

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

**SOAH DOCKET NO. 453-04-5855.M2**

April 28, 2004

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

MDR Tracking #: M2-04-1151-01  
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

\_\_\_ is a 50-year-old woman who sustained a work-related injury on \_\_\_. Records indicate the patient was struck by falling merchandise causing a contusion to the face and the scalp. The treating physician is \_\_\_. Over the course of the years, the patient has undergone multiple diagnostic studies to include x-rays of the skull, cervical spine, MRIs of the cervical spine, brain, EMG/NCV studies and a CT scan/myelogram with fluoroscopy examination of the cervical spine. She has seen multiple consultants and has undergone several RME/IME/DDEs.

\_\_\_ has seen \_\_\_, a neurosurgeon in \_\_\_. His records indicate that as of February 2004 this patient was complaining of persistent neck pain and bilateral trapezial pain with

intra-scapular pain. It was the doctor's opinion that the patient had a cervical radiculopathy, which stems from the original injury of \_\_\_\_\_. This patient was complaining of numbness and tingling in both of her hands and the distal right arm.

She has completed conservative therapy that has included include physical therapy, anti-inflammatory medicines and a trial of epidural steroid injections. She has been using Darvon for pain relief. She is NIDDM.

The most recent examination reveals that she has tenderness to palpation over the right and left trapezial muscles. She had decreased ROM of the cervical spine. She was neurologically intact with reflexes at +2/4 and muscle strength of 5/5. Sensory exam was unremarkable. EMG/NCV study dated January 2, 2004 revealed bilateral carpal tunnel syndrome with a left ulnar neuropathy of the wrist.

It was the neurosurgeon's opinion that the patient had a cervical radiculopathy with calcification of a disc protrusion at C4/5, C5/6 and C6/7. It was his opinion the patient needs a cervical CT myelogram to evaluate the disc.

#### REQUESTED SERVICE

A cervical myelogram with CT is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

Based on the medical records and examinations by \_\_\_\_\_, the reviewer finds that the requested cervical myelogram with CT is warranted in this patient. \_\_\_\_\_ does have evidence of ongoing neck pain and possible cervical radiculitis. Given her prior history and multiple MRIs, a CT myelogram would be reasonable to rule out any significant nerve root impingement.

\_\_\_\_\_ 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 28<sup>th</sup> day of April 2004.**