MDR Tracking Number: M5-03-2857-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on July 10, 2003.

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 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 fees were the only fees involved in the medical dispute to be resolved. As MRI was not found to be medically necessary, reimbursement for date of service 7/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of September 2003.

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

September 3, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2857-01

An independent review of the above-referenced case has been completed by a doctor 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
Patient sustained work related injuries on ___. Apparently, patient sought treatment from a physician who obtained x-rays, prescribed medications, and instructed the patient to follow-up with his doctor if pain continued. He then saw ___ on 6/19/02 who diagnosed a back strain. No notes were available from these visits. The patient saw ___, on 6/24/02 who obtained x-rays and diagnosed lumbar segmental dysfunction syndrome. An L5 spine MRI done on 7/18/02 was normal. He had subsequent visits with ___ and had multiple chiropractic adjustments and various treatment modalities.

REQUESTED SERVICE (S)
L5 spine MRI

DECISION
Uphold previous denial.

RATIONALE/BASIS FOR DECISION
The patient sustained a work related back injury on ___. He saw several physicians who apparently diagnosed lumbosacral musculoskeletal strain. No radicular pain or evidence of discogenic pain were noted on exam or radiographs. No documentation is noted to support the need or medical necessity for an L5 spine MRI. Therefore, denial of requested services is upheld.