

Independent Reviewers of Texas, Inc.

1701 N. Greenville Ave Ste 202

Richardson, TX 75081

877-333-7374 (phone)

972-250-4584 (fax)

independentreviewers@hotmail.com

Notice of Independent Review Decision

DATE OF REVIEW: 08/16/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: CT scan of pelvis region without contrast; CPT Code: 72194 and CT scan of the abdomen without contrast; CPT Code: 74170

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

Texas Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Mental Health Evaluation report, 08/15/03
2. Documentation from Dr. 08/28/03, 10/28/03, 04/02/04, 05/12/04, 05/26/04, 06/30/04, 07/14/04, 08/12/04, 08/30/04
3. Cervical MRI report, 09/04/03, 11/26/04, 06/14/07, 06/19/09
4. Lumbar MRI report, 09/04/03, 04/21/06
5. Electrodiagnostic assessment report, 10/02/03, 01/04/07
6. Documentation from Physical Therapy, 10/06/03, 10/08/03, 10/10/03, 10/13/03, 10/15/03
7. Documentation from Chiropractic Center, 11/05/03, 11/11/03, 11/12/03, 11/17/03, 11/18/03, 11/19/03, 11/20/03, 12/02/03, 12/03/03, 12/04/03, 12/05/03, 01/14/04, 01/19/04, 01/27/04, 01/30/04, 02/04/04, 02/09/04, 02/16/04, 02/19/04, 03/01/04, 04/05/04, 06/30/04, 07/02/04, 08/13/04, 08/23/04, 09/09/04, 10/11/04, 10/14/04, 10/18/04, 10/21/04, 10/28/04, 11/01/04, 11/11/04, 11/15/04, 11/18/04, 11/29/04, 12/13/04, 01/12/05, 01/31/05, 02/22/05, 03/03/05, 03/14/05, 03/21/05, 03/24/05, 03/28/05, 04/04/05, 06/06/05, 06/27/05, 06/30/05, 07/12/05, 07/21/05, 09/06/05,

- 09/08/05, 09/10/05, 09/22/05, 10/05/05, 10/20/05, 10/25/05, 11/01/05, 11/07/05, 11/14/05, 12/01/05, 12/05/05, 12/19/05, 01/24/06, 01/31/06, 02/07/06, 02/13/06, 02/16/06, 02/23/06, 02/28/06, 03/07/06, 03/13/06, 03/20/06, 03/30/06, 04/03/06, 04/13/06, 04/18/06, 04/20/06, 04/24/06, 04/27/06, 05/01/06, 05/04/06, 05/08/06, 05/11/06, 05/15/06, 05/22/06
8. Documentation from Dr. 06/22/04, 01/04/07
 9. Documentation from Dr. 08/03/04, 08/16/04
 10. Documentation from Dr. 10/18/04
 11. Documentation from Dr. 11/19/04, 03/04/05
 12. Cervical CT scan/myelogram report, 04/08/05
 13. Lumbar CT scan/myelogram report, 04/08/05
 14. Documentation from Dr. 07/18/05, 08/25/05, 09/15/05, 10/20/05, 12/20/05, 12/29/05, 03/07/06, 07/07/06, 08/08/06, 09/05/06, 09/28/06, 11/22/06, 12/20/06, 07/25/07, 09/14/07, 10/10/07, 07/02/08, 07/17/08, 04/22/09, 05/26/09
 15. Documentation from Dr. 09/01/05
 16. Documentation from Dr. 01/18/06, 04/25/07, 05/25/07, 06/13/07, 06/20/07, 08/01/07, 08/23/07
 17. Documentation from Dr. 03/02/06, 04/05/06, 04/24/06, 06/15/06, 07/10/06, 09/11/06
 18. Documentation from Dr. 05/24/06
 19. Lumbar CT scan report, 12/21/06
 20. Documentation from Dr. 01/29/07
 21. Left hip x-ray report, 01/30/07
 22. Documentation from Dr. 03/12/07, 02/18/08, 02/02/09, 04/20/09
 23. Documentation from Dr. 09/19/07, 10/09/07
 24. Documentation from Dr. 11/08/07, 11/29/07, 01/03/08, 02/22/08
 25. Documentation from Dr. 12/20/07
 26. Left hip MRI report, 06/05/08
 27. Pelvic MRI report, 06/05/08
 28. Functional Capacity Evaluation (FCE) report, 07/23/08, 10/28/08
 29. Documentation from Back Care, 08/06/08, 08/08/08, 08/12/08, 08/13/08, 08/16/08, 08/22/08, 08/26/08, 08/27/08, 08/28/08, 12/19/08, 01/16/09, 02/03/09, 02/20/09, 03/16/09, 04/17/09, 05/23/09, 06/08/09, 06/19/09, 06/25/09
 30. Documentation from Dr. 03/05/09
 31. Psychological evaluation report, 03/07/09
 32. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee sustained an injury in the workplace on xx/xx/xx. On that date, the employee fell down approximately fifteen stairs. The employee developed difficulty with cervical pain and low back pain.

