SOAH DOCKET NO. 454-06-0898.P1
DWC NO. _____

NATIONAL FIRE INSURANCE COMPANY, Petitioner	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION, AND ALBERT TURK, M.D., Respondents	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

National Fire Insurance Company (Carrier) challenges a medical interlocutory order (MIO) issued by the Texas Department of Insurance, Division of Workers' Compensation (Division), requiring it to pay for certain office visits and medications provided over a ninety-day period. The Administrative Law Judge (ALJ) concludes that Carrier did not persuasively show that the requested care was medically unnecessary. As a result, Carrier's appeal should be denied.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The MIO was issued on December 13, 2005, pursuant to the Division's Prospective Review of Medical Care (PRM) rules at 28 TEX. ADMIN. CODE (TAC) § 133.650. Carrier filed a timely request for hearing. After several continuances, the hearing convened on September 5, 2007, at the State Office of Administrative Hearings (SOAH), before the undersigned ALJ. Carrier and the Division filed post-hearing arguments on September 19, 2007. The hearing closed on that date. Carrier and the Division were represented by counsel, who appeared in person. Albert Turk, M.D., participated *pro se*, by telephone. Claimant appeared by telephone and was assisted by Anthony Walker, Ombudsman.

SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §§ 402.073(b) and 413.055 and TEX. GOV'T CODE ANN. ch. 2003.

II. DISCUSSION

A. Background

On _____, while employed as a truck driver for an oilfield service company, Claimant injured his neck when he climbed down off a "frack tank," and fell three and one-half to four feet on to the left side of his head and left shoulder area. He continued to feel pain and saw his family physician, Dr. Turk, who evaluated him on December 7, 2000. He complained of neck pain with radiation into both arms with associated numbness and tingling.

A magnetic resonance imaging (MRI) performed on January 2, 2001, showed, among other matters, anterior and posterior degenerative spurring with associated chronic disc herniation at the C5/C6 level of Claimant's spine. There was a decrease of the AP diameter of the bony spinal canal with posterior degenerative spurring, causing mild anterior midline indentation on the cervical cord and moderate right neural foraminal impingement with mild left neural forminal impingement secondary to posterior degeneration spurring at the joints of Luschka. At the C6/C7 level, there was anterior and posterior degenerative spurring with associated disc herniation which causes mild cord flattening and moderate right neural foraminal impingement and left foraminal impingement. There was alteration of the curvature of the cervical spine associated with anterior and posterior degenerative spurring at the C5-6 and C-6-7 levels.[1]

A March 22, 2001, EMG study revealed longstanding C6 radiculopathy on the left and C7 radiculopathy on the right.[2]

[1] Ex. 1 at 131-132.

[2] *Id.*

Claimant was referred to Richard Hubbard, M.D., a neurosurgeon and Mark Workman, M.D., a pain management specialist. Dr. Workman gave Claimant epidural steroid injections that provided no lasting relief. On February 2, 2002, Dr. Hubbard performed an anterior discetomy at C5/C6 and C6/C7 with internal fixation with anterior plating and screws.

A peer review doctor, John Sklar, M.D., opined on June 22, 2005, that the effects of Claimant's work-related injury had resolved and that his current treatment has not changed his pain or functional abilities.[3]

On the basis of Dr. Sklar's opinion, on September 8, 2005, Carrier disputed benefits, saying that any current medical condition is not related to Claimant's compensable injury. It asserted that the compensable injury does not extend to and include multi-level degenerative disc disease with a large posterior osteophyte at C5-6 and C6-7; the injury was a cervical sprain with a limited cervical spine injury, necessitating a two-level fusion at C5/C6 and C6/C7; due to the post-surgery stability of the fusion, Claimant's current condition and need for prescription drugs results from a multi-level degenerative process in the entire cervical spine as opposed to the fusion levels; and that the multi-level degenerative process was an ongoing condition that was not aggravated by the compensable injury at C5-6 and C6-7.[4]

On January 19, 2006, the Division's Hearings Division ruled, among other matters, that the compensable injury extends to and covers the cervical HNP at C5/C6 and C6-C-7; there is aggravation of cervical degenerative disc disease; Claimant has cervical radiculopathy at the C6 and C7 levels; and Claimant has a serious injury with lasting effects that prevent him from returning to prior employment.[5]

The MIO, dated December 12, 2005, was based on a November 16, 2005, prospective review medical examination (PRME) report from Angelita Bautista Frando, M.D. The MIO said Claimant

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[3] *Id.* at 121-122; Ex. 2, Ex. G.

