

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-2218.M2**

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** November 26, 2003

**RE: MDR Tracking #:** M2-04-0362-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Clinical History**

According to the supplied documentation, it appears that the claimant injured her shoulder while working on \_\_\_. The claimant injured her right shoulder and was treated surgically with arthroscopy and arthroscopic debridement. The claimant has undergone a plethora of treatment including, but not limited to MRIs, CT scans, shoulder surgery, chiropractic therapy and medical prescription medications. The documentation reveals notes, reports, exams, impairment ratings and therapy for the previous 5 years. The most recent documentation reports that the claimant is continuing to have pain in her neck and is requesting a MRI to proceed with surgery. There was a significant amount of documentation supplied for review, which was read in its entirety.

**Requested Service(s)**

Please review and address the medical necessity of the proposed services of repeat MRI regarding the above mentioned injured worker.

**Decision**

I disagree with the insurance company and agree with the treating doctor that the services requested are medically necessary.

### **Rationale/Basis for Decision**

After careful review of the supplied documentation, it appears that the claimant sustained an injury to her right shoulder on \_\_\_\_\_. The claimant has had an adequate amount of medically services rendered for the compensable injury. Approximately 2 years post injury, the claimant's complaints appeared to change or focus on her cervical region.

The original MRI performed on 09/12/1998 at \_\_\_\_\_ revealed that the claimant had a disc bulge at C3-4, C4-5 and at C5-6 with osteophytic spurring in multiple levels of the cervical spine. A second MRI on 11/25/1998 revealed that the claimant had disc desiccation at C5-6 and did not definitively report disc bulging. \_\_\_\_\_ reported that the claimant had some degenerative changes in the cervical spine. The symptoms that were seen on the initial MRI findings suggest that the claimant had some pre-existing changes in her cervical spine prior to her \_\_\_\_\_ work injury. I am informed that medical necessity is the only issue with which I am to consider, therefore, I will not consider any compensability issues. Since the continued therapy has not provided enough relief for the claimant to return to her previous job duties, a repeat MRI is warranted and considered medically necessary in her case. Future medical decisions will be based upon the findings in her MRI report and validate its necessity.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.