MDR Tracking Number: M5-02-2528-01

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 and cervical MRI's rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the lumbar and cervical MRI's rendered 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 9/13/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 25th day of September 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

September 20, 2002

Re: Medical Dispute Resolution
MDR #: M5-02-2528-01
IRO Certificate No.: IRO 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is a doctor of Chiropractic Medicine.

The physician reviewer AGREES with the determination of the insurance carrier in this case. The reviewer is of the opinion that an MRI of the Cervical and Lumbar spine on 09.13.01 was not medically necessary.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him

and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is ___. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2528-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request/Response.
2. Explanation of Benefits for MRI of the neck, lumbar spine, and leg/foot.
3. ___ letter, ___, Medical Audit, 4/18/02.
4. Letter of medical necessity by treating doctor, 3/01/02.
5. MDR Position Statement, 5/13/02, ___, treating doctor.
6. Update Medical Report, 1/23/02.
7. Initial Medical Report, ___, Orthopedic surgeon, 9/24/01.
8. Treating doctor's daily notes from 9/11/01 to 3/22/02.
9. Initial FCE, 2/07/02.
10. Oswestry Low Back Pain Disability Questionnaire and Neck Disability Index Questionnaire, 2/07/02.
11. Neurodiagnostics test of the lower extremity (NCV), ___, 10/03/01.
12. X-ray report of the cervical, thoracic, and lumbar spine, 9/18/01, ___.
13. MRI of the cervical spine, ___, 9/07/01.
14. MRI of the lumbosacral spine, ___, 9/13/01.
15. MRI of the left knee, ___, 9/13/01.

B. BRIEF CLINICAL HISTORY:

The patient suffered a work-related injury on ___ from a front-end collision motor vehicle accident. He complained of neck, midback, and low back pain, and pain radiating to the left lower extremity, also chest pain and left knee pain. MRI of the cervical, lumbar, and knee were ordered six days later on 9/13/01.

He was referred to an Orthopedic surgeon for a left knee evaluation on 9/24/01. He was then referred out for an NCV on 10/03/01which was normal. Treatment by ___, a chiropractor, continued. An initial FCE on 2/07/02 was performed.

C. DISPUTED SERVICES:

Medical necessity of an MRI of the cervical and lumbar spine on 9/13/01. The insurance carrier

states the documentation does not support the medical necessity of cervical and lumbar MRI.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

1. The case history of ___ is vague, without documentation of mechanism or severity of motor vehicle accident/injury to support the immediate recommendations of an MRI.

2. ___, the treating doctor, has not submitted or identified in the doctor exam and notes, or provided positive findings, that would identify a true radiculopathy of the lower extremity or upper extremities to warrant an immediate recommendation or referral on the first week of treatment.

3. There were no second opinions from an M.D. (Orthopedic) to support the need for an MRI. An Orthopedic exam of the left knee, on 9/24/01, ___ states, "Without radiculopathy, anesthesia, and paresthesia into the lower extremities."

4. The NCV of 10/03/01 was negative. Why was an NCV ordered instead of an EMG to identify radiculopathy or entrapment of the upper or lower extremities?

5. ___, the treating doctor, has not identified an initial working diagnosis to support a treatment plan, much less supported recommendations for appropriate diagnostic testing; for example, McKenzie protocols, identifying the type of disk derangement, their application, and patient response to treatment.

6. ___ has not identified or laid out initial conservative appropriate treatment plan for this patient; for example, in "Recommendations," there was no mention of ice, clinically or at home, high volt galvanic stimulation of any kind, McKenzie protocols, etc. Patient response should have been noted.

7. The full effect of an injury altering or compromising nerve tissue is more appropriate when identified at three weeks, at which time there should be documentation of patient response to initial appropriate conservative protocols, an update on the working diagnosis and appropriate recommendations with a treatment plan and noted direction of where the doctor is going with this information. Appropriate tests are used to establish treatment protocols and decisions; these were not noted on exam or doctor notes. How was the MRI used by the doctors in treatment and how would the patient's care improve by providing this diagnostic test? The course and type of treatment was not delineated.

E. RATIONALE OR BASIS FOR DECISION:

1. "American College of Radiologists' Appropriate Criteria for Acute Low Back Pain" published in the *Journal of Radiology, 2000.*
2. *Washington State Department of Labor and Industries, 1999 Guidelines.*
3. McKenzie protocols.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 17 September 2002