[4] Ex. 3 at 3-4.

[5] Ex 3 at 30-31.

needed continuous pain medication for the cervical fusion and needed one office visit per month with Dr. Workman. The disputed medications include Hydroco/Agap substituted for Lortab 10, 4 per day for 90 days; Fentanyl substituted for Duragesic 25CG/HS Dis, 1 every other day; Hydroxyz Pam, substituted for Viistaril 25mg cap, 1 three times per day as needed; Aciphex 1 per day; and Trazodone, 1 at bedtime.[6]

A September 26, 2006 MRI concluded, in relation to the C5-C-6 and C6/C7 levels, that there are no unusual post-operative findings, the spinal canal and foraminal clearance appear satisfactory, facets appear unremarkable, and the spinal cord appears unremarkable. There was degenerative disc disease at the C3-4 and C4-5 levels, causing mild contour changes to the spinal canal and neural foramina, with clearance at the low limit of normal and reversal of the normal cervical lordosis, which can be positional or due to degenerative arthritis or cervical sprain.[7]

Employees have a right to necessary health care under TEX. LABOR CODE ANN. (Labor Code) §§ 408.021 and 401.011. Section 408.021(a) provides: "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. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment." Section 401.011(19) of the Labor Code provides that health care includes "all reasonable and necessary medical . . . services."

The Carrier has the burden of proof in this proceeding.[8]

B. Party Positions

Carrier acknowledged Claimant's compensable _____ injury, but pointed out that at the time of the injury, he also had chronic pain from low back and right shoulder injuries,[9] lumbar disc

[6] Ex. 2, Ex. A.

[7] Ex. 1 at 165-166.

[8] TEX. LAB. CODE ANN. § 413.055; 28 TEX. ADMIN. CODE (TAC) § 148.14(a).

disease, systemic rheumatoid arthritis, and degenerative joint disease of the knees. It contended the overwhelming weight of evidence is that the disputed medications are to treat these conditions. It cited evidence showing that Claimant's pain specialist, Dr. Workman, and Dr. Turk treated and prescribed medications concurrently for his low back, cervical spine, right shoulder, and arthritis pain, and that he had been treated for his low back and right shoulder injury as late as 2005.

Carrier asserted that the pain caused by Claimant's compensable injury resolved after his February 7, 2002 surgery. It cited testimony from Samuel Bierner, M.D., a board-certified Physical Medicine and Rehabilitation specialist, that Claimant's most recent MRI showed no cervical stenosis.[10] According to Carrier, there is nothing to indicate that Claimant's pain is related to his neck injury. Dr. Bierner said the medications were to treat Claimant's other conditions. Carrier asserted there is no way to know what the PRME doctor or other doctors would have said had they known the results of the September 2006 MRI.

Carrier also cited the above-described June 22, 2005 report from Dr. Sklar, indicating that Claimant's current pain is not related to the compensable injury.

According to Carrier, Claimant's doctors have not attempted to distinguish the symptoms resulting from different pain generators. It contended this omission is in violation of Texas Medical Board rules at 22 TAC §§ 170.1-170.3, requiring doctors to document the nature and intensity of the patient's pain; current and past treatments for pain; any underlying coexisting diseases and conditions; and, in the case of chronic pain, how the medication relates to the chief presenting complaint of chronic pain. It cited Labor Code § 408.021, requiring that medical treatment be necessary to treat the compensable injuries only.

