

MDR Tracking Number: M5-04-2254-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-23-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The MRI of the lumbar spine performed on 9/08/03 was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 9/08/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 6th day of July 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

June 24, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2254-01
IRO Certificate #: IRO4236

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 Medicine. TMF's 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 TMF 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 patient sustained a work-related injury on ___ when he slipped from his tractor landing on his left side and injuring his left arm and hip. The patient was receiving chiropractic care and continued to complain of pain to his lower back radiating to his lower extremities. The treating chiropractor referred the patient for an MRI of the lower spine to rule out a herniated nucleus pulposus. The MRI was performed on 09/08/03 and indicated 1. Diffuse disc bulge is present at the lower three lumbar levels. The disc bulge at L5-S1 is asymmetric toward the right but produces no significant degree of spinal canal or neural foraminal stenosis. 2. Posterior annular tear present at L5-S1. 3. No evidence of spinal canal stenosis, neural foraminal stenosis, or disc herniation at any level.

Requested Service(s)

MRI of the lumbar spine

Decision

It is determined that the MRI of the lumbar spine dated 09/08/03 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient was experiencing lumbar pain with radiation into his lower extremities following a fall. As a result, there was a significant indication present to warrant diagnostic imaging of the affected area. The medical necessity for the MRI was also documented by the results that indicated a posterior annular tear present at L5-S1 level. Since the MRI did indeed reveal disc pathology, the test was both indicated and medically necessary.

Sincerely,