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Notice of Independent Review Decision

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**Notice of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: July 27, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan of the chest (72175).

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

M.D., Board Certified in Radiology.

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)

The requested diagnostic procedure, CT scan of the chest (72175), is not medically necessary for evaluation of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 5/26/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/06/12.
3. Notice of Assignment of Independent Review Organization dated 7/09/12.
4. Medical records from MD dated 4/11/12 and 5/08/12.

5. Undated Preauthorization Request Form from MD.
6. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. Per the medical records dated 4/11/12, the patient was originally injured when he was on top of a roof and fell through a hole and landed on a piece of angle iron on the right side of his back. The note reported the patient was taken to the emergency room and was found to have 7 fractured ribs on CT scan. The patient was discharged from the hospital after four days. Approximately one week later, he developed shortness of breath and was admitted for another three to four days in the hospital. On 4/11/12, the patient continued to complain of some discomfort when taking a deep breath. Physical examination revealed good equal chest expansion on taking a deep breath, with complaints of some discomfort on the right side. There was also slight prominence on the right side of the chest just below the sternal clavicular junction that was minimally tender. On 4/11/12, x-rays revealed no evidence of pneumothorax. Costophrenic angles were sharp, with no evidence of blunting, and rib fractures were seen on the right side involving at least ribs 5, 6, and 7. The provider recommended a repeat CT scan of the chest.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic procedure. Specifically, the URA's initial denial stated that the requested CT scan of the chest will not result in any changes in treatment, since surgical intervention for rib fractures is not a normal standard of care. On appeal, the URA indicated that ODG criteria do not recommend an additional CT scan of the chest at this time, and the requested diagnostic procedure should be reserved for significant changes in symptoms and/or findings suggestive of significant pathology.

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

The requested CT scan of the chest is not medically necessary in this patient's case. The documentation submitted for review indicates the patient sustained seven right rib fractures secondary to a fall on xx/xx/xx. On 4/11/12, the patient had continued slight discomfort with deep breathing. Chest x-rays revealed fractures of the 5th, 6th, and 7th ribs, with concern for displacement and continued non-healing. This patient has mild residual pain complaints, and a chest CT scan would not change the patient's treatment plan. The ODG criteria do not routinely recommend CT scans of the chest in this clinical setting. The ODG criteria note that CT scans of the chest may be indicated in specific clinical situations, including for establishing the diagnosis of bronchiectasis, evaluating patients with presumed interstitial lung disease, and preoperative staging and post-therapeutic evaluation of bronchogenic carcinoma. Additionally, ODG criteria note that a CT scan of the chest should be performed for patients with either a known or suspected lung cancer. This patient does not meet ODG criteria for a CT scan of the chest.

Therefore, I have determined the requested CT scan of the chest (72175) is not medically necessary for evaluation of the patient's medical condition.

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)