MEDICAL CONTESTED CASE HEARING NO. 10161
M6-10-24329-01

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.

ISSUES

A contested case hearing was held on April 13, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a low pressure lumbar discogram with post CT Scan with contrast at L4-L5 and L5-S1 for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by JO, ombudsman. Petitioner/Provider Dr. B appeared without representation. Respondent/Carrier appeared and was represented by KB, attorney.

BACKGROUND INFORMATION

Claimant, an airline technician, was injured in the course and scope of his employment on _____. While working on an aircraft installing a part, Claimant twisted his knee and injured his lower back. Regarding his lumbar spine, Claimant was diagnosed with a right L5-S1 disc herniation with lumbar radiculopathy. Claimant was treated with medications, physical therapy, injections, and chiropractic adjustments. Dr. W, orthopedic surgeon, performed a lumbar decompression on the right at L5-S1 on July 2, 2008. Subsequent to surgery, Dr. W ordered a repeat MRI that was performed on September 11, 2008. The MRI revealed post surgical changes at L5-S1 and a disc bulge at L4-L5. The remainder of the MRI was reported as normal. On February 5, 2009, Dr. W noted that Claimant may have a recurrent herniation and recommended pain management. Dr. W stated that if symptoms persisted, Claimant would be a candidate for a revision decompression or a more significant lumbar reconstruction. The medical records indicate Claimant is currently receiving chiropractic care from Dr. B for his injuries and has been referred to Dr. B, orthopedic surgeon, for surgical evaluation.

Dr. B examined Claimant on September 22, 2009, October 28, 2009 and October 29, 2009 and diagnosed him with a herniated disc at L5-S1. Dr. B discussed surgery with Claimant and referred him for a psychological evaluation. The psychological evaluation indicated that Claimant fell into the average to above average range on all testing. Dr. B's October 29, 2009 visit note indicates Claimant has mechanical back pain of diskogenic origin and that the pain could be coming from the protrusion at L4-L5 or the herniation at L5-S1, or both. Dr. B recommended a lumbar discogram with post CT Scan to aid in his determination regarding fusion surgery.

After Dr. B requested pre-authorization for the discogram, two utilization reviews were conducted. Both utilization reviews denied the request because the Official Disability Guides (ODG) does not recommend discography. Dr. B appealed the Carrier's decision to an Independent Review Organization (IRO). The IRO upheld the Carrier's denial and provided the same reason as the utilization reviews. Dr. B appealed the decision of the IRO to a Medical Contested Case Hearing.

DISCUSSION

Texas Labor Code Section 408.021 provides that 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. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) 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. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be 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. 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. (Texas Labor Code Section 413.011(e).) Medical services consistent with the medical policies and fee guidelines adopted by the Commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and 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. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered parties to an appeal. 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."

With regard to discography, the ODG provides as follows:

> Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain

reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion). (Carragee-*Spine*, 2000) (Carragee2-*Spine*, 2000) (Carragee3-*Spine*, 2000) (Carragee4-*Spine*, 2000) (Bigos, 1999) (ACR, 2000) (Resnick, 2002) (Madan, 2002) (Carragee-*Spine*, 2004) (Carragee2, 2004) (Maghout-Juratli, 2006) (Pneumaticos, 2006) (Airaksinen, 2006) (Manchikanti, 2009) Discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These finding are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with

small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 2009) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD). **Discography is Not Recommended in ODG.**

Patient selection criteria for Discography if provider & payor agree to perform anyway:

o Back pain of at least 3 months duration

o Failure of recommended conservative treatment including active physical therapy

o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)

o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of

significant back pain for prolonged periods after injection, and therefore should be avoided)
o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
o Briefed on potential risks and benefits from discography and surgery
o Single level testing (with control) (Colorado, 2001)
o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

To overcome the IRO's decision, Dr. B provided his expert medical testimony. During his testimony, Dr. B relied on several medical journal articles to support the medical necessity of the discogram, including an article cited by the ODG from the Pain Physician Journal 2009; 12:541-559 entitled, "Systemic Review of Lumbar Discography as a Diagnostic Test for Chronic Low Back Pain," by Dr. Laxmaiah Manchikanti et. al. He also cited an article from the Journal of the American Academy of Orthopaedic Surgeons 2006; 14:46-55 by Drs. Spiros G. Pneumaticos, Charles A. Reitman, and Ronald W. Lindsey. The article by Pneumaticos et. al. (2006) contains the following information regarding indications for discography:

o Unremitting spinal pain, with or without extremity pain of >4 months' duration, not responsive to all standard methods of conservative treatment.
o Persistent disk-related pain, suspected when other evaluation modalities are equivocal
o Persistent pain in the postoperative period as a result of suspected intervertebral disk degeneration, recurrent herniation, or a pseudoarthrosis
o Disk space evaluation in a spine segment considered for fusion to determine whether it is a pain generator
o Determination of the primary symptom producing level or levels when chemonucleosis or other intradiskal procedures are being contemplated.

The potentially painful level should be consistent with the findings on physical examination, plain radiographs, and MRI. In these select discogenic back pain patients, discography serves as a test to confirm, not determine, the need for surgical intervention.

Dr. B testified that he believes Claimant is a good candidate for a lumbar discogram. Dr. B testified that Claimant has had back pain for many months; he has undergone conservative treatment; a psychological screen indicates no confounding issues and the MRI performed on September 11, 2008 indicates positive findings at L4-L5 and L5-S1. Dr. B stated that the lumbar discogram will aid in his determination regarding a proposed lumbar L5-S1 discectomy and fusion. Dr. B's testimony supports the criteria found in the article by Pneumaticos et. al. as well as the criteria found in the ODG.

Dr. B testified that the fusion section of the ODG recommends discography prior to surgery. Dr. B testified that he has reviewed the discography section of the ODG and its conclusions rely heavily on studies performed by authors E.J. Carragee and R. Chou. Dr. B stated that there are recent studies supporting the use of discography, specifically the 2009 article by Manchikanti et. al. In his testimony, Dr. B referenced the conclusion found in the Manchikanti article which indicates that discography may be a useful tool for evaluation of chronic lumbar discogenic pain. Dr. B also testified that the 2005 articles by Dr. Richard Derby and Dr. Lee Wolfer that are referenced in the ODG do not rule out lumbar discography as an effective diagnostic tool. Dr. B's testimony supports the medical necessity of the lumbar discogram with post CT Scan and he relies on medical literature in recognized professional journals to support his opinion. The claimant and provider have shown by a preponderance of evidence-based medicine that the requested lumbar discogram with post CT Scan is health care reasonably required for the compensable injury.

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 _____, Claimant was the employee of (Employer).

   C. Claimant sustained a compensable injury on _____.

   D. The Independent Review Organization determined that the requested service was not a reasonable and necessary health care service for the compensable injury of _____.

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

3. A low pressure lumbar discogram with post CT Scan with contrast at L4-L5 and L5-S1 is 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 contrary to the decision of the IRO that a low pressure lumbar discogram with post CT Scan with contrast at L4-L5 and L5-S1 is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to a low pressure lumbar discogram with post CT Scan with contrast at L4-L5 and L5-S1 for the compensable injury of _____.

ORDER

Respondent/Carrier is liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is:

CORPORATE SERVICES
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701

Signed this 21st day of April, 2010.

Jacquelyn Coleman
Hearing Officer