

True Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 12/16/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan of the chest

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Reviewer is Board Certified in Family Practice

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines

Utilization review requests and denial dated 11/07/07, 11/14/07

Disability Determination Note, Dr. 11/24/07

Letters requesting MRI C-spine 11/15/07 and CT chest 11/7/07 from
Clinic

Rehabilitation Progress notes: 6/26/07-9/5/07

Clinical Notes from Dr., 9/06/07,7/31/07

MRI report, Shoulder with contrast, 6/28/06

Left rib series X-ray reports: 6/7/06, 9/05/06

Medical Center Summary, Dr., 10/15/07

Clinical Notes from clinic : 4/18/06, 5/10/06, 6/7/06, 6/30/07, 8/4/06, 9/5/06,
10/3/06, 11/1/06, 12/5/06, 1/5/07, 2/5/07, 3/2/07, 4/5/07, 4/24/07, 5/8/07, 6/5/07,
7/2/07, 8/1/07, 8/30/07, 10/2/07, 10/12/07, 11/6/07

Independent medical exam 12/21/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient fell while at work on xx/xx/xx. He sustained a left shoulder, chest (left sided) and neck injury at that time. He was seen by Dr. initially on xx/xx/xx. X-rays of the chest confirmed 3rd and 4th rib fractures (4/2006 and 6/2006). When patient's pain in his shoulder did not improve with anti-inflammatories and pain medications, an MRI of the shoulder was done and showed an advanced rotator cuff tear. (6/28/06) The patient was referred to several different Orthopedists in the period of time from 9/2006 to 11/2006. (Notes seem to indicate this may be related to worker's comp not approving surgery/surgeon). Once patient's surgery was approved there are clinic notes that seem to indicate it may have been initially delayed due to uncontrolled diabetes. From the time of the initial injury to the last available note, the patient complained of shoulder and rib pain. The patient underwent shoulder surgery in June of 2007 and had physical therapy afterward for several months (6/26-9/5/07). Because the patient continued to have neurological symptoms, a NCS was done and a C spine MRI recommended. Due to the patient's continued left rib cage pain, a chest CT was recommended but not done due to denial by worker's comp insurer.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient sustained a shoulder and rib cage injury at work in xx/xx. In question at this time is the medical necessity of a CT scan of the chest for this patient.

The patient has consistently complained of left rib/rib cage area pain since the time of the injury. He did not improve with time, physical therapy or with medications. X-rays done in 2006 confirmed the presence of fractures of the 3rd and 4th ribs. These fractures should have healed within a period of months. Although, there is not an X-ray report in the last year to confirm the healing, it would not change the next step in the evaluation of left sided chest pain. The next step in the clinical workup is a chest CT. This would rule out other causes of left sided chest pain; including but not limited to tumor, infection, unhealed fracture, scarring. Although not all of these would be a result of the worker's comp injury, one must rule these things out before proceeding with other chronic pain treatments for the patient's left sided chest/rib pain.

The ODG guidelines do not specifically outline treatment guidelines for rib fractures or continued chest pain. The neck and upper chest section does say this about CT scan: "MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery".

Therefore, the reviewer disagrees with the prior decision and finds a CT scan of the chest to be medically necessary in this case.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)