The employee was evaluated by Dr. on xx/xx/xx. On that date, the employee was diagnosed with a cervical strain and probable left C7 radiculopathy, as well as a lumbar strain. It was recommended that a lumbar MRI, a cervical MRI, and an electrodiagnostic assessment be accomplished.

A cervical MRI was obtained on 09/04/03. This study disclosed findings consistent with disc desiccation with a minimal posterior disc bulge at the C5-C6 and C6-C7 levels.

A lumbar MRI was obtained on 09/04/03. This study disclosed findings consistent with disc desiccation at the L5-S1 disc level with a disc protrusion at the L4-L5 level.

A bilateral lower extremity electrodiagnostic assessment was obtained on 10/02/03. This study disclosed evidence that was described as "suggestive" of a mild S1 radiculopathy on the left lower extremity.

The employee received at least nine sessions of supervised physical therapy services from the date of injury until xx/xx/xx.

Dr. evaluated the employee on 10/28/03. On that date, it was noted the employee requested treatment in the form of chiropractic treatment.

The employee received at least eighty-five sessions of supervised therapy services at Chiropractic Center from 11/05/03 through 05/22/06.

Dr. evaluated the employee on 04/22/04. It was recommended that consideration be given for treatment in the form of a lumbar epidural steroid injection.

On 05/12/04, the employee received a left L5-S1 intralaminar epidural steroid injection. This procedure was performed by Dr.

Dr. evaluated the employee on 05/26/04, at which time it was recommended the employee receive treatment in the form of chiropractic treatment sessions.

A Designated Doctor Evaluation was conducted by Dr. on 06/22/04. This physician did not place the employee at Maximum Medical Improvement (MMI) on this date.

On 06/30/04, the employee underwent a left L5-S1 intralaminar epidural steroid injection by Dr.

Dr. reevaluated the employee on 07/15/04, at which time it was noted the employee received no significant benefit from treatment in the form of lumbar epidural steroid injections.

The employee was evaluated by Dr. on 08/03/04 at the request of Dr. On this date, Dr. indicated the employee could be an appropriate candidate for treatment in the form of an interdisciplinary pain management program.

Dr. evaluated the employee on 08/12/04. On that date, it was recommended the employee would be an appropriate candidate for participation in the PRIDE program.

Dr. evaluated the employee on 08/16/04. On that date, Dr. asked for the employee to be reevaluated by Dr. as the employee expressed a desire to review her situation with Dr. prior to commencement of an interdisciplinary functional restoration program.

Dr. evaluated the employee on 08/30/04, at which time it was noted the employee was on Lortab and Flexeril. It was recommended a cervical MRI and lumbar MRI be accomplished.

The employee was evaluated by Dr. on 11/19/04. On this date, it was recommended that a repeat cervical MRI and lumbar MRI be accomplished.

A cervical MRI was obtained on 11/26/04. This study disclosed findings consistent with "moderate hypertrophic spurring". The report did not describe many findings worrisome for a compressive lesion upon any of the neural elements in the cervical spine.

Dr. evaluated the employee on 03/04/08. It was documented that a cervical MRI "demonstrates spurring at C4-C5 and C5-C6, but without definite nerve root compression". It was also noted that a lumbar MRI had been accomplished, which revealed "disc desiccation and mastic endplate changes at L4-L5 and to a lesser extent at L5-S1". It was recommended that a cervical myelogram be obtained.

A CT scan/myelogram of the cervical spine and lumbar spine was obtained on 04/08/05. This study disclosed evidence for a prior suboccipital craniectomy for decompression of a Chiari I malformation. There was no evidence of a cervical disc herniation. There was evidence of a posterior disc protrusion or herniation at L4-L5 and L5-S1. The report also described findings consistent with bilateral renal calculi.

The employee was evaluated by Dr. on 07/18/05. On that date, it was recommended treatment be considered in the form of a comprehensive pain management program.

On 08/25/05, Dr. performed a lumbar nerve root block to the L4 and L5 levels.

Dr. evaluated the employee on 09/15/05. It was noted that treatment in the form of a lumbar epidural steroid injection "only helped some".

A psychological assessment was accomplished on 09/01/05. It was noted the employee had an adjustment disorder with depressive symptoms. It was also noted the employee was in the midst of a wrongful death lawsuit related to the employee's husband.

