MEDICAL CONTESTED CASE HEARING NO. 13062

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 medical contested case hearing was held on January 30, 2013 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 MRI, with and without contrast, for the compensable injury of (Date of Injury)?

The record remained open following the January 30, 2013 contested case hearing so that Carrier's representative had the opportunity to respond to Claimant's Exhibits C-2 through C-4, which she had not received prior to the date of the hearing. Carrier's law firm changed between the time of the prehearing in this matter and the date of the hearing. Claimant's ombudsman had previously attempted to exchange those exhibits with the Carrier representative, but the documents were returned as undeliverable (*See* Hearing Officer's Exhibit HO-3). The record was initially held open until the close of business (5:00 p.m.) on February 6, 2013 to afford Carrier an opportunity to file additional argument or evidence in response to the admission of Claimant's Exhibits C-2 through C-4, but the record ultimately closed on February 13, 2013 after neither party offered any additional argument, evidence, or objection to the admission of proposed Hearing Officer's Exhibit HO-4 (an updated version of the Carrier information form received from Carrier after the hearing on January 30, 2013).

PARTIES PRESENT

Claimant appeared and was assisted by BP, ombudsman. Carrier appeared and was represented by CE, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

> For Claimant: Claimant.
>
> For Carrier: None.

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1A, HO-1B, HO-2, HO-3, and HO-4.

Claimant's Exhibits C-1 through C-5.

Carrier's Exhibits CR-A through CR-D.

BACKGROUND INFORMATION

The evidence presented in the hearing revealed that Claimant, an electrician, sustained a compensable injury to include his lumbar spine on (Date of Injury) following a fall while in the course and scope of his employment with (Employer), Employer. A January 3, 2003 MRI of Claimant's lumbar spine was interpreted to reveal a large extruded disc fragment on the left at L5-S1. The evidence presented indicates that Claimant received conservative treatment for the compensable injury, including medications, physical therapy, injections, and work hardening, as well as surgical intervention in March 2004 in the form of a left L5-S1 hemilaminotomy, foraminotomy, and discectomy. The surgery was performed by RL, M.D., a neurosurgeon. Claimant's testimony indicated that he continued to experience radiating pain, a left foot drop, and left toe numbness after the surgery. Claimant's testimony also indicated that his symptoms began to worsen in 2010 and he received another lumbar injection from Stephen MS, M.D., his pain management doctor, in 2011 and that this injection provided relief for approximately one month. The records in evidence indicated that Claimant has been referred to another neurosurgeon, L. G T III, M.D., who has recommended the repeat MRI made the basis of this dispute in order to assess the utility of performing another surgery to Claimant's lumbar spine.

The necessity of the proposed repeat lumbar MRI was denied after an initial review by a Utilization Review Agent (URA) and this denial was upheld by a second URA following a request for reconsideration. Claimant then requested review by an Independent Review Organization (IRO). The IRO reviewer upheld the denial of the procedure based on the Official Disability Guidelines (ODG). Claimant appealed the unfavorable decision of the IRO to this medical contested case hearing (MCCH).

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. 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 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 are 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."

The Low Back Chapter of the ODG provides as follows with regard to the necessity of a magnetic resonance imaging (MRI) of the lumbar spine:

> Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (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) 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) Despite guidelines recommending parsimonious imaging, use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. (Deyo, 2009) As an alternative to MRI, a pain assessment tool named Standardized Evaluation of Pain (StEP), with six interview questions and ten physical tests, identified patients with radicular pain with high sensitivity (92%) and specificity (97%). The diagnostic accuracy of StEP exceeded that of a dedicated screening tool for neuropathic pain and spinal magnetic resonance imaging. (Scholz, 2009) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading Richard Deyo, in the Archives of Internal Medicine to call the fascination with lumbar spine imaging an idolatry. (Pham, 2009) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for spinal CTs (53%), and for

spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study. (Matsumoto, 2010) This large case series concluded that iatrogenic effects of early MRI are worse disability and increased medical costs and surgery, unrelated to severity. (Webster, 2010) Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011) The National Physicians Alliance compiled a "top 5" list of procedures in primary care that do little if anything to improve outcomes but excel at wasting limited healthcare dollars, and the list included routinely ordering diagnostic imaging for patients with low back pain, but with no warning flags, such as severe or progressive neurologic deficits, within the first 6 weeks. (Aguilar, 2011) Owning MRI equipment is a strongly correlated with patients receiving MRI scans, and having an MRI scan increases the probability of having surgery by 34%. (Shreibati, 2011) A considerable proportion of patients may be classified incorrectly by MRI for lumbar disc herniation, or for spinal stenosis. Pooled analysis resulted in a summary estimate of sensitivity of 75% and specificity of 77% for disc herniation. (Wassenaar, 2011) (Sigmundsson, 2011) Accurate terms are particularly important for classification of lumbar disc pathology from imaging. (Fardon, 2001) Among workers with LBP, early MRI is not associated with better health outcomes and is associated with increased likelihood of disability and its duration. (Graves, 2012) 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. For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) 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 findingsor other neurologic deficit)
Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"
Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit
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

Claimant, as the party challenging the IRO decision, has the burden of proof to overcome the IRO decision by a preponderance of evidence-based medical evidence. Evidence-based medical evidence entails the opinion of a qualified expert that has some basis in evidence-based medicine. Expert evidence is required in all medical necessity disputes and Claimant's lay testimony is not probative on questions requiring expert evidence, such as the inquiry into the medical necessity of the procedure at issue.

The decision of the IRO was based on evidence-based medicine – i.e., the ODG. The ODG Low Back Chapter excerpt highlighted above includes a provision that repeat lumbar MRIs are "not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology", such as tumor, infection, fracture, neurocompression, and recurrent disc herniation. While Claimant put forth letters authored by Drs. T and S to support his position that the proposed repeat MRI was health care reasonably required for the compensable injury of (Date of Injury), the opinions contained in those letters lacked sufficient reference to evidence-based medicine to support the doctors' conclusions on necessity. Additionally, a review of the objective medical evidence presented did not conclusively establish that Claimant meets the ODG recommendations for a repeat MRI.

Based on the evidence presented, Claimant did not meet his burden of proof to overcome the decision of the IRO by a preponderance of evidence-based medical evidence. As a preponderance of the evidence is found not to be contrary to the decision of the IRO that the requested lumbar MRI, with and without contrast, is not health care reasonably required for the compensable injury of (Date of Injury), Claimant is held not to be entitled to that procedure.

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 (Date of Injury), Claimant was the employee of (Employer), Employer, and sustained a compensable injury.

   C. On (Date of Injury), Employer provided workers' compensation insurance coverage through Service Lloyds Insurance Company.

   D. The Independent Review Organization (IRO) determined that the health care at issue in this case is not reasonably required for the compensable injury of (Date of Injury).

2. Carrier delivered to 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 4.

3. A lumbar MRI, with and without contrast, is not health care reasonably required for the 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 is not contrary to the decision of the IRO that Claimant is not entitled to a lumbar MRI, with and without contrast, for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a lumbar MRI, with and without contrast, for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

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

JOSEPH KELLEY-GRAY, PRESIDENT
6907 CAPITOL OF TEXAS HIGHWAY NORTH
AUSTIN, TEXAS 78755

Signed this 19th day of February, 2013.

Jennifer Hopens
Hearing Officer