APPEAL NO. 001401

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on May 31, 2000. With respect to the single issue before him, the hearing officer determined that the appellant's (claimant) request for spinal surgery should not be approved. In his appeal, the claimant asserts error in that determination and requests that we reverse the hearing officer's decision and render a new decision approving the requested spinal surgery. In its response to the claimant's appeal, the respondent (carrier) urges affirmance.

DECISION

Affirmed.

It is undisputed that the claimant sustained a compensable low back injury on _____. On July 28, 1998, Dr. M performed a laminectomy and discectomy at L5-S1. On August 7, 1998, the claimant returned to surgery and Dr. M repaired a dural leak. The claimant testified that he began a course of postoperative physical therapy thereafter and that his back pain largely resolved. He stated that he then began a pain management program, which was similar to physical therapy but which he attended eight hours per day, and that he did not complete the program because he developed significant low back pain. The claimant returned to Dr. M, who ordered a repeat MRI. That MRI revealed recurrent herniation at L5-S1 and Dr. M recommended surgery, namely an anterior lumbar interbody fusion and complete discectomy with BAK cage fusion at L5-S1. Dr. M submitted a Recommendation for Spinal Surgery (TWCC-63) and the spinal surgery second opinion process was initiated.

Dr. JR was selected by the carrier as its second opinion doctor. In a report dated December 13, 1999, Dr. JR stated:

> I do not agree with the plan for interbody fusion with discectomy. I think prior to this [claimant] would need a discogram to really evaluate exactly where his back pain is coming from. In addition, in this patient with documented symptom magnification, I think that evaluation by a pain psychologist for whether or not he would psychologically be able to benefit from surgery is in order.

In a document entitled a "Follow-up Progress Note," which is also dated December 13, 1999, Dr. JR states that the "patient is not recommended for surgery at this time. I would recommend that we review his MRI scans and also recommend a discogram to evaluate his situation as well as pain management evaluation."

Dr. RR was selected to serve as the claimant's second opinion doctor. Dr. RR examined the claimant on January 7, 2000. In his report, Dr. RR stated that he would recommend "an L4-5 discogram to ensure that this disc is not painful. Otherwise, the

anterior lumbar interbody fusion and complete discectomy and decompression from the front would be indicated, as per [Dr. M]." On February 15, 2000, the claimant underwent a lumbar discogram at L2-3, L3-4, L4-5, and L5-S1, which was performed by Dr. S. The discogram was interpreted as revealing concordant pain at L3-4, L4-5, and L5-S1, with the worst pain being at L5-S1 and a normal disc at L2-3. In a "Follow-up Progress Note" dated March 6, 2000, Dr. RR stated that he had reviewed the records forwarded to him concerning the claimant's discogram. Dr. RR concluded:

> Given the fact that the patient has positive provocation studies at the lower three levels, it is my opinion that the patient is not a candidate for a single level disc replacement. Should [Dr. M] wish to alter his surgical plan and recommend multi-level fusion, I think that this certainly could be considered given the chronicity and severity of this patient's problem. I would certainly leave that to both the patient and [Dr. M] to discuss. My only recommendation is that very strict adherence be paid to informed consent so the patient knows what he is buying into with less than likely satisfactory response to the surgery.

In Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 133.206(a)(13) (Rule 133.206(a)(13)) the term "concurrence" is defined as follows:

> A second opinion doctor's agreement that the surgeon's proposed type of spinal surgery is needed. Need is assessed by determining if there are any pathologies in the area of the spine for which surgery is proposed (i.e. cervical, thoracic, lumbar, or adjacent levels of different areas of the spine) that are likely to improve as a result of the surgical intervention. Types of spinal surgery include but are not limited to: stabalizing procedures (e.g. fusions); decompressive procedures (e.g. laminectomy); exploration of fusion/removal of hardware procedures; and procedures related to spinal cord stimulators.

Rule 133.206(k)(4) provides that of the three recommendations and opinions, those of the surgeon and the two second opinion doctors, presumptive weight will be given to the two which have the same result and that their result will be upheld unless the great weight of the other medical evidence is to the contrary. The hearing officer determined that neither Dr. JR nor Dr. RR concurred in the proposed surgery and that the great weight of the other medical evidence was not contrary to the result reached by Dr. JR and Dr. RR. Thus, he further determined that the proposed spinal surgery should not be approved.

In his appeal, the claimant contends that Dr. JR "gave a tentative agreement conditioned upon obtaining a discogram and psychological evaluation prior to approval." We find no merit in this assertion. In his report, Dr. JR stated that he did "not agree with the plan for interbody fusion with discectomy" and that "the patient is not recommended for surgery at this time." Accordingly, we cannot agree that the hearing officer erred in

determining that Dr. JR's opinion was not a concurrence within the meaning of Rule 133.206(a)(13).

The claimant also contends that Dr. RR concurred in the proposed surgery, based upon Dr. RR's January 7, 2000, report. In that report, Dr. RR recommended an L4-5 discogram to ensure that that disc was not painful and stated that "[o]therwise, the anterior lumbar interbody fusion and complete discectomy and decompression from the front would be indicated . . . ." As noted above, the discogram was performed, Dr. RR reviewed the results, and he issued a revised report dated March 6, 2000. In order to qualify as a concurrence under Rule 133.206(a)(13), the second opinion doctor must agree on the proposed type of spinal surgery and the region (cervical, thoracic, lumbar, or sacral) of the spine involved. However, the second opinion doctor does not have to agree on the approach (anterior, posterior, instrumentation, cages, etc.) or on the number of levels within the region in which the recommended surgery will be performed. Thus, if Dr. RR agrees that the claimant needs fusion surgery within the meaning of Rule 133.206(a)(13), albeit at three levels, then that recommendation would serve as a concurrence with the surgery proposed by Dr. M. Thus, the critical question becomes one of determining if Dr. RR's March 6, 2000, report recommends that three-level fusion surgery is needed. In considering that question, it is instructive to consider the language of Dr. RR's report within the framework of the definition of the term concurrence in Rule 133.206(a)(13). Dr. RR states "[g]iven the fact that the patient has positive provocation studies at the lower three levels, it is my opinion that the patient is not a candidate for a single level disc replacement. Should [Dr. M] wish to alter his surgical plan and recommend multi-level fusion, I think that this certainly could be considered given the chronicity and severity of this patient's problem." By stating that a three-level fusion "certainly could be considered," we cannot agree that Dr. RR is opining that three-level fusion surgery is "needed" within the meaning of Rule 133.206(a)(13). Rather, at most, he appears to be proposing three-level fusion surgery as a possibility. In addition, it is important to note that Rule 133.206(a)(13) provides that need "is assessed by determining if there are any pathologies in the area of the spine for which surgery is proposed (i.e. cervical, thoracic, lumbar, or adjacent levels of different areas of the spine) that are likely to improve as a result of the surgical intervention." (Emphasis added.) In his report, Dr. RR also states that "[m]y only recommendation is that very strict adherence be paid to informed consent so the patient knows what he is buying into with less than likely satisfactory response to the surgery." From this language, it follows that Dr. RR's opinion cannot qualify as a concurrence in that he does not believe that the claimant's condition will improve as a result of the surgery. To the contrary, he predicts a poor surgical response. For the foregoing reasons, we believe that the hearing officer properly determined that Dr. RR's opinion is not a concurrence as that term is defined in Rule 133.206(a)(13).

As noted above, pursuant to Rule 133.206(k)(4), presumptive weight is given to the two opinions that reach the same result, unless the great weight of the other medical evidence is to the contrary. The hearing officer determined that the great weight of the other medical evidence was not contrary to the opinions from Dr. JR and Dr. RR that the proposed type of surgery was not indicated; thus, he further determined that the surgery

should not be approved. Our review of the record does not demonstrate the hearing officer's decision in that regard is so against the great weight of the evidence as to be clearly wrong or manifestly unjust. Accordingly, no sound basis exists for us to reverse the decision on appeal. Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986); Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

The hearing officer's decision and order are affirmed.

Elaine M. Chaney
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Robert W. Potts
Appeals Judge