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 June 8, 2009, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to a lumbar myelogram with post myelogram CT scan for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by KF, ombudsman. Carrier appeared and was represented by attorney, JM. Present on behalf of Employer were CB and MV.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained an injury during the course and scope of her employment on _____, while working as a school custodian. She testified that at the time she was injured she was lifting a heavy mop bucket and twisted. She felt sudden pain in her low back, which radiated down her left leg.

Claimant testified that she initially treated conservatively for a back strain. When an MRI revealed a herniated disc at L4-5, Claimant underwent left L4-5 hemilaminectomy and foraminotomy, fasciectomy and discectomy surgery on October 2, 2001.

Claimant testified that the surgery was successful for a couple of years and she began experiencing problems again.

The medical records show that Claimant complained of back pain after her surgery. Her doctors suspected scar tissue at L5-S1 as the possible cause of her pain. Her surgeon opined that the scarring was verified by MRI in 2002. An EMG performed on November 25, 2002 revealed subacute and chronic left L5-S1 denervation.

An MRI performed on March 17, 2006 revealed a broad-based disc bulge and annular tear at L5-S1 with no significant evidence of central stenosis. The radiologist noted some moderate left L5-S1 lateral recess stenosis due to left-sided facet hypertrophy as well as moderate left L5-S1 neural foraminal narrowing.

Claimant returned to her surgeon in February of 2008 with complaints of low back pain and left radiculopathy. He performed an SI injection and ordered a repeat MRI.

An MRI performed on March 5, 2008 revealed marked hypertrophic changes in the facet joints, which narrowed the lateral recess bilaterally and mildly narrowed the central canal at L5-S1. The radiologist noted mild distortion of the left S1 nerve root in the lateral recess.

Claimant's surgeon referred Claimant to a pain management doctor for epidural steroid injections. The injections provided no relief and a spinal cord stimulator was recommended.

On August 26, 2008, Claimant saw a second surgeon, Dr. D. He opined that it was unlikely Claimant's pain was secondary to nerve root scarring as that should have been manifested sooner after surgery. He was more concerned with the possibility of foraminal compromise or a recurrent herniated lumbar disc. He noted that he would obtain the results of the MRI, and ordered a myelogram and CT scan of the lumbar spine to insure there was no nerve root compression.

On September 29, 2008, Dr. D noted that the MRI revealed post laminectomy changes at L4-5 with a bulging disc at L5-S1 and lateral recess stenosis bilaterally, left greater than right. He opined that Claimant would benefit from "minimally invasive nerve root decompression on the left hand side-laminectomy." Carrier contested compensability of the L5-S1 level and denied the surgery.

In November and December, 2008, Dr. D's physician's assistant wrote reports in which he explained the need for the surgery. In the November report, he referenced the bulging disc at L5-S1, but did not mention the MRI. In the December report, apparently in response to some information about prior MRIs and the possibility of a pre-existing condition relating to the compensability issue, he stated that Dr. D had not looked at any MRI other than the May 5, 2008 MRI, and stated that Dr. D based his surgical decision on that MRI.

In February of 2009, Dr. D's physician's assistant ordered a CT myelogram of the lumbar spine "to better evaluate the patient's disc level at the L5-S1 level and to give Dr. D a better evaluation of the patient's lumbar spine" and explained that the CT myelogram was being used as a presurgical diagnostic study to determine whether Claimant was a surgical candidate and, if so, to determine what surgical intervention would be needed.

In reviewing Dr. D's request for a lumbar myelogram with post myelogram CT scan, the first utilization reviewer noted Dr. D's office staff had informed the reviewer that the MRI was performed at an outside facility and the doctor did not trust the results of the MRI. The reviewer ultimately denied the requested procedure "based on the medical records submitted for review."

The utilization review doctor who reviewed the request on reconsideration also denied the requested treatment. That reviewer cited the *ODG* and concluded that the need for the procedure was not validated by the office notes or the *ODG*.

An IRO reviewer and board certified orthopedic surgeon reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO cited the *ODG* and stated that an MRI is recommended by the *ODG* unless there are specific reasons that one is not possible. The reviewer noted that an MRI had been performed in March of 2008, and was diagnostically adequate.

The reviewer further noted that a myelogram would only be indicated if the patient had physical findings not explained by the MRI. The reviewer opined that Claimant was not a surgical candidate, but the MRI was adequate to plan surgical intervention if surgery were required. The IRO upheld the Carrier's denial of the requested service.

