C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 387-2647
Email: resolutions.manager@ciro-site.com

Review Outcome

Description of the service or services in dispute:

CT of the XX XX XX without contrast.
XX - CT of the XX XX without dye

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Occupational Medicine

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

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

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. XX was involved in a XX XX XX and developed XX XX pain and XX XX / XX pain. The primary diagnosis was strain of muscle, XX, and tendon of XX XX (XX.XX). The ongoing diagnoses were unspecified internal XX of the XX XX (XX.XX), contusion of the XX XX, subsequent encounter (XX.XX), strain of muscle, XX and tendon of XX XX, subsequent encounter (XX.XX); and strain of unspecified muscle, XX and tendon at XX and XX XX level, XX XX, subsequent encounter; and unspecified fracture of XX XX XX, subsequent encounter for fracture with routine healing (XX.XX).

XX evaluated XX. XX on XX for ongoing XX XX pain that was rated 8/10. XX also reported that the symptoms in XX XX had reduced. Overall, the XX XX symptoms had remained the same. Per the report, XX. XX had initially visited the XX where XX was found to have a XX fracture on x-rays. XX returned on XX for XX. XX was referred to XX, who diagnosed XX with XX XX XX of the XX side and nuclear XX XX. On XX examination, there was full range of motion, muscle spasms along the XX muscles (decreased) and tenderness (decreased). XX extremities showed normal range of motion. Straight XX raise test was negative. The diagnoses were XX XX XX, XX XX; unspecified internal XX of XX XX; contusion of XX XX, subsequent encounter; strain of unspecified muscle, XX and tendon at XX and XX XX level; XX XX, subsequent encounter; unspecified fracture of the XX XX XX, subsequent encounter for fracture with routine healing. Prior medications were discontinued. XX and X were started. XX documented that XX. XX stated the pain was “excruciating;” however, XX was XX on the XX comfortably and had not taken any medications that morning. XX vitals were normal and XX had full range of motion of the XX XX as well as full strength on examination. No neurocompromise or changes were noted in the XX extremities. XX description of pain was “sharp” and to the XX side of XX pain only. XX pointed to the XX XX region and denied any radiating pain into XX XX. X-rays of the XX XX from XX were reviewed when XX had another work-related injury. At that time, XX had diffuse XX changes with XX-XX disc XX XX. It was

felt that at the time, XX. XX would benefit from a repeat CT scan to check the healing progress of transverse process fractures. XX did not feel the XX findings were from the work-related injury. On XX, XX. XX reported that XX pain was unchanged at 8/10. Examination findings were unchanged from previous.

An MRI of the XX XX without contrast was obtained on XX. The study identified XX-XX mild-to-moderate XX and mild XX XX XX, with appearance of contact exiting the XX XX XX in the XX regions.

Treatment to date included medications (XX, XX, XX, XX, XX), referral to XX therapy and work restrictions.

A peer review was completed by XX on XX. XX opined that the CT of the XX XX XX without contrast was not medically necessary. According to XX, "As noted in ODG, MRI imaging had largely replaced CT imaging for non-invasive evaluation of the XX conditions due to superior soft tissue resolution. While ODG acknowledges that CT imaging scan be employed in cases where XX MRI is contraindicated and / or performed, here, the claimant had already had prior XX MRI imaging, effectively obviating the need for the CT scan in question. It was unclear why a CT scan was needed so soon after the claimant had had XX MRI imaging dated XX. Therefore, CT of the XX XX XX without contrast is not medically necessary." These opinions were reflected in the utilization review decision letter dated XX.

A Medical Necessity report was completed by XX on XX. XX opined that the appeal for medical necessity for CT of XX XX XX without contrast was not medically necessary. Per the report, an x-ray of the XX XX dated XX, reported an XX transverse fracture on the XX. XX stated, "The guidelines support MRI / CT diagnostics for individuals with a history of trauma, neurological findings, progressive changes and red flags. The guidelines do not support routine MRI imaging and supported repeat imaging with findings of red flags or progressive changes suggesting internal XX. Thus, the patient has recently undergone a XX MRI, which is the preferred non-invasive method of evaluation of the XX XX and there is no clear rationale provided for CT evaluation. The request is not supported as it does not meet the guideline recommendations. Thus, the request is not certified." A utilization review letter dated XX was certified as not medically necessary by the Physician Advisor.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for CT of the XX XX XX without contrast. XX - CT of the XX XX without dye is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination. The submitted clinical records indicate that the patient underwent XX MRI on XX, approximately XX months ago. There is no clear rationale provided to support a CT scan at this time. There is no documentation of a significant change in clinical presentation. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low XX Pain
- ☐ Interqual Criteria

Notice of Independent Review Decision

Case Number: ***XX*** Date of Notice: 04/01/19

- [x] Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- [ ] Mercy Center Consensus Conference Guidelines
- [ ] Milliman Care Guidelines
- [x] ODG-Official Disability Guidelines and Treatment Guidelines
- [ ] Pressley Reed, the Medical Disability Advisor
- [ ] Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.