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[9] Claimant testified that his treating doctor told him he had the worst low back he had ever seen. Claimant said he has not undergone surgery for his low back and that he received a 14 to 15 percent impairment rating for his low back injury.

[10] This is contrary to findings by Drs. Turk and Workman, and Mark E. Huff, M.D., which concluded that Claimant has spinal stenosis.

Citing pages from the Physician's Desk Reference (PDR),[11] Carrier asserted further that the specific medications are not helpful in treating Claimant's condition. It said hydrocodone can be habit forming and should not be used over a long-term period and that Fentanyl, Aciphex, and Vistaril are for conditions that are unrelated to the compensable injury. With respect to Trazadone, it said that no doctor has related Claimant's depression to the compensable injury.

The Division maintained the preponderant evidence is that the disputed services were medically necessary. It cited the January 2006 Division Order, in which the Hearing Officer concluded that the compensable injury includes a cervical herniation at C5/C6 and C6/C7, aggravation of cervical disc disease, and cervical radiculopathy at C6 and C7. It cited the following additional evidence in support of its position:

- Required Medical Examination (RME)[12] doctor Michael D. Ciepiela, M.D., an orthopedic surgeon, found on November 11, 2004, that Claimant had residual left upper extremity radiculopathy, the medical treatment was related to the compensable condition, and there will be no resolution of Claimant's problem because of continuing problems with multiple-level cervical spinal fusion.

- Dr. Workman concluded on September 22, 2005, that the pain is directly related to the compensable condition because Claimant did not have pain complaints prior to his at-work injury. Dr. Workman's documented pain visits from January 2003 until June 2006 refers to chronic pain related to the cervical radiculopathy.

- Division RME doctor Dr. Huff, an orthopedic surgeon, concluded on November 3, 2005, that Claimant suffers from severe spinal stenosis as well as herniation at C5/C6 and C6/C7, with encroachment of neural foramina and nerve roots producing neck pain and radiculopathy, and that Claimant's current condition is directly related to the compensable injury. Dr. Huff said Claimant had degenerative disc disease before his injury that was aggravated by the injury.

- PRME doctor, Angelita Frando, M.D., concluded that Claimant has decreased strength in his upper left extremity with decreased shoulder and neck range of motion with left upper extremity radiculopathy.

[11] These are un-numbered pages at the end of Exhibit 1 following page 167.

[12] A RME doctor examines an employee's condition in response to a request from an insurance carrier or the Division to provide an independent evaluation. 28 TAC § 180.22(f).

- A post-operative February 22, 2002 x-ray shows apparent bone material anterior to the disc space at C6/C7 which may be a portion of a bone graft that has slipped anteriorly, and that there may have been a failure of the bone graft fusion.

- Drs. Sklar and Bierner acknowledged that the effects of the surgery are part of Claimant's compensable injury.

- Carrier's peer review doctor Neal H. Blauzvern, D.O., said a complete resolution of Claimant's symptoms is unlikely to occur (because he thought Claimant's surgery had failed).

- Dr. Workman said chronic pain may be present and develop even with resolution of the initial underlying insult.

- Citing pages in Dr. Workman's notes concerning Claimant's pain, the Division contended Claimant's medical records comply with Texas Medical Board rules by documenting Claimant's chief complaint, current pain medication, interval history, pain medication compliance, pain medication adverse effects, past history, review of systems, physical exams, impressions, and plan.

- Dr. Turk testified that a clinical evaluation rather than an MRI is the best indication of radiculopathy.

According to the Division, Carrier's position in its denial of benefits, that Claimant's condition is the result of multi-level degenerative process in the entire cervical spine as opposed to the fused levels, ignores the fact that the C6/C7 levels are part of the cervical spine.

The Division maintained that Claimant has suffered unique neck and shoulder pain until the present day. It cited statements from Dr. Turk and Dr. Workman that Claimant had not complained of neck pain before the _____ injury.

