

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

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan for the compensable injury on \_\_\_\_\_?

**PARTIES PRESENT**

The petitioner/claimant appeared and was assisted by TM, ombudsman. The respondent/carrier appeared and was represented by BJ, attorney.

**BACKGROUND INFORMATION**

The claimant sustained a slip and fall compensable injury on \_\_\_\_\_. She suffered left knee and low back injuries which resulted in two knee surgeries and a laminectomy/discectomy at the L4-5 level of her lumbar spine in 2008. The claimant has continued to have unremitting lumbar and lower extremity pain despite the surgery, epidural injections, physical therapy, and pain management programs. Dr. P, D. O., the claimant's treating doctor requested a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan. In reviewing the request, the first utilization review doctor, a rehabilitation and physical medicine physician, denied the request based on a lack of physical therapy progress notes indicating non-improvement, and an absence of objective documentation of the claimant's clinical and functional response from the epidural steroid injections, i.e. insufficient documentation of the failure of conservative care.

The utilization review doctor who reviewed the request on reconsideration, an orthopedic surgeon, also denied the request for the discogram, again on the basis of insufficient documentation of the "failure of conservative management done to the [claimant] including physical therapy progress notes . . . [and] of the [claimant's] clinical and functional response from the . . ." epidural injections.

An IRO reviewer, a doctor of physical, rehabilitation and pain management medicine, upheld the carrier's denial of the lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan. The IRO reviewer noted that the discogram was being "requested for possible pre-surgical planning, but the specific surgical interventions being considered are not documented." The reviewer also noted that discograms are not supported by the Official Disability Guides (ODG).

## 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 are 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."

On the date of this medical contested case hearing, the ODG provides the following with regard to lumbar discograms:

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 findings 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

Dr. F, M. D., a doctor specializing in physical medicine, was called as an expert witness by the claimant. Dr. F testified that, having treated the claimant for several years, he was aware of her ongoing pain and the failure of conservative medicine, and that the claimant had been cleared by a psychological evaluation for lumbar surgery. Dr. F endorsed the request for the discogram. However, Dr. F testified that the claimant was a “potential” lumbar surgical candidate, and that if the discogram confirmed the suspected pain generator that the claimant would probably be recommended for fusion surgery. That is, the discogram was being requested as a diagnostic tool to determine whether or not to recommend fusion surgery.

In the record was an October, 2009 report from Dr. P, the claimant's treating doctor, in which he described why he believed the discogram he was requesting and recommending was valid treatment for the claimant. He asserted that there were just as many studies supporting discography as there were critical of the procedure. However, none of the studies he cited were in evidence, and he did not testify. And, as did Dr. F, Dr. P, who also specializes in physical medicine and rehabilitation and pain management, described the discogram as being a “. . . presurgical planning tool and given the MRI results, it is crucial to identify which level(s) are involved as it will impact the type and extent of surgery. His[sic] surgeon (Dr. R) would like a discogram . . . to identify the pain generator.”

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. As doctors of physical medicine, rehabilitation and pain management, Dr. F and Dr. P are qualified to offer opinions on the claimant's treatment. The trier of fact must then determine whether an opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See Black vs. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995).

Health care providers are directed to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be reasonably required. (28 Tex. Admin. Code § 137.100 (Rule 137.100)). The discogram recommended by Dr. F and Dr. P is not consistent with the directives contained in the current edition of the ODG. Dr. F and Dr. P failed to support their opinions with evidence based medicine. Although qualified to render opinions on the best course of treatment for the claimant, Dr. F and Dr. P have failed to show that the proposed course of care is medically necessary in light of evidence based medicine, and the preponderance of the evidence is not contrary to the IRO decision.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet her burden of overcoming the IRO decision by a preponderance of the evidence-based medicine.

The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan prescribed in the ODG. The requested discogram does not come within the very limited exceptions for approval by the ODG—the request is for a two, not one, level discogram with control, and the discogram is for the pre-surgical purpose of determining whether fusion surgery should be recommended for the claimant. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to the proposed lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan.

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 Workers' Compensation Division of the Texas Department of Insurance.
  - B. On \_\_\_\_\_, the claimant was the employee of (Employer).
  - C. On \_\_\_\_\_, the claimant sustained a compensable injury to her left knee in the form of a strain, and a disc herniation at the L4-5 level of her lumbar spine.
  - D. The IRO determined that the claimant is not entitled to a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan.
2. The carrier delivered to the claimant a single document stating the true corporate name of the carrier, and the name and street address of the carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. A lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan is not health care reasonably required for the compensable injury of \_\_\_\_\_.

### **CONCLUSIONS OF LAW**

1. The Workers' Compensation Division of the Texas Department of Insurance 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 a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan is not health care reasonably required for the compensable injury of \_\_\_\_\_.

**DECISION**

The claimant is not entitled to a lumbar discogram at L3-4, L4-5, and L5-S1 with a post-CT scan for the compensable injury of \_\_\_\_\_.

**ORDER**

The carrier is not liable for the benefits at issue in this hearing. The claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is:

**RON WRIGHT  
6210 EAST HIGHWAY 290  
AUSTIN, TEXAS 78723-1098**

Signed this 20<sup>th</sup> day of May, 2010.

William M. Routon, II  
Hearing Officer