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

SOAH DOCKET NO. 453-04-0821.M5

MDR Tracking Number: M5-03-3091-01

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 July 28, 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 office visits, therapeutic exercises, myofascial release, joint mobilization, electrical stimulation, hot or cold packs, group therapy procedures were 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 treatment office visits, therapeutic exercises, myofascial release, joint mobilization, electrical stimulation, hot or cold packs, group therapy procedures were not found to be medically necessary, reimbursement for dates of service from 9/30/02 through 12/12/02 is denied and the Division declines to issue an Order in this dispute.

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

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

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 9/18/03

MDR Tracking Number: M5-03-3091-01

September 15, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application

of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Chronic low back pain purportedly secondary to an injury wherein she slipped and fell onto her 'tail bone' on ___. Her pain was temporarily alleviated by facet blocking procedures.

REQUESTED SERVICE(S)
Office visits, therapeutic procedure, myofascial release, joint mobilization, electrical stimulation, hot/cold packs, group therapy procedures for dates 9/30/02 through 12/12/02.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
Chronic pain syndrome patients are inappropriate candidates for passive therapeutic modalities including myofascial release, joint mobilization, electrical stimulation and hot/cold packs. Chronic pain syndrome patients are inappropriate candidates for unidisciplinary therapies.

Pivotal peer reviewed articles by ___ and ___ are references.

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.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of September 2003.