DOCKET NO. 453-03-0185.M2
[MDR TRACKING NO. M2-02-0936-01]

_____	§	**BEFORE THE STATE OFFICE**
	§	
Petitioner	§	
	§	**OF**
V.	§	
	§	
	§	
HARTFORD UNDERWRITERS INSURANCE COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent		

DECISION AND ORDER

Petitioner, ____ a workers' compensation claimant, appealed the Independent Review Organization's ("IRO's") decision that denied his request for a discogram.[1] Hartford Underwriters Insurance Company ("Carrier") argued that the discogram was unnecessary. This decision finds in Petitioner's favor and preauthorizes the discogram at levels L1-2 and L2-3.

I. Notice, Jurisdiction, and Procedural History

Notice and jurisdiction were not disputed and are discussed only in the findings of fact and conclusions of law. The hearing convened on December 9, 2002, at State Office of Administrative Hearings facilities, 300 West Fifteenth Street, Austin, Texas. The Petitioner represented himself with assistance from Luz Loza, Ombudsman. James Loughlin represented the Carrier. Two witnesses, Petitioner and the Carrier's medical expert, testified at the hearing, and twenty-one exhibits were admitted into evidence.

II. Discussion

After a previous injury, Petitioner had a spinal fusion at level L3-L4 in 1993. Petitioner subsequently suffered a work-related injury on_____, during which the first fusion broke. On September 17, 2000, Petitioner had level L3-L4 re-fused and underwent decompression and posterior fusion with a discectomy and rod placement at level L4-L5.

1. Petitioner's Surgeon

[1]Some medical providers whose reports are cited used the spellings "disc" and "discogram" and others used "disk" and "diskogram." With the exception of material that is directly quoted, the first form is used in this decision.

Throughout his many medical summaries, Petitioner's orthopedic surgeon, Allen S. Kent, adamantly insisted that the discogram is medically necessary. In January 2002, Dr. Kent reported that until a discogram has been successfully completed, "we may be overlooking a significant lumbar spinal abnormality, which requires repair, not just treatment with analgesics."[2]

Dr. Kent performed an impairment rating on Petitioner that month. At the time, Petitioner was barely able to stand upright, "much less flex and extend his lumbar spine." Dr. Kent concluded that Petitioner had a 30 percent whole person impairment rating.[3]

During an April 2002 examination, Dr. Kent found deterioration in the lumbar extension and flexion. Three out of four lumbar ranges of motion were worse.[4] After an MRI scan revealed a bulging disc but no herniation at L2-3 (directly above the current fusion level), Dr. Kent concluded that a discogram was still needed. He conceded that it might not be "practical to fuse the spine at more than two levels," but said that if L2-3 was abnormal, it might require surgical treatment "whether or not it is an ideal situation." He reiterated that Petitioner required the discogram to determine whether or not the **L1-2 and L2-3** disks are symptomatic and causing his current pain and whether or not any of the other discs at the previously fused levels are still symptomatic.[5] (Emphasis added.)

In August 2002, Dr. Kent wrote, "[Petitioner] will be kept totally off work until the discogram is performed, and I strongly urge the insurance company and the TWCC board to allow this to be done so this case may be bought to some type of closure."[6]

Two months later, Dr. Kent wrote:

> The diskogram need has been outlined in detail in numerous medical documentations in medical records of the past several months.
>
> To summarize again, the lumbar provocative diskogram is necessary and beneficial in the appropriate care of this patient, as he continues to experience severe pain in the

[2]Ex. 11.

[3]Ex. 12.

[4]Ex. 13.

[5]Ex. 15.

[6]Ex. 17.

mid-lumbar spine, aggravated with increased standing and sitting, with persistent, severe pain in the lower lumbosacral spine. The most recent MRI study of the lumbar spine did reveal bulging of the L2-L3 disk; directly above the current fusion level, and the diskogram would be extremely helpful in determining whether or not this is a symptomatic bulging disk and whether or not to subject this patient to additional surgery at that level.

If the diskogram is performed at **L1-L2 and L2-L3** and is negative, then I would definitely not recommend any more surgery; conversely, if the diskogram is positive, then this gentleman deserves surgical treatment to help relieve his current symptoms.[7] (Emphasis added.)

