MDR Tracking Number: M5-03-1197-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2003 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that MRI was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that the MRI was the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 5/16/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

May 1, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: MDR #: M5-03-1197-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:

This female claimant was injured on the job on ___. She began to experience pain and numbness in her hands and fingers and pain in her elbows and shoulders, the right being greater than the left. Chiropractic treatment was begun on 05/06/02.

Disputed Services:

MRI of the upper extremity on 05/16/02.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the MRI was not medically necessary in this case.

Rationale for Decision:

The patient was evaluated on ___, approximately one week after her on-the-job injury and positive findings were revealed. However, on the initial day of treatment, it appears that the doctor not only ordered conservative therapy, but also ordered bilateral wrist MRI's to rule out internal derangement, x-rays to rule out pathologies, as well as electrodiagnostic testing to rule out nerve entrapments. All of these tests were ordered prior to attempting any conservative treatment.

The x-rays were ordered on the same day the MRI's were ordered. The NCV's were not performed until 06/05/02, but are typically the usual diagnostic tests that confirm or rule out carpal tunnel syndrome, along with needle EMG.

When these services were performed there were no TWCC treatment guidelines in effect. However, it is not usual, reasonable, customary, or medically necessary to order bilateral wrist MRI's on the same date that you ordered x-rays and/or electrodiagnostic testing. Although the MRI's were not performed until 05/16/02, they were ordered regardless of the patient's response to conservative care.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,