

MEDICAL CONTESTED CASE HEARING NO. 13002  
**M6-10-23364-01**  
**M6-12-37296-01**

**DECISION AND ORDER**

These cases are consolidated and are decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

**ISSUES**

A medical contested case hearing (MCCH) was opened on June 14, 2012 with the record closing on August 20, 2012 to decide the following disputed issue:

Is the preponderance of the evidence-based medical evidence contrary to the decision of the Independent Review Organization (IRO) dated November 19, 2009 that the Claimant is entitled to a lumbar discogram post-CT scan for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Petitioner/Carrier appeared and was represented by JC, attorney. Respondent/Provider, Dr. KB, appeared by telephone on his own behalf. The Claimant appeared and was assisted by SG, ombudsman.

**BACKGROUND INFORMATION**

It was undisputed that the Claimant sustained a compensable injury on (Date of Injury), and the evidence showed that the injury to his lumbar spine occurred when he and a co-worker lifted some 4 X 10's, which caused him to feel a pop in his back and low back pain. On July 9, 2009, the Claimant was first seen by Dr. KB, who is a board certified orthopedic surgeon. After examining the Claimant and reviewing a lumbar MRI performed on him on December 22, 2008, Dr B's impression was that the Claimant's condition included a herniated disc at L5-S1, bilateral protrusion at L3-4 and L4-5, neurogenic claudication, and axial mechanical back pain. Dr B noted that prior to his initial visit with the Claimant, he (the Claimant) had already completed physical therapy, as well as two epidural steroid injections (ESIs), with no relief. Dr B referred the Claimant to undergo an EMG, which was performed on September 17, 2009 and showed a chronic bilateral L5 radiculopathy. Dr B determined that the Claimant was a possible surgical candidate, and to that end he ordered a psychosocial screen that, in his opinion, showed that the Claimant did not have any barriers to having lumbar surgery. To ascertain the pain generator in the Claimant's lumbosacral spine prior to requesting approval to perform spinal surgery, Dr B recommended that the Claimant undergo a lumbar discogram post-CT scan (hereinafter "the procedure"). He requested pre-authorization from the Carrier to perform the procedure.

### ***Procedural History and Basis for Consolidation of Sequence of Disputes Nos. 02 & 06***

The procedural history of Dr B's requests for approval to perform the procedure is somewhat convoluted in this case. After he initially requested pre-authorization to perform the procedure upon the Claimant, the Carrier's utilization review agents denied the request. Dr B requested an IRO review, which was accomplished. The IRO, in a report dated November 19, 2009, overturned the Carrier's denial of the procedure. The Carrier appealed the November 19, 2009 IRO decision, and an MCCH was set to resolve the Carrier's appeal. The appeal by the Carrier is sequence of disputes no. 02 herein.

On April 20, 2010, the MCCH in sequence of disputes no. 02 was dismissed without prejudice by the Hearing Officer to whom the case was assigned, because the parties needed to resolve an extent of injury issue prior to litigating the medical necessity of the procedure at an MCCH. On May 4, 2011, a contested case hearing (CCH) was held in this case to determine whether the Claimant's compensable (Date of Injury) injury extends to and includes lumbar radiculitis, and herniated discs/protrusions at L3-4, L4-5 and L5-S1. The Claimant prevailed on this issue at the CCH. On August 1, 2011, in Appeals Panel Decision 110728, the Division's Appeals Panel affirmed the Hearing Officer's extent of injury determination. Thereafter, no party sought to have the MCCH in sequence no. 02 placed back on the docket.

After August 1, 2011, given that the Claimant had prevailed in the extent of injury dispute and the November 19, 2009 IRO decision overturned the Carrier's denial of the procedure, Dr B sought to proceed with the procedure. Instead of seeking to have the MCCH in sequence no. 02 placed back on the docket, Dr B again requested pre-authorization from the Carrier to perform the procedure, the Carrier again denied it, and Dr B sought another IRO review. This IRO, in a report dated October 20, 2011, upheld the Carrier's denial of the procedure. Dr B appealed the October 20, 2011 IRO decision, and that MCCH was set on the undersigned's docket. The appeal of the October 20, 2011 IRO decision by Dr B is sequence of disputes no. 06.

