[Cite as *State ex rel. Wilson v. Indus. Comm.*, 2012-Ohio-323.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State ex rel. Danny L. Wilson,	:	
Relator,	:	
v.	:	No. 11AP-48
Industrial Commission of Ohio and Star Leasing Company,	:	(REGULAR CALENDAR)
Respondents.	:	

D E C I S I O N

Rendered on January 31, 2012

Charles Zamora Co., L.P.A., and *Karen D. Turano,* for relator.

Michael DeWine, Attorney General, and *Kevin J. Reis,* for respondent Industrial Commission of Ohio.

Weston Hurd LLP, Michael J. Spisak and *Jennifer A. Riester,* for respondent Star Leasing Company.

IN MANDAMUS
ON OBJECTIONS TO MAGISTRATE'S DECISION

BRYANT, J.

{¶1} Relator, Danny L. Wilson, commenced this original action requesting a writ of mandamus that orders respondent Industrial Commission of Ohio to vacate its order

refusing to authorize the requested surgery and instead to authorize the surgery because it meets the applicable criteria.

I. Facts and Procedural History

{¶2} Pursuant to Civ.R. 53 and Section (M), Loc.R. 12 of the Tenth Appellate District, this matter was referred to a magistrate who issued the appended decision, including findings of fact and conclusions of law. In her decision, the magistrate noted relator's argument that the commission abused its discretion in denying his request for the Anterior Lumbar Interbody Fusion ("ALIF") procedure based on the August 21, 2009 report of Dr. Hauser, the September 18, 2009 report of Dr. Cooper, and the March 15, 2010 report of Dr. Siegel. Relator argued the reports do not support the commission's decision because (1) the reports of Drs. Hauser and Cooper pre-date the intradiscal electrothermic therapy ("IDET") procedure and thus do not consider its failure, and (2) Dr. Siegel's report erroneously indicates that Dr. White requested the ALIF procedure due to relator's annular disc tear and radiculopathy, the latter not being an allowed condition in the claim. Concluding relator's challenge to the three reports lacks merit, the magistrate determined the requested writ should be denied.

II. Objections

{¶3} Relator filed objections to the magistrate's conclusions of law:

> **A. The Magistrate Erred By Concluding Dr. Hauser and Dr. Cooper's Report Constitutes "Some Evidence" Upon Which The Commission Could Rely Because The Reports Do Not Consider The Most Recent Medical Procedure And Proffer An Opinion On the Correctly Allowed Conditions.**
>
> **B. The Magistrate Erred By Concluding Dr. Siegel's Report Constitutes "Some Evidence" Upon Which The**

Commission Could Rely Because Dr. Siegel's Opinion Is Equivocal With Reference To The Appropriateness Of The Surgery Directed At The Annular Tear At L5-S1.

Relator's objections largely reargue those matters adequately addressed in the magistrate's decision. For the reasons set forth in the magistrate's decision, we overrule the objections.

A. *First Objection*

{¶4} Relator initially contends the reports of Drs. Hauser and Cooper cannot constitute some evidence upon which the commission may rely because the reports, which pre-date relator's IDET procedure, neither consider the failure of that procedure nor offer an opinion on the allowed conditions in relator's post-procedure status.

{¶5} Initially, relator points out that the reports of Drs. Hauser and Cooper both refer to relator's allowed conditions and note radiculopathy is not one of them. The truth of the statement is not contested: all parties agree that relator did not seek, and was not granted, radiculopathy as an allowed condition in his claim. Accordingly, under the circumstances involved here, the doctors' reference to radiculopathy neither supports nor takes away from the merits of their reports. Rather, the significant aspect of each report is its conclusion that the ALIF procedure is inappropriate for the conditions allowed in relator's claim. For example, Dr. Hauser opined that the ALIF procedure was "warranted only for significant degenerative disk disease with, at least, partial collapse of the disk," but also noted relator's claim was "specifically disallowed for lumbosacral disk degeneration." (Mag. Dec., ¶71.) The commission thus could rely on Dr. Hauser's opinion, since the conditions that would support the ALIF procedure are not part of the allowed conditions in relator's claim.