B. Referral to Dr. Cantu

Dr. Phillip Cantu also treated Petitioner, and in a July 2001, medical history noted that Petitioner experienced severe pain most of the time (ten on a scale of one to ten). Because of knee injuries prior to and concurrent with his back injury, Petitioner walked with a cane and placed his weight on the left side of his body. He experienced sitting, standing, and bending forward intolerance. As a result of walking in this way, he had developed carpal tunnel syndrome. At the time, Petitioner smoked two packs of cigarettes a day. He took several medications and used a TENS unit for pain.[8]

As Dr. Cantu noted, the MRI scan showed that disc spaces L3-L4 and L4-L5 had normal disc height but were darkened, suggesting possible disc pathology. The MRI also showed pedicle screw fixation intact at L3 to L5 without evidence of acute or recurrent disc herniation, spinal stenosis, or neural foraminal narrowing. The MRI showed degenerative disc disease at L3-L4 and L4-L5, but the L2-L3 disc appeared normal, even though there was some facet arthrosis at L2-L3. Dr. Cantu recommended a discogram at four levels, L2 through S1.[9] Dr. Cantu also found that Petitioner met the criteria for intra-discal-electro-thermal therapy.[10]

C. Psycho-Social Factors

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[7] Ex. 1.

[8] Ex. 2.

[9] Ex. 2.

[10] Ex. 4.

In some medical reports, Drs. Cantu and Kent expressed concerns about Petitioners use of narcotics. Dr. Kent wrote in December 2001, "I do not want to continue to prescribe schedule II narcotics, and I am therefore at a loss for pain management beyond the above prescriptions which are to be taken exactly as directed to wean him of this medication."[11]

[11]Ex. 10.

Because of the number and types of pain medications Petitioner had taken, Dr. Cantu recommended referring Petitioner to an addictionologist.[12] At various times, Petitioner had used Vioxx, Oxycontin, opiate lumbar epidural injections, Darvocet, Duragesic patches, Flexiril, Zanaflex, Ambien, and for depression, Celexa.

In January 2002, Dr. Kent wrote, "The patient has also exhibited frequent chills and has felt warm but his temperature taken today was normal. He states that he has had this for one or two months, but whenever he takes Darvocet, it goes away. This sounds like withdrawal symptomatology."[13]

4. Independent Medical Examination ("IME")

Dr. Charles Xeller, an orthopaedic surgeon, performed an IME on January 9 , 2002. Dr. Xeller noted that Petitioner appeared to be in pain and was limping badly, putting all of his weight on his left side. Petitioner told Dr. Xeller that he was in severe pain and could walk only 100 feet before he has to sit down. Petitioner described his back pain as constant and becoming worse.

Dr. Xeller found that Petitioners back range of motion was severely limited. "He has no extension whatsoever," Dr. Xeller noted. Petitioner had full range of motion in his hip and left knee, but his left knee lacked full extension and he had extreme quadricep atrophy. Dr. Xeller further noted right-sided atrophy and bilateral radiculopathy down into Petitioners plantar foot, but he did not find nerve root abnormality at L2-L3. Dr. Xeller concluded that Petitioner has "failed surgical syndrome, status-post fusion from L3-L5." He agreed that a "discogram would be in order, to see if he has internal disc disruption at **L5-S1**."[14] (Emphasis added.)

5. IRO

The parties did not know what documents the IRO reviewed. The IROs August 5, 2002, decision states:

[12]Ex. 5.

[13]Ex. 11.

[14]Ex. 7. Part of Dr. Xeller's report has been "whited out." Apparently, he recommended some type of procedure because the legible part of the sentence states, "pro_ _ _ _re would give him some relief."

> The various fusion procedures with facet injections and discectomy have made it very unlikely that discography will be very helpful in coming to conclusions regarding this patients pain source. The patient continues to have lower extremity discomfort, as if there were still radiculopathy. . . . Two of the levels that are recommended for disco graphic evaluation have had discectomy: L3-4 and L4-5. After discectomy, discography is thought to be not indicated as a means of determining problems at that inter space. It is probable that some disk disruption may have occurred at the other levels, also, considering the number of injections and surgical procedurals that have been performed.[15]

6. Carrier

In a March 25, 2002, denial of the preauthorization request, a nurse care manager for the Carrier wrote, "It is not practical to fuse the spine at more than two levels (L3 to L5 have already been fused). The only reason a discogram is necessary is to see if that disc is injured. This is already apparent from other studies and the discogram is not necessary to provide the patient with excellent treatment."[16]

At the hearing, the Carrier called board-certified orthopedic surgeon N.F. Tsourmas as a witness. He described a discogram as an invasive, needling technique in which a needle passes dye into a disc. Where and how much dye goes into the disc provides evaluative information. One goal of discography is to reproduce pain; the procedure hurts even a person whose back is normal. The goal of discography is to exactly reproduce the pain an injured person feels by pressure points. And as with any invasive procedure, there is a risk of infection.

Dr. Tsourmas also noted that the May 2001 MRI answered all questions that remain; an MRI gives more complete information than a discogram. A discogram looks at one level while Petitioners MRI showed the entire lumbar spine and showed a mild diffuse bulge without neural encroachment. Had there been neural involvement, a physician might treat the area with a laminectomy/diskectomy to relieve pressure on the nerves. But , in this case, no such treatment is indicated by the MRI, Dr. Tsourmas said. The MRI showed multiple degenerative changes at every level, he explained.