The MCCH in sequence of disputes no. 06 commenced on June 14, 2012. At the MCCH, Dr B's testimony included much of the procedural history regarding his attempts to obtain approval for the procedure, as set forth above. At that point, since this was the first time that this history was made known to the undersigned, the MCCH was recessed, it was ordered that sequence nos. 02 and 06 would be consolidated, and it was ordered that the Carrier would have the burden of proof on the issue, since the Carrier filed the first appeal in this case regarding the medical necessity of the procedure. Neither party raised any objection to proceeding in this fashion. The determinations made in this decision resolve the issue in both sequence nos. 02 and 06 regarding the medical necessity of the lumbar discogram post-CT scan requested by Dr B in this case.

## 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 findings 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) More in vitro evidence that discography may cause disc degeneration. (Gruber, 2012) 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:***

- Back pain of at least 3 months duration
- Failure of recommended conservative treatment including active physical therapy
- 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)
- 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)
- Intended as screening tool to assist surgical decision making, 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.
- Briefed on potential risks and benefits from discography and surgery

- Single level testing (with control) (Colorado, 2001)
- Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification.

Dr B is considering performing a spinal fusion upon the Claimant, but he is seeking to have the lumbar discogram post-CT scan done preoperatively to determine the Claimant's pain generator, and specifically to rule out the disc at level L4-5 as the Claimant's pain generator. It is Dr B's opinion that the Claimant's spinal problems are primarily due the disc herniation at level L5-S1. The Patient Selection Criteria in the ODG for spinal fusion refer to discography and are as follows:

***Patient Selection Criteria for Lumbar Spinal Fusion:***

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. (Andersson, 2000) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)

***Pre-Operative Surgical Indications Recommended:*** Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)

For average hospital LOS after criteria are met, see Hospital length of stay (LOS). (Emphasis added).

To support the November 19, 2009 IRO decision, Dr. KB provided his expert medical testimony, along with an excellent analysis of the articles cited by the ODG in the discography section relative to its position that discography is “Not recommended.” Dr B’s analysis is persuasive, and it reflects that several of the articles cited by the ODG in the discography section do not stand for the proposition that discograms are not recommended in all instances. Indeed, as can be seen above, even the ODG acknowledges the use of a lumbar discogram in combination with an MRI preoperatively to determine whether a spinal fusion is indicated for a patient like the Claimant. Dr B’s opinion is that the Claimant is a good candidate for a lumbar discogram post-CT scan, given his condition and the lack of relief from conservative treatment. The November 19, 2009 IRO decision agrees with Dr B, and both Dr B and the first IRO on this issue are of the opinion that there are no psychosocial barriers that are at issue in this case. Dr B’s testimony shows that the Claimant meets the requirements for a spinal fusion for primary mechanical back pain under the ODG, but the discogram is needed preoperatively to ascertain the pain generator. After a careful review of the entire record, it is determined that the Carrier has not met its burden to show that the preponderance of evidence-based medical evidence is contrary to the IRO decision dated November 19, 2009. Accordingly, it is determined that the requested lumbar discogram with post-CT scan is health care reasonably required for the Claimant’s compensable (Date of Injury) 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 (Date of Injury), Claimant was the employee of (Employer), Employer.
  - C. On (Date of Injury), Employer had workers' compensation insurance coverage with Valley Forge Insurance Co., Carrier.
  - D. On (Date of Injury), the Claimant sustained a compensable injury while in the course and scope of his employment with (Employer), Inc.
2. Carrier delivered to Dr B and the 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
3. A lumbar discogram with post-CT scan is health care reasonably required for the Claimant's compensable injury of (Date of Injury).

## 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 not contrary to the November 19, 2009 decision of the IRO that a lumbar discogram with post-CT scan is health care reasonably required for the Claimant's compensable injury of (Date of Injury).

## DECISION

Claimant is entitled to a lumbar discogram with post-CT scan for the compensable injury of (Date of Injury).

## ORDER

Petitioner/Carrier is **ORDERED** to pay medical benefits in accordance with this decision, the Act and the implementing Rules.

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

**CINDY GHALIBAF  
5221 NORTH O'CONNER BLVD., STE. 400  
IRVING, TX 75039-3711**

Signed this 13<sup>th</sup> day of September, 2012.

Patrice Fleming-Squirewell  
Hearing Officer