

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-04-7289.M5

MDR Tracking Number: M5-04-2189-01

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 March 17, 2004.

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 Est Ofc/Oth O/P Vst/Evl., myofascial release, joint mobilization/osteomani, therapeutic 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 listed above were not found to be medically necessary, reimbursement for dates of service from 03-24-03 to 05-03-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28<sup>th</sup> day of May 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

May 11, 2004  
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a medical physician 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 \_\_\_\_, 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

42-year-old male status post \_\_\_ injury with lumbar radiculopathy. He has undergone extensive therapies, injections, radiology and electrodiagnostics. Lastly, he has undergone L5-S1 microdiscectomy, and has multiple psychiatric Axis I diagnoses.

#### REQUESTED SERVICE (S)

Est Ofc/Oth O/P Vst/Evl, myofascial release, joint mobilization/osteo mani, therapeutic procedures for dates of service 3/24/03 – 5/3/03.

#### DECISION

Uphold denial.

#### RATIONALE/BASIS FOR DECISION

According to the Agency for Health Care Policy and Research (AHCPR) Guidelines, the North American Spine Society (NASS) treatment algorithms and Dr. Braddom's text *Physical Medicine and Rehabilitation*, therapeutic modalities are adjunctive treatments rather than primary curative interventions. Furthermore, ongoing therapies, especially passive treatments in this setting i.e. chronic pain, are not supported in the peer review literature.