently supported this request. Further, the request was for three studies, which does not allow for changes in the worker's care needs. For this reason, the current request for three electrocardiograms done over an unspecified period of time is not medically necessary.