

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 December 6, 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 MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities is not health care reasonably required for Claimant's compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by JM, ombudsman. Carrier/Respondent appeared and was represented by RT, attorney.

BACKGROUND INFORMATION

In this Decision and Order, the acronyms MRI refers to magnetic resonance imaging, EMG refers to electromyography, and NCV refers to nerve conduction velocity. The NCV is sometimes referred to as a NCS or nerve conduction study. Concerning the merits of Claimant's case, it is undisputed that Claimant sustained a compensable lumbar sprain/strain and an L5/S1 annular tear injury on _____. Claimant has undergone conservative treatment, including prescribed medication, lumbar epidural steroid injections, and diagnostic tests. Claimant has treated with several health care providers, and currently is treating with Dr. C, D.O. Dr. C has recommended that Claimant undergo a lumbar MRI and an EMG/NCV study of the bilateral lower extremities.

Claimant underwent a lumbar MRI on February 16, 2000, that revealed Claimant had a minimal disc bulge at L3/4 without central stenosis or neural foramina encroachment; and a probable small annular tear L5/S1 disc without central stenosis, focal herniation, or neural foramina encroachment. On March 17, 2000, Claimant underwent an EMG/NCS of the bilateral lower extremities that revealed mild L5 radiculopathy on the right. Dr. H (1), M.D., examined Claimant on August 22, 2000, diagnosed Claimant with low back pain and lumbosacral radiculopathy, and referred Claimant to Dr. H (2), M.D., for a series of lumbar epidural steroid injections. Dr. H (2) treated Claimant from December 4, 2000, through April 1, 2001, and diagnosed Claimant with degenerative disc disease of the lumbar spine, annular bulging at L3/4 and L4/5, and radiculopathy of the lower bilateral extremities. Dr. H (2) administered a series of lumbar epidural steroid injections to Claimant in 2001.

Claimant subsequently came under the care of Dr. C. Dr. C initially treated Claimant from April 2, 2003, through September 25, 2003, and diagnosed Claimant with lumbar degenerative disc

disease, degenerative joint disease, intractable lumbar pain, and bilateral lower extremity radiculopathy. Dr. C resumed treating Claimant in either 2009, or 2010, and indicated in a letter dated November 2, 2009, that he last examined Claimant on September 25, 2003. In the interim, Claimant obtained additional prescribed medication from Dr. H (1) in 2004, and underwent a required medical examination with Dr. F, M.D., on April 22, 2004. Dr. F performed a lumbar MRI on April 22, 2004, and determined that Claimant had a minimal bulge at L5/S1 with disc desiccation at L3/4 and L5/S1.

Dr. S, M.D., performed a CT scan of Claimant's lumbar spine at the (VA) on March 7, 2007. Dr. S (1), a radiologist, determined that Claimant's lumbar CT scan was essentially normal with no focal herniated discs at L3 through L5, and a minimal annular bulge at L3/4. On April 24, 2009, Claimant underwent an EMG/NCV study of his bilateral lower extremities at the VA that revealed evidence of severe sensorimotor peripheral neuropathy, and was determined to be worse than the EMG/NCV study performed on March 7, 2005. The EMG/NCV further revealed that there was no electromyographic evidence of acute lumbosacral radiculopathy. Claimant underwent a lumbar MRI at the VA on May 11, 2009, that revealed partially desiccated discs at L3/4 and L5/S1, and mild central canal stenosis at L3/4. Dr. V, M.D., examined Claimant and reviewed Claimant's diagnostic studies at the VA, and diagnosed Claimant with low back pain, facet joint arthropathy, degenerative joint disease, and moderate to severe sensorimotor peripheral neuropathy.

Claimant subsequently sought additional medical treatment with Dr. C, and Dr. C recommended that Claimant undergo an MRI of the lumbar spine and EMG/NCV of the bilateral lower extremities for the compensable injury. Dr. C forwarded his preauthorization request to Carrier. On June 28, 2010, Dr. S (2), M.D., performed a utilization review (UR). Dr. S (2), an orthopedic surgeon, recommended that Carrier deny Dr. C's request for the MRI of the lumbar spine and EMG/NCV of the bilateral lower extremities based on Claimant not meeting the Official Disability Guidelines (ODG) criteria. In addition to citing the ODG, Dr. S (2) opined that the requested MRI of the lumbar spine was not reasonable or medically necessary because Claimant has undergone conservative treatment since the date of his compensable injury, and there was no indication that a repeat lumbar MRI would have any impact on Claimant's treatment plan. Dr. S (2) further opined that it was obvious that Claimant had been clinically diagnosed with radiculopathy, and that a repeat EMG/NCV of the bilateral lower extremities was not recommended by the ODG. Carrier denied Dr. C's request for an MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities for the compensable injury as being not reasonable or medically necessary.

