

  
**INDEPENDENT REVIEW INCORPORATED**

November 14, 2006

Revised on November 15, 2006

Re:   **MDR #:**        **M2 07 0191 01**        **Injured Employee:**   \_\_\_  
      **DWC #:**        \_\_\_                    **DOI:**                   \_\_\_  
      **IRO Cert. #:** **5055**                **SS#:**                   \_\_\_

**TRANSMITTED VIA FAX TO:**  
**TDI, Division of Workers' Compensation**  
Attention: \_\_\_  
Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT:**                    **Texas Municipal League**

**REQUESTOR:**                   **Jacob Rosenstein, MD**

**TREATING DOCTOR:**        **Charles Marable, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to all participating parties and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

P.O. Box 855  
Sulphur Springs, TX 75483  
903.488.2329 \* 903.642.0064 (fax)

## Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 14, 2006.

Sincerely,



Jeff Cunningham, DC  
Office Manager



**REVIEWER'S REPORT  
M2 07 0191 01**

MEDICAL INFORMATION REVIEWED:

1. DWC assignment with Table of Disputed Services and notification of IRO assignment
2. Multiple insurance company denials from Corvel
3. Requestor's records including notes from Dr. Jacob Rosenstein's office
4. Carrier's records including physician's statement from the insurance company's attorneys
5. Insurance company denial letters
6. Records from Dr. Rosenstein's office
7. Letter of medical necessity and appeal from Dr. Rosenstein
8. MRI scan report, Dr. Michael Jones

BRIEF CLINICAL HISTORY:

The patient injured his shoulder and neck during a work-related activity. The patient was found to have a rotator cuff tear that was treated with physical therapy and injections. Because of persistent symptoms, the patient's orthopedic surgeon referred him to a neurologist, and both the orthopedic surgeon and neurologist felt that the patient's arm pain was radicular in nature and cervical in origin. He was referred to Dr. Rosenstein, a neurosurgeon. After MRI scan showed disc bulges and uncovertebral hypertrophy, he recommended a CT myelogram for better evaluation of nerve roots. This was denied.

DISPUTED SERVICES:

CT myelogram with reconstruction have been denied as medically unnecessary.

DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

As an orthopedic surgeon that specializes in the hand and upper extremity surgery, many times I see patients with both shoulder and cervical pathology, and both need to be worked up, particularly if the patient does not respond to one treatment just as this has. Multiple providers have felt that this patient has radicular pain, and the workup is appropriate by the neurosurgeon. Therefore, the CT myelogram should be approved as medically necessary and appropriate.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:

My board certification in orthopedic surgery as well as fellowship in hand and upper extremity disorders allows me to make this decision, as I treat this condition on a day-to-day basis. In addition, the Journal of Bone and Joint Surgery, Orthopedic Knowledge Update, and Campbell's Orthopedics were also used as treatment guidelines.