Petitioner, Dr. Tsourmas said, will have lumbar spine problems for life. Dr. Tsourmas described how, after a fusion, the discs on each end of the fusion must bear the load of movement. The rods currently prevent movement in discs L3-4 and L4-5, placing a burden on each end, at L2-3 and S1-5. In Dr. Tsourmass opinion, Petitioners pain may be caused by scar tissue and degeneration at the ends of the current fusion. Some of the medications Petitioner takes are good and safe for long-term use. Dr. Tsourmas also said that a chronic pain management clinic could also be helpful.

[15]Ex. 18.

[16]Ex. 20, p. 28.

But, medicine does not have a cure for Petitioners situation, and a discogram would not be helpful for him.

Dr. Tsourmas thought that a discogram is contraindicated because Petitioner has experienced depression, and persons with psycho-social issues are not good candidates for discography. Discography is highly subjective, and Dr. Tsourmas was concerned that persons with psychological and social issues might misperceive pain at pressure points, leading the evaluator to incorrect conclusions. Further, because it is so highly subjective, the person who may perform surgery should not be the person who performs a discogram, Dr. Tsourmas noted.

Dr. Tsourmas uses discograms when considering possible fusions. He was concerned that Dr. Kent may be contemplating fusion at a third level. In Dr. Tsourmass opinion, three-level-lumbar-spine fusions do not work. One level fusions seem to work, but the success of the procedure even at two levels is uncertain.

Dr. Tsourmas also relied on two publications, a U.S. Department of Health and Human Services ("DHSS") newsletter article, published in 1994,[17] and another medical periodical regarding a study of discography. The author of the DHHS article reviewed 42 articles on discography and noted that only one met review criteria for adequate evidence about efficacy. That study evaluated discography in 195 patients with persistent low back pain but with no history of prior back surgery. All patients went on to have back surgery, either spinal fusion or laminectomy and/or discectomy. They were followed postoperatively for two to ten years. Those who had spinal fusion were excluded if x-rays revealed pseudoarthrosis at the site of the attempted fusion. Treatment success was noted in 89 percent of the 137 patients who had positive pain response on discography and abnormal discograms.

The DHHS article notes that discography is an invasive procedure with complication risks, such as disc and disc space infections, disc herniation, and significant amounts of ionizing radiation exposure. Discography is also expensive. In summary, the article concluded:

> the main reason put forward for using discography appears to be to determine the levels at which spinal fusion will be successful in patients with persistent low back problems (due to discogenic disease). . . . There is no good evidence that discography is useful to promote better treatment outcomes in patients with acute low back problems. . . . The rationale for using discography is to select patients who would most benefit from spinal fusion. . . . [However,] . . . there is limited evidence that discography can help select patients who would benefit from spinal fusion and no evidence that it is helpful in patients with acute low back problems. . . . The use of discography . . . to diagnose herniated discs appears to offer no significant advantage over other imaging methods with less potential risk of harm.

[17] Ex. 21.

In an award-winning study, Eugene Carragee, M.D., found that neither discography nor MRIs could reliably indicate where pain emanates. Discography did not prove capable of discriminating between symptomatic and asymptomatic high-intensity zones ("HIZs"). "Although an HIZ is associated with a painful disc injection, it appears to be independent of chronic low back pain illness," Dr. Carragee said.[18]

7. Petitioners Rebuttal

Petitioner has recently stopped smoking. He also testified that he would willingly go to a pain clinic. He wants to get back to work. "I want my life back. For almost three years, Ive been a prisoner in my own home," Petitioner said.

Petitioner said he was not sure a discogram could help him, but he did not see how it could hurt. He felt his doctors who had examined him over time had his best interests in mind. "No one who has disapproved the discogram has examined me," Petitioner noted. Petitioner admitted taking medications and attending counseling for depression from 1988 to 1990, after a divorce. Also, as a result of depression he experienced related to his current injuries, he did take medications for depression, but he stopped taking those medication in late 2001 .

III. Applicable Law

Pursuant to TEX. LAB. CODE ANN. § 408.021, 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. The employee is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting from the compensable injury;
(2) promotes recovery; or
(3) enhances the ability of the employee to return to or retain employment.

An insurance carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury, but certain categories of health care, including discograms, must be preauthorized. 28 TEX. ADMIN. CODE 134.600.

IV. Analysis

The administrative law judge (ALJ) has denied a request for a discogram in another case based on Dr. Carragees study, which is persuasive. Nevertheless, in this case , the ALJ finds that Petitioner met his burden of proof. Dr. Tsourmas is a very credible witness, and one cannot help but be concerned that a third-level fusion may be contemplated. But, discography is not treatment; it is a diagnostic tool. In this case, the greater weight of evidence supported its medical necessity.