The Division cited case law holding that workers' compensation laws are meant to include coverage for employees whose injuries are incurable,[13] and that an aggravation of a prior injury is intended to include a covered injury.[14] It cited Labor Code § 408.021, which provides that an injured employee is entitled to all health care reasonably required as and when needed.

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[13] *Travelers Ins. Co. v. Wilson*, 28 S.W. 3d 42, 46 (Tex. App.– Texarkana 2000, no writ)

[14] *Cooper v. St. Paul Fire & Marine Insurance Company*, 985 S.W. 2d 614, 617 (Tex. App.–Amarillo 1999, no writ).

The Division cited Dr. Bierner's acknowledgment that adjacent segment disease or degeneration could manifest after 10 years.[15]

C. Analysis

The ALJ concludes that Carrier did not convincingly show the disputed care was medically unnecessary to treat Claimant's compensable injury.

Carrier's strongest evidence, upon which Dr. Bierner's testimony is primarily based, is the September 2006 MRI. It is the most recent objective evidence of pathology at the C5-6 and C6-7 levels of Claimant's spine and, as Carrier pointed out, was performed after most of the doctors who saw Claimant diagnosed his condition. The MRI shows no unusual post-operative findings, normal facets, and a normal spinal cord.

However, the ALJ finds the preponderant evidence is that Claimant has significant neck pain that began with his _____ at-work injury. Claimant's continuing neck pain is shown by his testimony that he attempted to stop his medications, but his neck and head hurt so much that he had to start them again. He said his neck hurts all the time and he has very little low-back pain at present. He sees several other doctors for his arthritis.[16] The ALJ found Claimant's statements to be candid and truthful, as did all of the doctors who examined him.[17] An example of his candor was his testimony that he has left-shoulder pain as well as neck pain, even though he believes his left shoulder pain has not been included as part of his compensable injury. Dr. Turk testified that Claimant's most recent complaints, as of August 16, 2007, are of pain in his neck and left shoulder

[15] The Division cited pages from the Occupational Disability Guideline (ODG) in support of certain assertions. These matters cannot be considered because the ODG was not tendered into evidence.

[16] Although, as argued by Carrier, Claimant did have pain before the compensable injury, the pain was in his low-back, knees, right shoulder, and hands.

[17] The ALJ disagrees with Dr. Bierner's testimony that Claimant's pain is not from his neck and the implication of his testimony that Claimant and Claimant's doctors are falsely attributing Claimant's pain to his neck to obtain insurance coverage for another pain source. All five doctors who personally examined Claimant concluded that his neck pain complaints were genuine. This includes not only his treating doctors, Drs. Turk and Workman, but also three doctors who provided an independent review of his condition: Drs. Ciepiela, Huff, and Frando.

and that his main reason for seeing Dr. Workman was the neck and left-shoulder pain. He said there has been no indication of symptom magnification or malingering by Claimant.

In light of the conclusion that Claimant has cervical neck pain, it appears that Carrier is limited to arguing that the neck pain is from problems not at C5/C6 and C6-C-7. Dr. Bierner testified if there is cervical pain, it is from a higher level of Claimant's cervical spine.[18] However, this position would be substantially the same as stated in Carrier's September 2005 benefits dispute in which it said Claimant's current condition and need for drugs results from a multi-level degenerative process in the entire cervical spine rather than the fusion levels and this process was an ongoing condition that was not aggravated by the compensable injury. The Division's January 19, 2006 Decision and Order, rejected this position. In determining Carrier's liability for Claimant's post-operative condition, the Division found that the compensable injury "includes aggravation of cervical disc disease;" "includes cervical radiculopathy at the C6 and C7 levels;" and "Claimant has severe [compensable] injuries **with lasting effects**."[19] (Emphasis added.) Carrier appears to be attempting to retry issues already decided by the Division.

The ALJ finds that Carrier did not otherwise carry its burden of proving that the disputed services are medically unnecessary. There is significant evidence to indicate that the MRI findings are not conclusive.

