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Notice of Independent Review Decision

DATE OF REVIEW: **12/17/08**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRA, head

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

REVIEW OUTCOME

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

☐Upheld (Agree)
X Overturned (Disagree)
☐Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Denial and associated review letters 10/08
ER note 12/3/07
records 21/4/07
Medical records 12/28/07 – 9/9/08, Dr.
MRI brain report 3/19/08
Medical records and MRI brain report June 2008, Dr.
Medical records, Dr.
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a xx-year-old male who apparently fell backwards and struck the back of his head, resulting in transient loss of consciousness and memory problems for a number of hours. The patient was hospitalized, and an initial non-contrast CT scan of the brain showed a very minimal right frontal lobe cerebral collection, suggesting a very small subdural hematoma, no mass affect. There was some sub-frontal blood representing a

mild contusion. Also noted was a fracture through the mastoid air cells on the right with air noted and soft tissue swelling. There also was opacification of the mastoid air cells posteriorly, probably related to the fracture on the right side. A chest PA and lateral was normal. Routine lab work included a CBC, clotting studies, cardiac enzymes and a metabolic panel were completely normal, except for slight elevation of the SGOT, SGPT liver enzymes. A repeat CT scan showed no change in the size of the subdural. The patient also stated that he could not hear out of his right ear, had generalized headache, worse when he gets up, and dizziness, but no true vertigo. He also had nausea. He had been in good health except for overweight and high blood pressure. Neurological examination showed abrasions in the occipital area. His eardrums were normal, but he has very distinct bilateral hemotympanum with outward bulging of the tympanic membranes. His general medical examination was normal. The neurologic examination showed blood in both ears, but no blood around the eyes. The neurologic examination was essentially normal, except the patient had diminished hearing to air and bone conduction on the right as compared to the left. A diagnosis was given of basilar skull fracture to the temporal bones bilaterally. There was some evidence of fractures on CT. In addition, he had occipital scalp abrasions without scalp laceration. He had historical evidence of possible spinal fluid leak because of headaches that occur when he gets up and get better when he lies down. He also has longstanding hypertension.

MRI of the brain on 12/4/07 showed fluid in the right mastoid and right middle ear, much less fluid in the left mastoid, and the internal auditory canals were normal. There appeared to be some temporal and bi-temporal spots in the brain. The ventricles in the brain were normal. There was an abnormal signal in the inferior frontal cortex on the right, and some edema in that area. Also, abnormal signal noted on the tip of the frontal lobe on the left. The opinion was that there was fluid in the right mastoid and fluid in the right middle ear, less so on the left. There were bi-frontal and bi-temporal lesions, and these represent small subcortical blood clots related to trauma, and no mass affect, and no extra axial fluid collection. The plain x-rays of the cervical spine were normal, without fracture. MRI of the brain was repeated 12/7/07. There was no evidence of any blood outside the brain, or in the subdural space. There was a CT scan of the temporal bones on 12/5/07 that showed an oblique fracture from the anterior aspect of the right mastoid. There was also a non-displaced fracture, and there was some evidence of some hemorrhage around the area and some swelling. The findings suggested there was sinus disease involving the sphenoid sinus, and involving all sinuses, including the left frontal sinus.

On examination 12/28/07 the patient noted complaints of dizziness, headache, numbness and weakness. The medical examination was normal. His auditory canals and eardrums were normal. The neurologic examination was reported as normal. The diagnosis was a closed skull fracture and hemorrhage and loss of consciousness. The patient was still having dizziness and it was recommended that he not work. The plan was also to reduce his blood pressure medication.

On 1/10/08 and again on 2/14/08, 3/20/08 and 4/8/08 the patient had the same complaints, and his examination was unchanged. The examination in general was

unremarkable, except for subjective hearing loss. Repeat MRI of the brain with and without contrast on 3/19/08 showed some fluid in the right mastoid air cells. There was no evidence of any intracranial abnormality, as the previously-seen hematoma in the brain had resolved. On 4/24/08 the patient complained of smell loss and some headaches. The patient saw a neurosurgeon on 6/24/08. he complained of tunnel hearing in the right ear. His headaches and dizziness had subsided. The neurologic examination was normal. He believed his diagnosis was skull fracture with contusion, without any neurosurgical reason for surgery. He wanted to be sure there was no CFS leak.

The patient had the same complaints of dizziness and hearing changes on 9/9/08.
AN MRI with and without contrast again on 12/16/08 showed chronic inflammatory sinus disease.. The intracranial GFS volume was normal and no signs of pneumocephalus, which argues against a CFS leak, although a nuclear medicine study would be required to be certain. No acute intracrainal abnormality was seen.
An ENT specialist found the patient to have bilateral hemotympanum, with evidence of right basilar skull fracture. Since then, he has been complaining of pulsatile tinnitus predominantly on the right, and also he has had loss of smell since the injury. He also reveals bilateral ethmoid opacification and polyps. He has had some dizziness and wears bilateral hearing aids. His examination showed some middle meatal polyps with swelling of the ethmoid mucosa. Audiogram was performed and revealed a sloping bilateral moderate to moderately severe sensory neuro-hearing loss. The opinion was that the patient had significant trauma, which likely produced sinus disease, and that that could well explain his tinnitus, due to the pulsatile nature of the tinnitus. There could be a possibility of an arterial venous malformation. Repeat CT scan of the sinuses and an arteriogram of his head and neck, and an MRI of the head were recommended to evaluate the possibility of a post-injury encephalocele.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
I disagree with the denial of the requested tests. The patient had a very significant head injury, which resulted in an occipital skull fracture, hemorrhagic abnormalities in the brain, hearing loss and continued problems with dizziness, and he has developed pulsatile tinnitus. Previous MRI revealed no evidence of residual hemorrhage. However, the CT of his sinuses still continues to show fluid and pathology, and his other studies suggest there is no evidence of a SFS leak. The ENT specialist who saw the patient on 8/3/08 reported that he is mainly concerned that the patient has significant sinus pathology, and he also has developed pulsatile tinnitus. In his experience, this could still be part of ongoing sinus disease that has been aggravated, and additionally produced by the head trauma, and also the possibility of a traumatic AV malformation in the posterior fossa region, and the possibility of a post-injury encephalocele that could have developed and be the cause of theses ongoing symptoms.

I concur with the ENT specialist that the patient could have developed a traumatic AV malformation or arterial dissection in the base of the skull, and also the possibility of an encephalocele and traumatic sinus pathology that all could be playing a part in his

symptoms. The previous MRI of the brain with and without contrast does not totally eliminate these diagnostic possibilities..

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**