

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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. This dispute was received on 4-9-04.

The IRO reviewed MRI upper extremity and MRI spinal canal on 10-8-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessary was the only issue involved in this medical dispute. As the services listed above were not found to be medically necessary, reimbursement for date of service 10-8-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 11th day of February 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



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NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 7, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1005-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 an orthopedic surgery reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The reviewer 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.

Submitted by Requester:

- Clinical notes from Concentra Medical Centers dated 9/11/03
- Clinical documents of Neal Griffin, D.C.
- Clinical documents of Fort Worth Pain Center
- Clinical documents of Mobile Diagnostics of Texas
- Clinical documents of Irving Imaging Center including MRI of left shoulder dated 10/8/03 and MRI of lumbar spine dated 10/8/03

Submitted by Respondent:

- Correspondence dated 2/11/04 and 4/6/04 from Irving Imaging Center
- MRI report of lumbar spine without contrast enhancement dated 10/8/03
- MRI report of left shoulder without contrast enhancement dated 10/8/03
- Non-authorization peer review from Concillium MD dated 3/5/04

Clinical History

The claimant is a 39 year old female who allegedly sustained injuries to lower back and left shoulder while lifting a gas grill on or about _____. Initial medical evaluation occurred on 9/11/03 where a normal neurologic exam and negative bilateral leg raise are documented. Testing of the shoulder revealed a positive impingement sign. Clinical assessment following the initial evaluation included a diagnosis of lumbosacral strain and shoulder impingement.

Requested Service(s)

(73221-WP 22) MRI any joint of upper extremity, without contrast materials; (72148-WP 22) MRI spinal canal and contents, lumbar spine, without contrast materials for date of service 10/8/03.

Decision

I agree with the insurance carrier that the requested interventions are not medically necessary.

Rationale/Basis for Decision

Generally treatment of impingement syndrome includes exhaustion of usual and customary conservative measures of treatment prior to pre-operative diagnostic testing. Upon review of all documentation provided there is no evidence indicating exhaustion of all conservative measures of treatment including but not limited to oral non-steroidal anti-inflammatory medication, oral corticosteroid medication and injection. Impingement syndrome is a clinical condition that is generally treated for 4 to 6 months prior to any consideration of surgical intervention. There is no documentation of suspicion of rotator cuff tear or labral tear to indicate medical necessity of imaging studies so soon after the alleged injury.

Generally MRI of the lumbar spine is indicated in the presence of radiculopathy and/or progressive neurological disorder when a mass lesion is suspected. The clinical diagnosis following the alleged injury related to the lumbar spine was a lumbosacral strain. The claimant exhibited a normal neurologic exam and negative straight leg raise test. There is no documentation of progressive neurological disorder and/or radiculopathy to indicate the medical necessity of MRI of the lumbar spine in this clinical setting.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder