MEDICAL CONTESTED CASE HEARING NO. 10155
M6-09-21293-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A medical contested case hearing was held on January 4, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (hereinafter "IRO") that the Petitioner / Claimant is not entitled to outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast for the compensable injury of _____?

PARTIES PRESENT

Petitioner / Claimant appeared and was assisted by MW, ombudsman. Respondent / Carrier appeared and was represented by TW, attorney.

BACKGROUND INFORMATION

Petitioner / Claimant injured his lower back on _____. A MRI performed on February 24, 2003 revealed a posterior disc herniation of 5 to 6 mm at L4-L5. He received medical treatment, but did not improve. Eventually, on May 23, 2005, Dr. B, M.D., performed a posterior lumbar decompression and fusion at L4-L5 with interbody fusion cages CODA with reduction of a spondylitises, posterolateral bone fusion at L4-L5 with autologous bone graft, pedicle screw fixation at L4-L5, medial facetectomy, foraminotomy, interbody fusion. It was documented in the evidence that Petitioner / Claimant continued to visit with Dr. B up through May 3, 2006. However, there is a gap in medical treatment until his visit with Dr. B on April 1, 2009. Dr. B requested a repeat MRI and a CT of the lumbar due to Petitioner / Claimant's complaints. Such requested treatment underwent utilization review on June 18, 2009 and was denied. Reconsideration was requested and such reconsideration was denied on July 20, 2009. Petitioner / Claimant then appealed the denials to an IRO and the IRO reviewer upheld the previous adverse determinations. Consequently, Petitioner / Claimant appealed the IRO decision and is the reason for the present discussion and decision.

DISCUSSION

Medical Necessity

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. TEX. LAB. CODE § 408.021. "Health care reasonably required" is defined as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine or, if evidence-based medicine is not available, then

generally accepted standards of medical practice recognized in the medical community. TEX. LAB. CODE § 401.011 (22a). Health care under the Texas Workers' Compensation system must be consistent with evidence-based medicine if that evidence is available. "Evidence-based medicine" means the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. TEX. LAB. CODE § 401.011 (18a). The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. TEX. LAB. CODE § 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with the Texas Labor Code. TEX. LAB. CODE § 413.017(1).

In accordance with the above statutory guidance, the Division has adopted treatment guidelines by rule. 28 Tex. Admin. Code § 137.100 (Division Rule 137.100). This Rule directs health care providers to provide treatment in accordance with the current edition of the *Official Disability Guidelines* (hereinafter "ODG") and that such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG.

The pertinent provisions of the ODG applicable to this case are as follows, to wit:

> **CT & CT Myelography (computed tomography):**
>
> Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. (Shekelle, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-*Lancet*, 2009)
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> **Indications for imaging -- Computed tomography:**
> - Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
> - Thoracic spine trauma: with neurological deficit
> - Lumbar spine trauma: trauma, neurological deficit
> - Lumbar spine trauma: seat belt (chance) fracture
> - Myelopathy (neurological deficit related to the spinal cord), traumatic
> - Myelopathy, infectious disease patient
> - Evaluate pars defect not identified on plain x-rays
> - Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)

MRI's (magnetic resonance imaging):

Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversary over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and annular tears, are poor, and these findings alone are of limited clinical importance. (Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. (Kinkade, 2007) Baseline MRI findings do not predict future low back pain. (Borenstein, 2001) MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. (Carragee, 2006) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (Kleinstück, 2006) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. (Shekelle, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-*Lancet*, 2009) Despite guidelines recommending parsimonious imaging, use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. (Deyo, 2009) As an alternative to MRI, a pain assessment tool named Standardized Evaluation of Pain (StEP), with six interview questions and ten physical tests, identified patients with radicular pain with high sensitivity (92%) and specificity (97%). The diagnostic accuracy of StEP exceeded that of a dedicated screening tool for neuropathic pain and spinal magnetic resonance imaging. (Scholz, 2009) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading Richard Deyo, in the Archives of Internal Medicine to call the fascination with lumbar spine imaging an idolatry. (Pham, 2009) There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or

subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. See also ACR Appropriateness Criteria™. See also Standing MRI.

Indications for imaging -- Magnetic resonance imaging:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

In the instant case, both parties relied on the ODG in support of their respective positions for or against the requested treatment. When both parties cite the ODG in support of their respective positions, such positions must be supported by sufficient medical evidence to justify application of the ODG in the manner promulgated. Both of the utilization review doctors denied the requested treatment and the IRO reviewer upheld the denial of the requested treatment citing to relevant provisions of the ODG. Specifically, there was no mention of and/or documentation of progressive neurological deficits or abnormalities in the clinical examinations of Petitioner / Claimant. *See* ODG, *supra*. As such, the IRO reviewer who is board certified in orthopedic surgery reviewed the records and upheld the adverse determinations of the utilization review doctors. Essentially, the IRO reviewer opined that the records were lacking clinical evidence explaining why the requested treatment was needed and as such the requested treatment could not be approved. Thereafter, the IRO reviewer cited medical judgment, clinical experience and expertise in accordance with accepted medical standards and the ODG in upholding the denials of the requested treatment.

When weighing expert testimony, the hearing officer must first determine whether the doctor rendering an expert opinion is qualified to offer such. In addition, the hearing officer must determine whether the opinion is relevant to the issues at bar and whether it is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See Black v. Food Lion, Inc.*, 171 F.3d 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *See Black*, 171 F.3d 308. In determining reliability of the evidence, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can

be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. *Kelly v. State*, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990) *aff'd*, 824 S.W.2d 568 (Tex. Crim. App. 1992).

Additionally, "[a] decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal." *See* Division Rule 133.308 (t). "In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence." *Id*. Accordingly, Petitioner / Claimant, as the party appealing the IRO decision, has the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. In this case, sufficient evidence-based medical evidence to justify application of the ODG in the manner promulgated was lacking. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that Petitioner / Claimant is not entitled to outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast for the compensable injury of _____.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Petitioner / Claimant was the employee of (Self-Insured), the Employer.

   C. On _____, Petitioner / Claimant sustained a compensable injury.

   D. The IRO determined that Petitioner / Claimant is not entitled to outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast for the compensable injury of _____.

2. Respondent / Carrier delivered to Petitioner / Claimant a single document stating the true corporate name of Respondent / Carrier, and the name and street address of Respondent / Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast is not health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that Petitioner / Claimant is not entitled to outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast for the compensable injury of _____.

DECISION

Petitioner / Claimant is not entitled to outpatient CT of the lumbar spine without contrast and MRI of the lumbar spine with and without contrast for the compensable injury of _____.

ORDER

Respondent / Carrier is not liable for the benefits at issue in this hearing. Petitioner / Claimant remains entitled to medical benefits for the compensable injury in accordance with § 408.021.

The true corporate name of the insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is

FR, INTERIM SUPERINTENDENT
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 26th day of January 2010.

Julio Gomez, Jr.
Hearing Officer