First, the evidence preponderates toward a finding that pain following a cervical spinal fusion is distinctly possible and, according to some experts, likely. RME Dr. Ciepiela, who examined Claimant on three different occasions, said there will be no resolution of the pain because multiple-level-cervical-spine fusion is a life-long condition. He said the goal of surgery is to stabilize the condition and prevent further worsening of the neurologic function.[20] Dr. Turk agreed that multi-level fusion frequently creates a life-long condition and that there would be no resolution of

[18] Dr. Bierner pointed out that the September 2006 MRI shows degenerative disc disease at the C3-4 and C4-5 levels causing mild contour changes to the spinal canal and neural foramina with clearance at the low end of normal. There was also reversal of the normal cervical lordosis, which can be positional or due to degenerative arthritis or cervical strain. Ex. 1 at 166.

[19] Ex. 3 at 30-31, Findings of Fact Nos. 5, 6, and 10.

[20] Ex. 1 at 104.

Claimant's problem. Dr. Workman said current research shows chronic pain may be present and develop even when the underlying insult has resolved and that once a person has neck surgery, there is every likelihood of degeneration above and below the surgery level.[21] Designated doctor Delbert McCaig, D.O., concluded that Claimant had cerviocodorsal myofascial pain likely secondary to his injury **and surgery**.[22] Dr. Bierner acknowledged the possibility of continuing problems with cervical-spinal fusion, but said that usually occurs after 10 years. When asked whether this might be the source of Claimant's pain, he said arthritis pain is "equally likely."

Second, it appears that chronic pain frequently is not shown by objective data. Dr. Workman said that often there will be no objective data to support continued pain complaints in a chronic pain situation.[23] Dr. Turk testified there is no good, effective test for measuring pain. He said that radiculopathy is caused by anything that presses on a nerve, including spinal stenosis (which the MRI ruled out), scarring, trauma, and muscle spasms.

Third, there is some objective data showing Claimant's pain generators at his C5-6 and C6-7 spinal levels. In a February 22, 2002 post-operative x-ray, the technician concluded there is some bone material anterior to the disc space at C6-7 and soft tissue swelling along the spine down from C3 past T1.[24] Dr. Turk testified that a clinical diagnosis can show radiculopathy. He can test the distribution of pain, loss of muscle strength, and changes in the sensory findings of a nerve by testing the strength or weakness of the muscle the nerve goes to. He presses a sharp or dull point on the patient to show this. He saw evidence in Dr. Ciepiela's November 11, 2004 record of neurologic testing,[25] where Dr. Ciepiela stated, under a heading for neurological examination, that sensation was decreased at C5-7 at the left. After examining Claimant, PRME Dr. Frando concluded that Claimant

[21] *Id.* at 129, 161.

[22] *Id.* at 24.

[23] *Id.* at 129.

[24] Ex. 1 at 21.

[25] *Id.* at 103.

has decreased strength in his upper left extremity with decreased shoulder and neck range of motion with left upper extremity radiculopathy.[26]

The foregoing discussion demonstrates significant evidence on both sides of the issue and considerable doubt as to the source of Claimant's pain. The ALJ finds that the evidence is inconclusive on that issue. He concludes that Carrier did not carry its burden of proof.

Carrier contended that, regardless of the cause of Claimant's pain, the specific medications he is taking are not medically necessary. Carrier maintained that Hydroco/Agap (Lortab) is contraindicated over long periods. However, the ALJ did not see a statement to that effect in the PDR pages included in the record.

Regarding Trazadone, Carrier argued that no physician has related Claimant's depression to the compensable injury. Aside from reversing the burden or proof, this argument ignores the fact that Trazadone has been prescribed at times that Claimant's primary complaint has been his neck pain.[27] This is persuasive circumstantial evidence that the Trazadone relates to the neck pain.

Carrier's argument that the other drugs, Fentanyl, Aciphex, and Vistaril, are unnecessary is based simply on its assertion that Claimant's pain is unrelated to his compensable injury. That issue is addressed above.

