MDR Tracking Number: M5-03-1290-01

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, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (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 magnetic image of the lumbar spine and spinal canal were 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 magnetic image of the lumbar spine and spinal canal fees were 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 4/17/02 is denied and the Division declines to issue an Order in this dispute.

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

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1290-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified neurosurgeon. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 47 year-old male who sustained a work related injury on ___. The patient reported that while at work as a construction worker, he was relocating cubicles when he twisted and hurt his back. The patient underwent an MRI of the thoracic and lumbar spine on 4/17/02 that showed degenerative disc disease with disc desiccation at L4-5 and L5-S1, central disc protrusion at the L5-S1 level, multilevel and thoracic spondylotic changes with posterior disc bulging at virtually every level from T6-7 through T11-12. The patient has been treated with myofasical release, neuromuscular reeducation, electrical muscle stimulation, and cryotherapy.

Requested Services
Magnetic Image of the lumbar spine and spinal canal.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 47 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the patient has been diagnosed with degenerative changes at multiple levels in the thoracic spine and a herniated disc at L5-S1. The ___ physician reviewer further noted that the patient has been treated with myofascial release, neuromuscular reeducation, electrical muscle stimulation and cryotherapy. The ___ physician reviewer explained that the clinical information supplied does not support the need for an MRI. Therefore, the ___ physician consultant concluded that the MRI of the lumbar spine and spinal canal was not medically necessary to treat this patient's condition.

Sincerely,