Dr. C requested reconsideration by Carrier. On July 10, 2010, Dr. W, M.D., performed a UR. Dr. W, an orthopedic surgeon, recommended that Carrier deny Dr. C's request for the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities based on Claimant not meeting the ODG criteria. Dr. W noted that Claimant's medical records had indicated that Claimant had sustained a low back injury, and had subjective findings of sciatic radicular symptomatology. Dr. W further noted that there was no medical diagnosis with supportive subjective/objective findings for which a lumbar MRI was indicated, including lumbar spine trauma; uncomplicated low back with suspicion of cancer, infection, radiculopathy after at least one month of conservative therapy; prior lumbar surgery or cauda equina syndrome; or myelopathy. Dr. W opined that Claimant's medical records did not document subjective or objective findings consistent with radiculopathy or nerve entrapment that was unresponsive to conservative treatment to support the medical necessity of the EMG. Dr. W further opined that there was no

consistent evidence-based medical evidence to support an NCV when Claimant was presumed to have symptoms of radiculopathy.

Carrier again denied Dr. C's request for the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities as not being medically necessary. Claimant requested an IRO review. The IRO reviewer rendered a decision on September 8, 2010, and noted that he utilized the ODG criteria in making his determination. The IRO reviewer, an orthopedic surgeon, reviewed Claimant's medical records, including diagnostic studies, and opined that the requested MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities was not medically necessary. The IRO reviewer opined that Claimant did not have additional injury or progressive neurologic deficit based on the diagnostic studies that he reviewed, and that Claimant's medical condition had improved since the lumbar MRI on May 11, 2009, and the EMG/NCV study performed on April 24, 2009. The IRO reviewer further concluded that Dr. C did not have the results from the prior diagnostic studies when he requested the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities.

Carrier offered the medical narrative dated October 21, 2010, from Dr. S (3), M.D. Dr. S (3), an orthopedic surgeon, stated that he had reviewed Claimant's medical records, and that based on his review, the requested MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities was not medically necessary. Dr. S (3) opined that Claimant's prior diagnostic studies indicated that there were no significant changes on neurologic exams that would warrant repeat studies, and there was a lack of objective evidence that indicated that Claimant had a progressive neurologic deficit. Dr. S (3) noted that he utilized the ODG criteria in making his determination.

DISCUSSION

Texas Labor Code §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 §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-base medical 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 §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 in making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence based, scientifically valid, and outcome focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code §413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable. Texas Labor Code §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 (sic) considered parties to an appeal. In a Contested Case Hearing (CCH), the part appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of the evidence-based medical evidence.”

With regard to the low back, under Magnetic Resonance Imaging (MRI), the ODG provides:

“Recommended for indications below. MRI’s are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (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 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) 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) This large case series concluded that iatrogenic effects of early MRI are worse disability and increased medical costs and surgery, unrelated to severity. (Webster, 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.

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”

With regard to the low back, under Electromyography (EMG), the ODG provides:

“Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography.)”

With regard to the low back, under Nerve Conduction Study (NCS), the ODG provides:

“Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.”

In accordance with Division Rule 133.308(t), Claimant, the appealing party of the IRO decision, had the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. In support of his position, Claimant stated that he would be relying upon his testimony and his medical records to establish that the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities was health care reasonably required for his compensable injury. Claimant's testimony focused on the mechanism of his injury, medical treatment that he had received for his compensable injury, and that Dr. C had recommended that he undergo a repeat MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities.

Based on a careful review, fair reading, and consideration given to the evidence, Claimant did not provide evidence-based medical evidence to overcome the determination of the IRO. The preponderance of the evidence-based medical evidence is not contrary to the decision of the IRO that the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities is not health care reasonably required for Claimant's 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 _____, Claimant was the employee of (Employer).
 - C. Claimant sustained a compensable lumbar sprain/strain and an L5/S1 annular tear injury on _____.
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 determined that the requested services of an MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities were not reasonable and necessary health care services for the compensable injury of _____.
 4. Claimant failed to present evidence-based medical evidence contrary to the IRO decision.
 5. The MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities 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 the MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to an MRI of the lumbar spine and an EMG/NCV of the bilateral lower extremities 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 of _____, in accordance with Texas Labor Code Ann. §408.021.

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

DAVID C. CUNNINGHAM
2435 NORTH CENTRAL EXPRESSWAY, SUITE 400
RICHARDSON, TEXAS 75080

Signed this 17th day of December, 2010.

Wes Peyton
Hearing Officer