The evidence shows that Hydroco/Agap and Fentanyl are for pain, Vistaril is for anxiety and sometimes for sleep, and Trazadone is an anti-depressant that is also used for sleep.

Aciphex is an anti-reflux drug. Dr. Bierner testified he believed this medication was to deal with the effects of Claimant's arthritis medications, rather than Hydroco/Agap or Fentanyl. He said that Hydrocodone does not cause stomach acidity that would be helped by Aciphex. However, Dr. Workman appears to disagree because he prescribed Aciphex to help with stomach upset caused by

[26] Ex. 2, Ex. B.

[27] Ex. 1 at 49, 161

Lortab (Hydrocodone).[28] Moreover, the PDR states that side effects of Lortab can include nausea and vomiting and of Fentanyl can include abdominal pain, indigestion, nausea, and vomiting.[29] The ALJ finds that Carrier did not prove that Aciphex is medically unnecessary.

The ALJ did not find it necessary to resolve the issue of whether Claimant's doctors' notes complied with Texas Medical Board rules. Compliance or lack of compliance with those rules is not persuasive in this particular case, one way or the other, on the issue of whether the medications and office visits are necessary to treat Claimant's compensable injury.

III. FINDINGS OF FACT

1. On ____, while employed as a truck driver for an oilfield service company, the injured worker (Claimant) injured his neck when he climbed down off a "frack tank," and fell three and one-half to four feet on to the left side of his head and left shoulder area.

2. Claimant continued to feel pain and saw his family physician, Albert Turk, M.D., who evaluated him on December 7, 2000.

3. Claimant complained of neck pain with radiation into both arms associated with numbness and tingling.

4. A magnetic resonance imaging (MRI) performed on January 2, 2001, showed, among other matters, anterior and posterior degenerative spurring with associated chronic disc herniation at the C5/C6 level of Claimant's spine; a decrease of the AP diameter of the bony spinal canal with posterior degenerative spurring, causing mild anterior midline indentation on the cervical cord and moderate right neural foraminal impingement with mild left neural forminal impingement secondary to posterior degeneration spurring at the joints of Luschka; at the C6/C7 level, anterior and posterior degenerative spurring with associated disc herniation which causes mild cord flattening and moderate right neural foraminal impingement and left foraminal impingement; and alteration of the curvature of the cervical spine associated with anterior and posterior degenerative spurring at the C5-6 and C-6-7 levels.

5. A March 22, 2001 EMG study revealed longstanding C6 radiculopathy on the left and C7 radiculopathy on the right.

6. Claimant was referred to Richard Hubbard, M.D., a neurosurgeon and Mark Workman, M.D., a pain management specialist.

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[28] *Id.* at 84.

[29] *Id.*

7. Dr. Workman gave Claimant epidural steroid injections that provided no lasting relief.

8. On February 2, 2002, Richard Hubbard, M.D., performed an anterior discetomy at C5/C6 and C6/C7 with internal fixation with anterior plating and screws.

9. A peer review doctor, John Sklar, M.D., opined on June 22, 2005, that the effects of Claimant's work-related injury had resolved and that his current treatment has not changed his pain or functional abilities.

10. On the basis of the peer review, Carrier disputed benefits on September 8, 2005, and said any current medical condition is not related to the compensable injury. Carrier also said: the compensable injury does not extend to and include multi-level degenerative disc disease with a large posterior osteophyte at C5-6 and C6-7; the injury was a cervical sprain with a limited cervical spine injury, necessitating a two-level fusion at C5/C6 and C6/C7; due to the post-surgery stability of the fusion, Claimant's current condition and need for prescription drugs results from a multi-level degenerative process in the entire cervical spine as opposed to the fusion levels; and the multi-level degenerative process was an ongoing condition that was not aggravated by the compensable injury at C5-6 and C6-7.