Dr. evaluated the employee on 10/20/05. It was recommended that consideration be given in the form of a "diagnostic L5-S1 selective nerve root block".

Dr. assessed the employee on 12/01/05. It was noted a lumbar transforaminal epidural steroid injection had been accomplished on 11/03/05, which had decreased the employee's pain symptoms. It was noted the employee appeared to be an appropriate candidate for a possible "disc decompression" procedure.

On 12/29/05, the employee underwent a lumbar nerve root block to the L4-L5 level. This procedure was performed by Dr.

The employee was evaluated by Dr. on 01/18/06. This physician recommended the employee be considered for a lumbar discogram.

The employee was evaluated by Dr. on 03/02/06. On this date, the employee was diagnosed with a left S1 radiculopathy. It was felt the employee was an appropriate candidate for a lumbar spinal fusion from the L4 level to the sacrum.

Dr. assessed the employee on 03/07/06. At that time, Dr. indicated the employee could return on an as needed basis.

Dr. evaluated the employee on 04/05/06. On that date, the employee received a left trochanteric bursa injection.

A lumbar MRI was obtained on 04/21/06. This study disclosed evidence of a central disc protrusion at the L5-S1 level with bilateral S1 nerve root impingement. There was also evidence of a disc bulge at the L4-L5 disc level.

Dr. evaluated the employee on 04/24/06, at which time it was recommended the employee undergo a lumbar spine surgical procedure from the L4 level to the sacrum.

The employee was evaluated by Dr. on 05/24/06. On this date, this physician evaluated the employee for surgical clearance as it related to an upcoming lumbar spine surgical procedure. It was documented the employee had a past medical history notable for thyroid cancer, as well as a history of an Arnold Chiari malformation, which required surgical intervention. Additionally, it was noted the employee had a history of renal stones that required treatment with lithotripsy.

The employee underwent a 360 degree fusion to the L4-L5 and L5-S1 levels on 06/02/06.

Dr. evaluated the employee on 06/15/06, at which time it was noted the employee had postoperative difficulties related to obstipation.

The employee was evaluated by Dr. on 07/07/06. On that date, the employee was provided a prescription for Dilotid.

Dr. evaluated the employee on 07/10/06. The employee had difficulties as it related to nausea.

On 08/08/06, the employee was evaluated by Dr. The employee was noted to be on Dilotid for management of pain symptoms.

On 09/05/06, Dr. reassessed the employee, at which time it was recommended the employee continue to utilize Dilotid for management of pain symptoms.

On 09/11/06, Dr. evaluated the employee. It was recommended a CT scan of the lumbar spine be accomplished to evaluate the status of the fusion.

On 09/28/06, Dr. assessed the employee. The employee was provided a prescription for Dilotid and Lunesta to help with pain and sleep difficulties respectively.

Dr. reevaluated the employee on 11/22/06 and 12/20/06. On 12/20/06, Dr. indicated the employee could return on an "as-needed" basis.

A lumbar CT scan was accomplished on 12/21/06. This study disclosed findings consistent with an intact anterior and posterior fusion of the L4-L5 and L5-S1 levels.

A Designated Doctor Evaluation was conducted by Dr. on 01/04/07. On this date, the employee was placed at Maximum Medical Improvement (MMI). The employee was awarded a total body impairment of 29%.

An electrodiagnostic assessment was accomplished on 01/04/07. This study disclosed findings consistent with a C5-C6 radiculopathy. This study was obtained on the bilateral upper extremities.

A left hip x-ray was accomplished on 01/30/07. This study was described as "radiographically unremarkable".

A post Designated Doctor Evaluation was performed by Dr. on 03/12/07. On that date, it was noted the employee had symptoms of left hip pain, although range of motion in the left hip was reportedly unremarkable. Dr. did not feel there were any findings on physical examination worrisome for osteoarthritis in the left hip.

The employee was evaluated by Dr. on 04/25/07. On this date, it was recommended a cervical MRI be accomplished as the employee had symptoms of cervical pain, consistent with a left C6-C7 radiculopathy.

Dr. assessed the employee on 07/25/07. On that date, it was noted the employee recently had been evaluated by an orthopedic hip specialist.

A cervical MRI was accomplished on 06/14/07. This study revealed findings consistent with nonspecific straightening and minimal diffuse reversal of the usual cervical lordosis. There were no findings worrisome for a compressive lesion upon any of the neural elements in the cervical spine.

Dr. evaluated the employee on 06/20/07, at which time it was recommended the employee receive access to treatment in the form of physical therapy for the cervical spine.

The employee underwent a cervical epidural steroid injection by Dr. on 09/14/07.

