MEDICAL CONTESTED CASE HEARING NO. 11136
M6-10-25805-01

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.

ISSUES

A contested case hearing was held on December 20, 2010 and April 25, 2011 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a lumbar discogram with post CT scan for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Provider, Dr. B, appeared on his own behalf. Carrier appeared and was represented by SS, attorney. Claimant did not appear and did not respond to the Division's 10 day letter that was mailed on December 29, 2010.

BACKGROUND INFORMATION

Although properly notified, Claimant failed to appear for the medical contested case hearing scheduled for 9:00 a.m. on December 20, 2010. A letter advising that the record would be held open for ten days to afford the Claimant the opportunity to respond and request that the hearing be rescheduled to permit him to present evidence on the disputed issue was mailed to the Claimant on December 29, 2010. The Contested Case Hearing was rescheduled for April 25, 2011. The Claimant failed to respond to the Division's 10-day letter and did not appear at the Medical Contested Case Hearing on April 25, 2011.

Claimant sustained a lumbar spine injury in the course and scope of his employment while shoveling dirt to cover a hole. Claimant had a lumbar laminectomy surgery on September 5, 2007. Claimant was referred to Dr. B who initially examined him on October 31, 2008. Dr. B noted complaints of back pain and numbness with radiation into Claimant's left leg. Claimant underwent ESI injections, but his symptoms persisted. Eventually, Dr. B recommended that Clamant undergo a fusion surgery.

Dr. B recommended that Clamant undergo a lumbar discogram prior to surgery. Dr. B's request was denied twice by the Carrier's Utilization Review Agents. Their denials were upheld by the Independent Review Organization (IRO). The IRO denied Dr. B's request because the IRO did not believe that Claimant was an appropriate candidate for a fusion surgery. Dr. B appealed the IRO's decision to a Medical Contested Case Hearing.

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. 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 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, 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 Official Disability Guidelines (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 is 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."

With regard to discography, the ODG provides as follows:

> Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for

fusion (but a positive discogram in itself would not allow fusion). (Carragee-*Spine*, 2000) (Carragee2-*Spine*, 2000) (Carragee3-*Spine*, 2000) (Carragee4-*Spine*, 2000) (Bigos, 1999) (ACR, 2000) (Resnick, 2002) (Madan, 2002) (Carragee-*Spine*, 2004) (Carragee2, 2004) (Maghout-Juratli, 2006) (Pneumaticos, 2006) (Airaksinen, 2006) (Manchikanti, 2009) Discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These finding are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely

innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 2009) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD). **Discography is Not Recommended in ODG.**

Patient selection criteria for Discography if provider & payor agree to perform anyway:

o Back pain of at least 3 months duration

o Failure of recommended conservative treatment including active physical therapy

o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)

o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)

o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical

procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
o Briefed on potential risks and benefits from discography and surgery
o Single level testing (with control) (Colorado, 2001)
o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

To overcome the IRO's decision, Dr. B provided his expert medical testimony. Dr. B testified that he believes Claimant is a good candidate for a lumbar discogram. Dr. B testified that Claimant has had back pain for many months; he has undergone conservative treatment; a psychological screen indicates no psychosocial barriers to recovery and the multiple MRIs that were performed indicated that Claimant has lumbar stenosis with positive findings at L4-L5.

Dr. B testified that the IRO did not believe Claimant was good candidate for fusion surgery because Claimant has not had two failed previous discectomies and there was no evidence of instability on flexion/extension x-rays. Dr. B stated that he agreed with the IRO that those two criteria were not present in this case. However, he testified that the ODG section on lumbar fusion lists six different indications for lumbar spinal fusion, including mechanical low back pain. Dr. B testified that Claimant has had mechanical low back pain that has lasted more than six months.

Dr. B testified and the medical records indicate that Claimant was referred to him for an orthopedic consultation by his treating doctor, Dr. M. Dr. B initially examined Claimant on October 31, 2008. At that time, Claimant had already undergone a prior lumbar surgery and received physical therapy, but he remained symptomatic. Dr. B's medical records indicate that he recommended a post-surgery MRI and additional conservative care. The medical records indicate that Claimant underwent lumbar epidural steroid injections and post injection physical therapy. In a medical note dated July 31, 2009, Dr. B stated that the initial injection had helped, but if Claimant's condition did not improve he was considering a lumbar fusion at L4-L5. Dr. B's medical records continued to document ongoing symptoms after Claimant had exhausted all conservative treatments. Therefore, on December 7, 2009, Dr. B began the pre-operative testing required for a lumbar fusion.

Dr. B testified, and his medical report dated February 8, 2010 also indicates, that he believes the pain generator is at L4-L5 and he is requesting the discogram to confirm this belief. Dr. B also testified that his ultimate goal in requesting the discogram was to decide whether to proceed with the fusion and that if the discogram indicated that surgery was not necessary he would not proceed with the lumbar fusion.

During his testimony, Dr. B relied on several medical journal articles to support the medical necessity of the discogram. Dr. B also provided his written analysis of the various medical journal articles cited by the ODG concerning discography and he placed multiple journal articles from professional medical journals into evidence. Dr. B testified that discography is a useful diagnostic tool and that prior problems with discography have been eliminated with better technology and technique. Dr. B specifically referenced two articles that are cited by the ODG. The articles are entitled, "Systematic Review of Lumbar Discography as a Diagnostic Test for

Chronic Low Back Pain," by Dr. Laxmaiah Manchikanti et. al. from the Pain Physician Journal 2009; 12:541-559 and an article from Neurosurgical Focus (2002) by Drs. DK Resnick, DG Malone, and TC Ryken entitled, "Guidelines for the Use of Discography for the Diagnosis of Painful Degenerative Lumbar Disc Disease."

Dr. B's testimony supports the medical necessity of the lumbar discogram with post CT scan for this Claimant and he relies on medical literature in recognized professional journals to support his opinion. The Petitioner/Provider has shown by a preponderance of evidence-based medical evidence that the requested lumbar discogram with post CT scan is health care reasonably required for the compensable injury.

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 present 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 injury on _____.

   D. The Independent Review Organization determined that Claimant is not entitled to a lumbar discogram with post CT scan.

2. Carrier delivered to Provider 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 Division sent a single document stating the true corporate name of the Carrier/Respondent and the name and street address of Carrier's/Respondent's registered agent for service with the 10-day letter to the Claimant at the Claimant's address of record. That document was admitted into evidence as Hearing Officer Exhibit Number 2.

4. Claimant failed to appear for the December 20, 2010 and April 25, 2011 medical contested case hearings and did not respond to the Division's letter dated December 29, 2010 offering him the opportunity to have the hearing rescheduled.

5. Claimant did not have good cause for failing to appear at the medical contested case hearings on December 20, 2010 and April 25, 2011.

6. A lumbar discogram with post CT scan is 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 based medicine is contrary to the decision of the IRO that a lumbar discogram with post CT scan is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to a lumbar discogram with post CT scan for the compensable injury of _____.

ORDER

Respondent/Carrier is 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 **AMERISURE MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is:

CINDY GHALIBAF
5221 NORTH O'CONNER BLVD.
SUITE 400
IRVING, TEXAS 75039-3711

Signed this 4th day of May, 2011.

Jacquelyn Coleman
Hearing Officer