11. On January 19, 2006, the Division's Hearings Division ruled, among other matters, that the compensable injury extends to and covers the cervical HNP at C5/C6 and C6-C-7; there is aggravation of cervical degenerative disc disease; Claimant has cervical radiculopathy at the C6 and C7 levels; and Claimant has a serious compensable injury with lasting effects that prevent him from returning to prior employment.

12. Dr. Turk requested medical care over a 90-day period, including one office visit per month with Dr. Workman; Hydroco/Agap substituted for Lortab 10, 4 per day for 90 days; Fentanyl substituted for Duragesic 25CG/HS Dis, 1 every other day; Hydroxyz Pam, substituted for Viistaril 25mg cap, 1 three times per day as needed; Aciphex 1 per day; and Trazodone, 1 at bedtime (disputed services).

13. On November 16, 2005, in a prospective review medical examination (PRME), Angelita Bautista Frando, M.D, concluded that the disputed services were medically necessary.

14. A medical interlocutory order (MIO) issued on December 12, 2005, ordered Carrier to cover the disputed services.

15. Not more than 20 days after receiving notice of the MIO, Carrier requested a hearing under the Division's PRME rules at 28 TEX. ADMIN. CODE § 134.650.

16. All parties received not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

17. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

18. A September 26, 2006 MRI found, in relation to the C5/C-6 and C6/C-7 levels, that there are no unusual post-operative findings, the spinal canal and foraminal clearance appear satisfactory, facets appear unremarkable, and the spinal cord appears unremarkable; and there was degenerative disc disease at the C3-4 and C4-5 levels, causing mild contour changes to the spinal canal and neural foramina, with clearance at the low limit of normal and reversal of the normal cervical lordosis, which can be positional or due to degenerative arthritis or cervical sprain.

19. Claimant has had neck pain since his _____ compensable injury.

20. Claimant did not have neck pain before his _____ compensable injury.

21. Pain following a multi-level cervical spine fusion is likely.

22. Pain is frequently not shown by objective data.

23. Radiculopathy can be caused by anything pressing on a nerve, including stenosis, scarring, trauma, and muscle spasms.

24. Neurologic testing by Michael D. Ciepiela, M.D., on November 11, 2004 showed that some sensation at the C5-C7 level of Claimant's spine on the left had decreased.

25. A February 22, 2002 x-ray, immediately after Claimant's surgery, showed some bone material anterior to the disc space at C6/C7.

26. At the time of Dr. Frando's PRME examination, Claimant had decreased strength in his upper left extremity with decreased shoulder and neck range of motion with left upper extremity radiculopathy.

27. The evidence is inconclusive on the source of Claimant's neck pain.

28. An assertion that Claimant's neck pain is from a source in his cervical spine other than the C6/C7 levels is contrary to the Division's January 19, 2006 Decision and Order.

29. Hydroco/Agap and Fentanyl are for pain, Vistaril is for anxiety and sometimes for sleep, Trazadone is an anti-depressant that is also used for sleep, and Aciphex is an anti-reflux drug.

30. Side effects of Lortab can include nausea and vomiting and of Fentanyl can include abdominal pain, indigestion, nausea, and vomiting.

31. The disputed medications were prescribed for Claimant's neck pain.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, under TEX. LAB. CODE ANN. §§ 402.073(b) and 413.055 and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Carrier has the burden of proof in this proceeding. TEX. LAB. CODE ANN. § 413.055, 28 TEX. ADMIN. CODE (TAC) § 148.14(a).

4. Carrier did not prove that the disputed services are not reasonably required by the nature of Claimant's compensable injury. TEX. LAB. CODE ANN. § 408.021.

5. Carrier's appeal should be denied. TEX. LAB. CODE ANN. § 408.021.

ORDER

IT IS ORDERED that National Fire Insurance Company's appeal, under 28 TEX. ADMIN. CODE § 134.650, of the medical necessity of three office visits, and Hydroco/Agap, Fentanyl, Hydroxyz Pam, Aciphex, and Trazadone provided to Claimant be, and the same is hereby, denied.

SIGNED November 12, 2007.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS