MDR Tracking Number: M5-03-2291-01

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 the lumbar MRI 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 the lumbar MRI fee were the only fee involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 2/28/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

July 16, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2291-01

An independent review of the above-referenced case has been completed by a medical physician [board certified] in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
___ has a long history of back problems including a MVA in ___ which symptoms resolved by 1997. A back injury in ___ had him obtain medical care from multiple physicians. Eventually, he had an IDET procedure done in December of 2000. ___ underwent two MMI assessments: one in April 2001 of 10% disability, and one in May 2001 of 12% disability. More recently, he saw ___ in February 2003 for low back pain.

REQUESTED SERVICE (S)
MRI L-5 spine

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
This patient has a complicated and long history of low back pain. He had received appropriate therapy including medications, therapy, TENS, and an IDET procedure. He reached MMI by May 2001. His continued symptoms place in the category of chronic low back pain syndrome. Along with the patient's pain syndrome, there is typically a significant psychological component, which is documented with ___. An MRI is not indicated by his most recent clinical information via his history or his exam. Also, no 'red flags' or worrisome neurological findings were noted.