

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 August 5, 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 a repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays are not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner (Claimant) appeared and was assisted by MF, ombudsman. Respondent (Carrier) appeared and was represented by BJ, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable injury on _____, when a ladder he was working on fell. Claimant's injuries were initially believed to be limited to his right shoulder and hip, but a transverse process fracture at L2-L3 was later diagnosed. Claimant had surgery on his right shoulder, but the transverse process fracture was believed to be adequately healed and he received no ongoing care for his back. In May of 2009, Claimant went to Dr. F, MD of the (Healthcare Provider) in (City), (State), complaining of chronic back pain, a loss of feeling in his hands, sharp pain in his fingers, and a popping sound associated with pain going down his left leg. Dr. F ordered an MRI that was performed on June 8, 2009. The MRI revealed multi-level degenerative changes with moderate degenerative disc disease at L5-S1, bulging at L3-4, L4-5, and L5-S1, and mild to moderate central spinal canal narrowing at L3-4.

Dr. F instituted conservative care. In the latter part of 2009, he decided to refer Claimant to Dr. B of the (Healthcare Provider 2). Before Dr. B would agree to see Claimant, he wanted a repeat MRI and AP lateral flexion and extension x-rays. Dr. F requested preauthorization for the studies, but Carrier's utilization review agent (URA) recommended that they be denied. In a letter dated January 20, 2010, Dr. F requested that Carrier reconsider his request for a neurosurgical or occupational health consultation. He advised Carrier that approval of the neurosurgical consult would require the approval of a repeat lumbar MRI and lumbar AP/flexion/extension x-rays because "it is the policy of the neurosurgeons (sic) that [these] tests (sic) performed within 6 months of the patients (sic) initial visit." On April 20, 2010, Dr. F wrote that he had tried to secure an appointment for Claimant with the neurosurgeons, but they required plain films, MRIs, and a guarantee of coverage from Carrier before the appointment could be scheduled.

The initial denial was appealed to a second URA and was again denied. Claimant then requested that the denial be reviewed by an IRO. The Texas Department of Insurance appointed (Independent Review Organization) as the IRO and (Independent Review Organization) forwarded the request to a medical doctor licensed to practice in the State of Texas. The IRO decision states that the physician reviewer is certified by the American Board of Orthopaedic Surgery. On March 15, 2010, the parties were notified that the physician reviewer had upheld Carrier's denial. The physician reviewer stated that there was no clinical indication for repeating the studies based on the data presented. He stated that the findings of the June 2009 MRI would explain Claimant's current symptoms, that there was no progressive neurologic deficit and no new symptoms and that the standards in the Official Disability Guidelines (ODG) for a repeat MRI had not been met. Claimant appealed that determination, requesting a contested case hearing.

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 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."

ODG entries on MRIs, radiography (x-rays), and flexion/extension x-rays, for treatment of the low back state:

MRI (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 controversy (sic) 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 anular 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) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study. (Matsumoto, 2010) 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. (Emphasis added.)

Radiography (x-rays)

Not recommend (sic) routine x-rays in the absence of red flags. (See indications list below.) **Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks.** However, some providers feel it “may” be appropriate when the physician believes it would aid in patient expectations and management. The theory is that this reassurance (sic) may lessen fear avoidance regarding return to normal activities and exercise, but this has not been proven. (Ash, 2008) Indiscriminant imaging may result in false positive findings that are not the source of painful symptoms and do not warrant surgery. A history that includes the key features of serious causes will detect all patients requiring imaging. (Kendrick, 2001) (Bigos, 1999) (Seidenwurm, 2000) (Gilbert, 2004) (Gilbert2, 2004) (Yelland, 2004) (Airaksinen, 2006) (Chou, 2007) According to the American College of Radiology, “It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies.” (ACR, 2000) A Recent quality study concludes that MRI is no better than x-rays in management of low back pain, if the cost benefit analysis includes all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) The new proposed HEDIS (Health plan Employer Data Information Set) report card on the use of imaging for low back is scheduled to go into effect on Jan 1, 2005. This new standard is the first one in which the issue is over utilization. In young and middle-aged adults, with new episodes of mechanical LBP, without any indication of comorbid complications, the new standard assumes that there is no indication for imaging. (HEDIS, 2004) The new ACP/APS guideline as compared to the old AHCPR guideline is similarly cautious about the use of plain x-ray imaging, but now more strongly supported by the availability of randomized trials showing no benefit for early x-ray imaging. (Shekelle, 2008) New research shows that healthcare expenditures for back and neck problems have increased substantially over time, but with little improvement in healthcare outcomes such as functional disability and work limitations. Rates of imaging, injections, opiate use, and spinal surgery have

increased substantially over the past decade, but it is unclear what impact, if any, this has had on health outcomes. (Martin, 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) See also ACR Appropriateness Criteria™. See also Flexion/extension imaging studies. (Emphasis added.)

Indications for imaging -- Plain X-rays:

- Thoracic spine trauma: severe trauma, pain, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma (a serious bodily injury): pain, tenderness
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70
- Uncomplicated low back pain, suspicion of cancer, infection
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient
- Post-surgery: evaluate status of fusion

Flexion/extension imaging studies

Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability (sic), may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. See Fusion (spinal).

Claimant offered medical reports from Dr. F and Dr. K, DO in support of his assertion that the preponderance of the evidence based medical evidence is contrary to the IRO decision. Dr. F, as noted above, recommended the repeat MRI and the plain x-rays because Dr. B would not agree to see Claimant without the new studies. Dr. K stated that it was his understanding that Dr. B had ordered the MRI in June of 2009 and wanted another MRI “so they can decide which treatment to do for [Claimant].” He hypothesized that Dr. B would probably refer Claimant to a pain management specialist for a discogram and possibly some epidural injections. If the discogram was positive, Dr. K believed that Dr. B would recommend a lumbar fusion. Neither Dr. F nor Dr. K offered an evidence-based medical opinion contrary to the IRO. The IRO opinion is consistent with the ODG. Under the facts in evidence, the preponderance of the evidence-based medicine is not contrary to the IRO decision.

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. Claimant sustained a compensable injury on _____, while employed by (Employer).
 - C. The Texas Department of Insurance appointed (Independent Review Organization) as the Independent Review Organization (IRO) in this matter.
 - D. The IRO upheld Carrier's denial of the request for a repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays.
- 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. The IRO decision that a repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays are not medically necessary is consistent with the recommendations in the most recent edition of the ODG.
 - 4. A repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays are not reasonably required health care 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 IRO that a repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays are not reasonably required health care for the compensable injury of _____.

DECISION

Claimant is not entitled to a repeat lumbar MRI and lumbar AP lateral flexion and extension x-rays for the compensable injury of _____.

ORDER

Carrier is not 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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**RON WRIGHT, PRESIDENT
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723**

Signed this 11th day of August, 2010.

KENNETH A. HUCTION
Hearing Officer