MDR: Tracking Number M5-03-1888-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The lumbar MRI was found to be medically necessary. The cervical MRI service rendered was not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these lumbar MRI charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 11/4/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 15th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/cl

July 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1888-01

___ 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 chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 34 year-old female who sustained a work related injury on ___. The patient reported that while at work she slipped and fell injuring her lumbar spine. The patient was transported via ambulance to the emergency room where she underwent X-Rays and was treated with oral medications. The patient underwent an MRI on 11/4/02. The diagnoses for this patient included displacement of lumbar IVD without myelopathy and displacement of cervical IVD without myelopathy. The patient has been treated with active and passive therapy, joint mobilization, electrical stimulation, cryotherapy and heat therapyrehabilitation, TENS unit, work hardening, chiropractic manipulations and oral pain medications.

Requested Services

Magnetic resonance imaging on 11/4/02.

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 34 year-old female who sustained a work related injury to her lumbar back on ___. The ___ chiropractor also noted that the diagnoses for this patient included displacement of lumbar IVD without myelopathy and discplacement of cervical IVD without myelopathy. The ___ chiropractor reviewer further noted that the patient has been treated with active and passive therapy, joint mobilization, electrical stimulation, cryotherapy and heat therapy. The ___ chiropractor reviewer indicated that the patient underwent a CT scan in the hospital after the injury. The ___ chiropractor reviewer noted that the CT scan was negative. The ___ chiropractor reviewer explained that there are no signs of nerve root compression or radicular symptoms that warrant doing a cervical MRI. The ___ chiropractor reviewer indicated that there are signs of radicular pain in the right leg, and a lumbar MRI to rule out a disc herniation or nerve root entrapment was a good idea and medically necessary to help direct future care. The ___ chiropractor reviewer explained that due

to the lack of any positive objective findings in the cervical spine or arms and the negative CT scan, an MRI of the cervical spine is not medically necessary. Therefore, the ___ chiropractor consultant concluded that the magnetic resonance imaging of the lumbar spine on 11/4/02 was medically necessary. However, the ___ chiropractor consultant concluded that the magnetic resonance imaging of the cervical spine on 11/4/02 was not medically necessary.

Sincerely,