

September 24, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 02 1194 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy with a specialty and board certified in Anesthesiology and with additional qualifications in pain management. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

I recently reviewed the medical information forwarded to me regarding ___ and her work-related event of ___. I have reviewed medical documentation submitted consisting of progress notes from ___ from 5-7-2002 through 7-23-2002. I have also reviewed previous physician adviser recommendations regarding requests for L4-5 and L5-S1 nucleoplasty.

There is no documentation in the records provided to me of the claimant's mechanism of injury. According to ___ notes, the claimant has bulging disks at L4-5 and L5-S1. She has failed a series of three epidural steroid injections, apparently as well as lumbar facet injections, and definitely radio frequency rhizolysis. He states nothing is helping the claimant's pain, which is described as lumbar pain radiating into the lower extremities bilaterally.

The claimant has also apparently been seen by at least one, possibly two, neurosurgeons, neither of who deems her to be a surgical candidate. ___ indicates in his 7-23-2002 note that the claimant has bulging disks that are "both intact". I do not, however, have the actual MRI report available to me for review.

Physical examination documents the claimant to weigh between 209 and 219 pounds, with no height given. Her physical exam documents generalized lumbar pain, with no neurologic deficits. On 6-4-2002 ___ documented a positive straight leg raising test bilateral at 5 degrees, causing

“severe pain”. His most recent physical exam documents lumbar spine tenderness, with no specific or focal findings.

REQUESTED SERVICE

L4-5 and L5-S1 Nucleoplasty

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

According to the physical examination, the claimant demonstrates positive straight leg raising at 5 degrees bilaterally. This is a non-physiologic finding, in all medical probability indicative of functional overlay, not true pathology. There is simply no mechanism by which a 5 degree straight leg raise could produce sufficient nerve root tension to cause any pain. Therefore, the documentation of such a result is more indicative of functional overlay than true physiologic pathology. According to ____, the claimant has bulging disks at L4-5 and L5-S1. Nucleoplasty is not medically indicated to treat “bulging disks.” It is indicated for treatment of self-contained disk herniations causing nerve root compression and subsequent physiologic pathology. There is no documentation of such a clinical condition in this claimant’s case.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TDI/TWCC.

Sincerely,

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.

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

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker’s Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).