The employee was evaluated by Dr. on 09/19/07. On this date, Dr. indicated the employee appeared to have 10% whole body impairment with respect to the lumbar spine. In total, Dr. felt the employee had a total body impairment of 32% as it related to the work injury of xx/xx/xx. It was documented the employee was not a participant in work activities.

On 10/10/07, the employee underwent a cervical epidural steroid injection by Dr.

Dr. evaluated the employee on 11/08/07. On that date, Dr. recommended the employee utilize the following prescription medications for management of pain symptoms: Zanaflex, Lidoderm Patch, and Topamax.

Dr. reevaluated the employee on 11/29/07. On that date, it was recommended the employee undergo bilateral knee x-rays as the employee had symptoms of bilateral knee pain.

A Designated Doctor Evaluation was accomplished by Dr. on 12/20/07. This physician felt the employee was capable of work activities with no lifting of greater than 10 pounds. The employee was awarded a total body impairment of 24%.

Dr. reevaluated the employee on 01/03/08. On that date, it was noted plain x-rays of the knees had been accomplished, which appeared to be "normal". At that time, the employee reportedly requested bilateral knee MRI be accomplished.

On 02/22/08, the employee was reevaluated by Dr. On that date, Dr. felt the employee could partake in sedentary work activities.

A Functional Capacity Evaluation (FCE) was accomplished on 07/23/08. This study revealed the employee to be capable of sedentary work type activities. It was felt the employee appeared to be an appropriate candidate for a six to eight week program in the form of a work conditioning program.

A left hip MRI was accomplished on 06/05/08. This study did not reveal any abnormalities to be present.

A pelvic MRI was accomplished on 06/05/08. This study revealed findings consistent with an oval area of fluid signal intensity within the right pelvis, possibly consistent with an ovarian cyst.

On 07/02/08, Dr. evaluated the employee. On that date, it was noted the employee had persistent pain in the left hip region. Dr. indicated an MRI of the pelvis and an MRI of the left hip had been obtained in the recent past, which "did not reveal any significant pathology that could account for the persistent pain that radiates into her left leg".

On 07/17/08, Dr. performed a left greater trochanteric bursa injection.

The employee received chiropractic treatment at Back Care. The employee received at least nineteen sessions of chiropractic treatment from 08/08/08 through 06/25/09.

An FCE was accomplished on 10/28/08. This study revealed the employee to be capable of sedentary type work activities.

The employee was evaluated by Dr. on 01/29/09. On this date, the employee had symptoms of abdominal pain. Dr. recommended consideration be given for a CT scan of the abdomen. Dr. indicated "a possible rheumatological process could be in place such as a fibromyalgia picture".

Dr. evaluated the employee on 02/02/09, at which time Dr. felt the employee had a "failed back syndrome and chronic pain syndrome".

Dr. assessed the employee on 04/22/09, at which time the employee was provided a prescription for Lortab and Flexeril.

A psychological assessment was accomplished on 03/07/09 at Center for Pain Management. On that date, it was noted the employee appeared to “meet criteria for pain disorder associated with psychological factors”.

A cervical epidural steroid injection was accomplished on 05/26/09. This procedure was performed by Dr.

A cervical MRI was accomplished on 06/19/09. This study disclosed findings consistent with a central disc herniation at the C6-C7 level. There was also evidence for edema within the right posterior vertebral body of the C4 level.

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

An extensive amount of medical documentation was made available for review. Based upon the medical records available for review; however, medical necessity for a CT scan of the pelvis and abdomen without contrast would not appear to have been established with respect to the work injury of xx/xx/xx. The records available for review documented the employee had a preexisting history of difficulties with respect to renal calculi.

The date of injury was listed as xx/xx/xx. It was noted that an MRI of the left hip and pelvis were accomplished on 06/05/08. Those studies did not reveal any findings worrisome for an acute pathological process that would be considered related to the work injury of xx/xx/xx.

Official Disability Guidelines do support consideration of a diagnostic study such as a CT scan of the abdomen and pelvis without contrast if there was consideration of medical pathology such as a subchondral fracture, an osteoma, and/or sacral insufficiency fractures. The records available for review did not provide any documentation to indicate that those types of medical conditions are a concern with respect to the work injury of xx/xx/xx. Additionally, an MRI of the pelvis and left hip were obtained approximately five years after the date of injury and those studies did not reveal any findings worrisome for a pathological process that would be considered related to the work injury of xx/xx/xx.

Thus, in regard specifically to the medical necessity for diagnostic studies in the form of a CT scan of the abdomen and pelvis without contrast as it relates to the work injury of xx/xx/xx, the medical necessity for such diagnostic testing is currently not established. **Official Disability Guidelines** did not provide criteria that would support this specific diagnostic testing to be a medical necessity.

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

1. Official Disability Guidelines

