MEDICAL CONTESTED CASE HEARING NO. 09050
M6-08-12756-01

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.

ISSUE

A benefit contested case hearing was held on July 15, 2008, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IR0) that Claimant is not entitled to a repeat MRI of the lumbar spine for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was represented by RB, attorney. Carrier appeared and was represented by attorney, DK.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained an injury during the course and scope of his employment on _____. The medical records show that Claimant has had complaints of low back and radiating leg pain. He has undergone conservative treatment including physical therapy and epidural steroid injections.

In October of 2004, Claimant sought medical treatment at an emergency room with complaints of low back pain and vomiting. An MRI was performed, which revealed degenerative changes, and Claimant was evaluated for possible kidney stones. His pain was determined not to be urologic, and he was diagnosed with low back pain secondary to muscular strain with mild facet arthropathy and hematuria of unknown etiology.

On January 10, 2005, Claimant had another lumbar MRI, which revealed a broad-based central/right paracentral disc protrusion at L5-S1 (stable when compared to previous study), and a shallow left paracentral disc protrusion at L4-5, which was not significantly changed from the prior study.

Reference was made to EMG/NCV testing in February of 2005, which was abnormal and consistent with possible lower extremity sensory neuropathy or possible chronic left lumbar radiculopathy.

The records of treatment show that Claimant continued to have increasing complaints of back and lower extremity pain for several years. Many doctors diagnosed Claimant with lumbar disc disease and left lumbar radiculopathy.

In November of 2005, his treating doctor of one year released him stating that he had referred him to several surgeons and pain management physicians as well as a psychiatrist, and he felt there was

nothing else he could offer Claimant.

On July 11, 2007, a designated doctor certified Claimant at statutory MMI on December 23, 2006, and assessed a 0% impairment rating for a diagnosed lumbar sprain. He noted that Claimant exhibited poor effort throughout the examination.

Claimant saw a surgeon, Dr. H, on July 11, 2007. Dr. H diagnosed spondylosis with disc protrusions at L4-5 and L5-S1 as well as chronic lumbar radicular syndrome. He recommended lumbar discography at the lower three lumbar levels and considered Claimant a surgical candidate.

On February 13, 2008, Dr. H noted that Claimant was still a surgical candidate (despite a designated doctor's opinion to the contrary), but recommended a new MRI as the last one was performed on January 10, 2005. Dr. H reasoned that he wanted a repeat MRI to confirm that the disc pathology was limited to the L4-5 and L5-S1 levels only.

In reviewing Dr. H's request for a repeat MRI of the lumbar spine, the first utilization review doctor, Dr. Tonn, a pain management and occupational medicine doctor, referenced a November 9, 2007 RME report and the July 11, 2007 designated doctor's report, as well as positive Waddell's signs and disproportionate pain behaviors as the basis for denying the requested service.

The utilization review doctor who reviewed the request on reconsideration, Dr. Y, a surgeon, also denied the requested repeat MRI. Dr. Y cited the *ODG* section regarding the low back, which provides for additional imaging when there is objective progression of neurologic symptoms. He also referenced the designated doctor's opinion that there was no neurological deficit as well as the positive Waddell's signs and forecast for a poor surgical outcome.

An IRO reviewer and board certified orthopedic surgeon reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO denied the repeat MRI of the lumbar spine. He noted the two prior MRIs, and opined that they revealed very minor disc protrusion at L4-5 and disc desiccation with protrusion at L5-S1 with some evidence of neural foraminal stenosis. He also noted that Claimant had multiple complaints that were not validated on independent examinations. He referenced the designated doctor's opinion that there was no neurologic deficit and compared that opinion to the contrary opinion of Dr. H, the requesting surgeon, on the same day. The IRO reviewer specifically found that there was no evidence of a progressive neurologic deficit that would warrant a repeat MRI of the lumbar spine, citing the *ODG* and the ACOEM Guidelines.

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." "Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG),* and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry in any dispute regarding medical necessity is whether the proposed care is consistent with the *ODG*. As the utilization review and IRO doctors in the instant case have stated, the *ODG* allows for repeat MRI only if there has been progression of neurologic deficit.

The *ODG* Treatment Guidelines discuss lumbar MRIs as follows:

MRI's (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 controversary 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) 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
- 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

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

Both of the utilization review doctors and the IRO doctor denied the requested repeat MRI. The IRO cited the relevant provisions of the *ODG*, specifically the fact that there was no showing of progressive neurologic deficit. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the presumption afforded the *ODG* and the opinions of the doctors correctly applying the *ODG*.

Other Evidence Based Medicine

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. 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). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the

technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. ***Kelly v. State***, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. The treatment proposed by Dr. H is a departure from the *ODG* in that he recommends a repeat MRI, but fails to show a progression of neurologic deficit. In a "Letter of Medical Necessity", Dr. H cited the same section of the ODG referenced herein and stated that Claimant has unequivocal evidence of radiculopathy and outlined Claimant's neurological deficits, his failure to respond to conservative treatment and the fact that he believed Claimant to be a surgical candidate. He opined, within a reasonable degree of medical probability, that Claimant fit the selection criteria for MRI according to the *ODG*. Dr. H did not, however, provide any justification for a repeat MRI and did not identify any medical records, which demonstrated the progression of neurologic deficit required by the *ODG* to warrant a repeat MRI. His conclusory statements, without sufficient reference to the *ODG* or other evidence-based medicine justifying departure from the *ODG*, do not meet the requisite evidentiary standard required to overcome the presumption afforded the IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested repeat lumbar MRI does not meet the criteria set out in the *ODG*.

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), when he sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

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

3. Claimant's surgeon recommended a repeat lumbar MRI.

4. The *ODG* recommends a repeat MRI only if there has been a progression of neurologic deficit.

5. The IRO decision upheld the Carrier's denial of the requested repeat lumbar MRI because the Claimant's medical records did not show a progression of neurologic deficit.

6. The requested service is not consistent with the *ODG* criteria for a repeat lumbar MRI.

7. The repeat lumbar MRI 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IR0 that a repeat lumbar MRI is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to a repeat lumbar MRI 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 Section 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

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701

Signed this 10th day of November, 2008.

Erika Copeland
Hearing Officer