

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

**SOAH DOCKET NO. 453-04-6425.M2**

May 11, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-1083-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient is a 36-year-old flight attendant for \_\_\_ who suffered a work-related injury on \_\_\_. A description of the injury reveals that she was taking the escalator to the gates at the airport when a passenger's oversized luggage fell onto the escalator and rolled into her, causing her injury. Since then, she has had intermittent neck and upper extremity pain.

She has been under the care of \_\_\_. Records indicate that she has had a MRI of the cervical spine that demonstrated a small central disc protrusion at C5/6. She has been given the diagnosis of central disc protrusion of C5/6 and cervical myofascial pain. This patient has undergone exhaustive physical therapy and anti-inflammatory medicines with

only short-term relief. She has undergone cervical epidural steroid injections with no long-term relief.

On January 22, 2003 she had an EMG/NCV study of the upper extremities by \_\_\_\_, and this was negative for any cervical radiculopathy or radiculitis. It was \_\_\_\_ opinion that this patient had multiple trigger points.

A CT myelogram was recommended by \_\_\_\_ and performed in January of 2004. This was essentially an unremarkable and negative study. The CT scan demonstrated mild facet joint hypertrophy on the right of C2/3 and C3/4. There was a 1 mm bulge at C5/6 with no spinal central stenosis or foraminal encroachment.

\_\_\_\_ has complaints of neck pain only with no neurological symptoms.

#### REQUESTED SERVICE

A cervical discogram with CT scan is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

Based on the medial records provided, the reviewer finds that the requested cervical discogram with CT scan is unwarranted in this patient. Please note that the patient's MRI, CT myelogram, EMG/NCV study and examination are inconsistent with symptomatic disc herniation. It is well documented in the literature that discograms are controversial studies and that their results can be skewed by various factors. A positive discogram does not confirm elimination of pain after surgical treatment.

\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## 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.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 11<sup>th</sup> day of May 2004.**