THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-1982.M5

MDR Tracking Number: M5-03-3315-01

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 August 18, 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 the MRI was not found to be medically necessary, reimbursement for date of service from 3/3/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 19th day of November 2003.

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

November 17, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-3315-01

___ 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 reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 male who sustained a work related injury on ___. The patient reported that he fell off a piece of heavy machinery and landed on the whole right side of his body and lower back. The patient underwent an MRI on 3/3/03 that showed Schmorl's node deformities, partial disc degeneration and a 3mm protrusion of the 4th intervertebral disc.

Requested Services

Lumbar MRI of 3/3/03.

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 ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the patient underwent an MRI of the lumbar spine on 3/3/03. The ___ chiropractor indicated that initial evaluation of 2/19/03 showed positive orthopedic tests, hypersensatin in left L2 and L3 levels and decrease left hip flexor weakness. However, the ___ chiropractor reviewer explained that a treatment note dated 3/1/03 showed only findings of muscle spasms, fications, tenderness and decreased spine range of motion. The ___ chiropractor reviewer noted that at this time the patient's pain level had dropped and the patient demonstrated a 15% improvement since the initial evaluation. The ___ chiropractor indicated that the treating providers note indicated that the patient was

progressing. The ___ chiropractor reviewer explained that the documentation provided did not demonstrate strength deficits, sensory deficits or evidence of radiculopathy. The ___ chiropractor reviewer also explained that indications for an MRI would included neurologic deficits, evidence of radiculopathy, suspected neurological disorders, localized back pain with radiculopathy and failure of 6 weeks of conservative care.

The ___ chiropractor reviewer further explained that at the time the MRI was ordered the patient had none of the listed indications requiring an MRI. Therefore, the ___ chiropractor consultant concluded that the lumbar MRI of 3/3/03 was not medically necessary to treat this patient's condition.

Sincerely,