

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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

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 May 11, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/th

**REVIEWER'S REPORT
M2-05-1316-01**

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Office notes 09/02/04 – 01/10/05

Electrodiagnostic evaluations 09/24/04 – 11/05/04

Radiology reports 07/21/04 – 12/17/04

Information provided by Respondent:

Correspondence

Designated doctor reviews

Information provided by Pain Management Specialist:

Office notes 08/12/04 – 09/21/04

Clinical History:

According to the records submitted, the claimant was involved in a work-related accident on _____. He apparently was initially taken to a hospital with complaints of low back and knee pain. He subsequently saw a chiropractor but did not improve. He ultimately sought treatment from the current treating doctor on 09/02/04. He had not noted any improvement with his chiropractic treatment and was seeking second opinion.

He subsequently underwent 2 EMG studies of the upper extremities and paracervical musculature and 2 separate MRI scans of the cervical spine. Both EMG studies were positive with the initial study of 09/24/04 interpreted as "showing evidence of left cubital tunnel syndrome; cervical EMG is within normal limits." The second study on 11/05/04 was interpreted as showing "electromyographic findings consistent with irritation of the bilateral C7 nerve root, greater on the left." The MRI scans, one performed on 09/09/04 was interpreted as "negative magnetic resonance imaging of the cervical spine; specifically, there is no evidence of disc herniation or other compromise of the spinal canal or neural foramina." The second study was performed on 12/17/04 with the impression being, "At C5/C6, a 1 or 2 mm posterior central disc protrusion causing slight concavity of ventral thecal sac without nerve root impingement. At C6/C7, a 1 or 2 mm right lateralizing posterior protrusion is present without nerve root impingement." Apparently the treating doctor has reviewed both MRI scans and disagrees with the radiologists' interpretations, specifically visualizing a large C6/C7 disc herniation with associated nerve root compression, and he has recommended anterior C6/C7 discectomy, interbody fusion, and plate procedure.

Disputed Services:

Anterior C6-7 discectomy interbody fusion and plate.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedure in dispute as stated above is not medically necessary in this case.

Rationale:

As was previously outlined in the designated doctor evaluation on 03/17/05, if EMG findings were consistent with cervical nerve root compression, then a myelogram and post-myelogram CT scan would be definitive in terms of diagnosis. In view of the disparate interpretations of the MRI scans by the radiologist and the treating doctor the definitive study would be a CT myelogram, which would determine one way or the other the necessity for the proposed surgical procedure. The gold standard for nerve root compression remains the CT myelogram. In view of the positive EMG findings, but relatively negative MRI scan findings interpreted by both radiologists with the contradictory interpretation by the treating doctor, CT myelogram would be the definitive study.