A peer review doctor and board certified orthopedic surgeon agreed with the IRO reviewer and testified that the MRI was sufficient and the requested myelogram and CT scan were not indicated by the *ODG*.

On April 30, 2009, Dr. D's physician assistant, wrote a letter in support of the requested lumbar myelogram procedure, which Dr. D signed as well. He stated that it was Dr. D's opinion that Claimant was a surgical candidate. He stated that Dr. D had "noted on a previous MRI that the patient had a large disc bulge at the L5-S1 level causing lateral recess stenosis bilaterally with the left being greater than the right" and Dr. D had previously recommended microdiscectomy, which was denied. The PA noted the dispute over compensability of the L5-S1 disc, which had by that time been resolved in favor of Claimant; and, stated that the CT myelogram was requested to better evaluate the impingement of the S1 nerve root and show if there is a defect in the filling of that nerve root better than the MRI.

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*. The *ODG* allows for myelography if an MRI is unavailable; and, restricts the use of CT myelography to those situations where an MRI is unavailable, contraindicated or inconclusive.

The *ODG* Treatment Guidelines for the low back discuss CT myelography and myelography as follows:

> **Myelography**: Recommended as an option. Myelography OK if MRI unavailable. (Bigos, 1999).
>
> **CT & CT Myelography (computed tomography)**: Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000) 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 computed tomography (CT) 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)
>
> **Indications for imaging -- Computed tomography:**
> - Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
> - Thoracic spine trauma: with neurological deficit
> - Lumbar spine trauma: trauma, neurological deficit
> - Lumbar spine trauma: seat belt (chance) fracture
> - Myelopathy (neurological deficit related to the spinal cord), traumatic
> - Myelopathy, infectious disease patient
> - Evaluate pars defect not identified on plain x-rays
> - Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)

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 reviewers and the orthopedic surgeon IRO reviewer denied the requested procedure. The IRO reviewer, and the testifying board certified peer reviewer, cited the *ODG*, specifically the fact that a diagnostically adequate MRI had already been performed and there was no need for a myelogram/CT scan. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome 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. Dr. D is a neurosurgeon and is certainly qualified to render an opinion regarding low back surgery and treatment. The treatment proposed by Dr. D, however, is a departure from the *ODG* in that the procedure is only recommended in the absence of an MRI or in cases where an MRI is contraindicated or inconclusive. Dr. D had no problem using the May 5, 2008 MRI upon which to base his recommendation for surgery in September of 2008, prior to the dispute regarding compensability of the L5-S1 disc. Dr. D himself did not offer an evidence-based medicine opinion to support the requested procedure. The only opinion offered was drafted by his physician's assistant.

Under the Act, treatment provided pursuant to the *ODG* is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**. Mere citation to the *ODG*, however, does not carry the day. When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. Dr. D's physician's assistant stated that he "was well aware of the *ODG* guidelines" but did not explain, how the *ODG* provisions regarding CT myelography for treatment of the low back apply in the instant case. Dr. D's records do not support a finding that the MRI was inconclusive, to the contrary, it was previously sufficient to prompt him to recommend surgery. Dr. D's physician's assistant's conclusory opinions, 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 IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested lumbar myelogram and post myelogram CT scan 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 (SELF-INSURED 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 lumbar myelogram and post myelogram CT scan for evaluation of Claimant's compensable lumbar spine injury.

4. For treatment of the low back, the *ODG* recommends CT myelography where an MRI is unavailable, contraindicated or inconclusive.

5. The IRO decision upheld the Carrier's denial of the requested lumbar myelogram and post myelogram CT scan because the Claimant's medical records did not show that an MRI was unavailable, contraindicated or inconclusive, in fact, Claimant's requesting surgeon had previously recommended surgery based on a March 5, 2008 MRI.

6. The requested service is not consistent with the *ODG* criteria for lumbar myelogram and post myelogram CT scan.

7. The requested lumbar myelogram and post myelogram CT scan 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 IRO that a lumbar myelogram and post myelogram CT scan is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to lumbar myelogram and post myelogram CT scan 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 **(SELF-INSURED EMPLOYER)** and the name and address of its registered agent for service of process is

TD, SUPERINTENDENT
(SELF-INSURED EMPLOYER)
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 11th day of June 2009.

Erika Copeland
Hearing Officer