

**MDR TRACKING #: M5-02-1961-01**

The Medical Review Division reviewed the decision of the Independent Review Organization (IRO) in the captioned medical dispute and concludes the dispute with the enclosed Decision.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you **five** days after it was mailed **and the first working day after the date this Decision was placed in the carrier representatives box** (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P. O. Box 40669, Austin, Texas, 78704-0012. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to all other parties involved in the dispute.

<p>I hereby verify that a copy of this Findings and Decision was placed in the insurance carrier representative's box and mailed to the requestor applicable to Commission Rule 102.5 this _____ day of _____, 2002. Per Commission Rule 102.5(d), the date received is deemed to be five days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.</p> <p>Signature of Commission Employee: _____</p> <p>Printed Name of Commission Employee: _____</p>
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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 MRI of the cervical spine was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that MRI 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 10-1-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Medical Dispute Resolution Officer  
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

May 31, 2002

Chief, Medical Dispute Resolution  
Medical Review Division  
Texas Workers Compensation Commission  
4000 South IH-35, MS 40  
Austin, TX 78704-7491

RE: Injured Worker: M5-02-1961-01  
MDR Tracking #: IRO Certificate #:

\_\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Clinical History**

This 42 year old female sustained a work-related injury when she fell and landed on her back on \_\_\_\_\_. Initial complaints at the company doctor were confined to the low back. The claimant sought chiropractic care on 09/19/01 complaining of low back, mid back and neck pain of significant levels. An x-ray examination performed on 09/19/01 revealed an essentially normal cervical spine with associated postural changes. Examinations on 09/19/01 and beyond revealed

no significant sensory changes as well as no neurological deficits. Records reflect that reflexes have remained within normal limits and muscle testing has been consistently 5/5 (normal). The claimant underwent a cervical MRI on 10/01/01.

Requested Service(s)

MRI of the cervical spine

**Decision**

It is determined that the MRI of the cervical spine was not medically necessary to treat this patient's condition.

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**Rationale/Basis for Decision**

According to accepted standards of care including TWCC Spine Treatment Guidelines, an MRI is not warranted or medically necessary to evaluate/treat soft tissue injury during the first 6-8 weeks without documentation of significant neurological deficits or severe sensory symptomatology. Another possible reason to employ an MRI during this initial period would be if there were rapidly deteriorating symptoms. The supplied documentation is clearly devoid of indications of significant neurological deficits, significant sensory symptomatology, or rapidly deteriorating symptoms. Therefore, the supplied documentation fails to support the medical necessity of this procedure in question.

Sincerely,



**TEXAS**  
**WORKERS' COMPENSATION COMMISSION**  
SOUTHFIELD BUILDING, MS-48, 4000 SOUTH IH-35, AUSTIN, TEXAS 78704-7491  
(512) 804-4800

**MEMORANDUM**

**DATE:**        \_\_\_/\_\_\_/\_\_\_

**TO:**            Austin Commission Representative, Box # 54

**CARRIER:**    Texas Mutual Insurance Co.

**FROM:**         Medical Review Division, 8th Floor, Suite 814

**RE:**            NOTICE of Independent Review Organization and  
                    Medical Dispute Resolution DECISIONS

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**This memorandum shall serve as your notice to present yourself to the Mail Room Service Counter:**

(X)            An IRO and MDR Decisions.

The above referenced document has been issued in a medical dispute case review pertaining to the following claimant:

**IDENTIFIER**

**MDR TRACKING #:** M5-02-1961  
**TWCC FILE #:**  
**CLAIMANT:**  
**DOI:**  
**SSN:**

I, the undersigned Representative of the above referenced insurance carrier, do hereby acknowledge receipt of the IRO and MDR Decisions applicable to a medical dispute resolution request solicited by the requestor.

Receipt of these Decisions is hereby acknowledged this \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Signature of Commission Representative: \_\_\_\_\_

Printed Name of Commission Representative: \_\_\_\_\_