[18] Ex. 22.

As Petitioner highlighted, his treating doctors and the IME who examined him have all recommended discography. Dr. Tsourmas testified and Dr. Carragees report indicates that an MRI provides more complete information. But, Drs. Kent, Cantu, and Xeller reviewed the MRI results and still thought a discogram would be helpful in finding the source of Petitioners pain. As the IME, Dr. Xeller has no ongoing relationship with either party, and this lends weight to his opinion.

Given the types of medications Petitioner has used for pain and depression, Petitioner obviously has contended with psycho-social issues. Indeed, his own physicians have had serious concerns about his medications. But, Petitioner testified that he no longer takes some of the medications that were a concern. Indeed, from the reports of Drs. Kent and Cantu, it appears that they withdrew him from the schedule II narcotics.

Petitioner ably represented himself in this case. He followed the testimony and provided appropriate rebuttal to the Carriers evidence and arguments. In the ALJs opinion, he should be able to adequately describe for his doctor how the discogram dye affects him.

Different physicians recommended discography at different levels. The ALJ agrees with the Carrier that discography at prior fusion sites is not required. From Dr. Tsourmass testimony about the burden placed on the spine at the ends of the fusion, one might think the best areas for discography would be at each end of the two-level fusion. Nevertheless, Dr. Kent has treated Petitioner over many years, and has most-often examined him. Therefore, the ALJ will follow his recommendation and order discography at the levels he most frequently mentioned in his medical reports: L1-2 and L2-3.

In summary, Petitioner met his burden of proving the medical necessity of a discogram at levels L1-2 and L2-3, and such treatment is preauthorized.

V. Findings Of Fact

1. After a previous injury, Petitioner,___., had a spinal fusion at level L3-L4 in 1993.

2. Petitioner subsequently suffered a work-related injury on_____, during which the first fusion broke.

3. At the time of the Petitioners injury, his employer had workers' compensation coverage through the Carrier, Hartford Underwriters Insurance Company.

4. On September 17, 2000, Petitioner had level L3-L4 re-fused and underwent decompression and posterior fusion with a discectomy and rod placement at level L4-L5.

5. In January 2002, Petitioner received a 30 percent whole person impairment rating.

6. In an April 2002 examination, three out of four of Petitioners lumbar ranges of motion were worse. Petitioners back range of motion is severely limited, and he has no extension.

7. Petitioner experiences sitting, standing, and bending forward intolerance.

8. Petitioner experiences severe pain and can walk only 100 feet before he has to sit down.

9. Petitioners pain is constant and becoming worse.

10. Petitioner experiences failed surgical syndrome from levels L3 to L5.

11. Even after an MRI scan revealed a bulging disc but no herniation at L2-3 (directly above the current fusion level), Petitioners surgeon strongly insisted that Petitioner still needs a discogram at spine levels L1-2 and L2-3, in order to properly identify the source of Petitioners pain.

12. A discogram may help locate a previously overlooked significant lumbar spinal abnormality.

13. A discogram may determine whether or not the L1-2 and L2-3 disks are symptomatic and causing Petitioners current pain.

14. Petitioner smoked two packs of cigarettes a day for many years but recently stopped smoking.

15. Petitioner stopped taking medications for depression in late 2001.

16. In a decision dated August 5, 2002, a physician with an independent review organization ruled against Petitioners request for a discogram, and Petitioner timely appealed.

17. Notice of the hearing on the Petitioners appeal was issued September 19, 2002.

18. Together, the hearing notice and IRO decision included a statement of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

19. At the December 9, 2002, hearing, the Carrier and Petitioner were present or represented.

VI. Conclusions Of Law

1. The Texas Workers Compensation Commission has jurisdiction to decide the issue presented pursuant to the Texas Workers Compensation Act (A The Act A) TEX. LABOR CODE ANN. § 413.031.

2. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to The Act § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. Adequate and timely notice of the hearing was provided as required by TEX. GOVT CODE ANN. §§2001.051 and 2001.052.

4. The hearing was conducted in accordance with the Administrative Procedure Act, TEX. GOVT CODE ANN. ch. 2001.

5. Petitioner, the party seeking relief, bore the burden of proof in this case. 28 TEXAS ADMIN. CODE §148.21(h).

6. A discogram may promote Petitioners recovery or enhance his ability to return to employment. The Act § 408.021.

7. The Petitioner met his burden of that a discogram at levels L1-2 and L2-3 should be preauthorized. The Act § 408.021 and 28 TEX. ADMIN. CODE 134.600.

ORDER

THEREFORE, a discogram for Petitioner ____ at spine lumbar levels L1-2 and L2-3 is preauthorized.

SIGNED this 17th day of January, 2003.

SARAH RAMOS
Administrative Law Judge
State Office of Administrative Hearings