{¶6} Similarly, Dr. Cooper set forth those conditions that in his opinion warrant the ALIF procedure, but relator suffers from none of them according to the evidence. Had the reports indicated the ALIF procedure was not appropriate unless an IDET procedure were performed and failed, relator's contentions would be more persuasive. Instead, both doctors opine that the ALIF procedure, an aggressive surgical procedure, was not appropriate to the conditions allowed in relator's claim.

B. *Second Objection*

{¶7} Relator's second objection challenges Dr. Siegel's March 15, 2010 report. In it, Dr. Siegel agrees both with Dr. Hauser's conclusion that relator's allowed conditions do not support performing the ALIF procedure and with Dr. Cooper's opinion that the procedure is indicated only for the type of instability or neurological compromise that relator does not have. Relator, however, notes Dr. Siegel indicated some anecdotal confirmation that the procedure is, at times, performed for an annular tear, one of the allowed conditions in relator's claim.

{¶8} As the magistrate appropriately concluded, however, Dr. Siegel's report is neither internally inconsistent nor ambiguous. The doctor's acknowledging the procedure has been performed for relator's condition does not negate his opinion, consistent with those of Drs. Hauser and Cooper, that the procedure is not appropriately performed in relator's circumstances.

III. Disposition

{¶9} Following independent review pursuant to Civ.R. 53, we find the magistrate has properly determined the pertinent facts and applied the salient law to them. Accordingly, we adopt the magistrate's decision as our own, including the findings of fact

and conclusions of law contained in it. In accordance with the magistrate's decision, we deny the requested writ of mandamus.

Objections overruled; writ denied.

SADLER and CONNOR, JJ., concur.

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APPENDIX

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Danny L. Wilson,	:	
Relator,	:	
v.	:	No. 11AP-48
Industrial Commission of Ohio and Star Leasing Company,	:	(REGULAR CALENDAR)
Respondents.	:	

M A G I S T R A T E ' S D E C I S I O N

Rendered on September 8, 2011

Charles Zamora Co., L.P.A., and *Karen D. Turano,* for relator.

Michael DeWine, Attorney General, and *Kevin J. Reis,* for respondent Industrial Commission of Ohio.

Weston Hurd LLP, Michael J. Spisak and *Jennifer A. Riester,* for respondent Star Leasing Company.

IN MANDAMUS

{¶10} Relator, Danny L. Wilson, has filed this original action requesting that this court issue a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order refusing to authorize the requested surgery and

ordering the commission to find that the requested surgery did meet the criteria and should be authorized.

Findings of Fact:

{¶11} 1. Relator sustained a work-related injury on February 20, 2007.

{¶12} 2. Relator signed an FORI-1 on March 9, 2007, alleging that the injury occurred when he "slipped on ice walking to service truck" and that he injured his "shoulder R knee + lower back" as a result.

{¶13} 3. On March 19, 2007, relator's employer, Star Leasing, rejected his claim arguing that the "injury occurred on transit to work and not while he was working."

{¶14} 4. An MRI taken September 25, 2007 revealed the following impressions:

> [a] Small right paracentral disc protrusion with abutment of the right L5 nerve root noted. A small disc bulge and a small left foraminal disc protrusion are identified at this level without significant canal or foraminal stenosis noted.
>
> [b] Small disc bulge and right paracentral annular rent at L5-S1.
>
> [c] Multilevel facet hypertrophy.

{¶15} 5. In a physician review dated February 5, 2008, Terri Wilkerson Riddiford, M.D., was asked to opine as to whether or not the conditions relator claimed were directly related to the injury. Dr. Riddiford concluded as follows:

> [B]ased on reasonable medical probability there is sufficient medical documentation to support the additional condition: Facet arthropathy L2/S1 by way of substantial aggravation of pre-existing condition and Annular tear L5/S1 as well as L/S radicullitis both by way of flow-thru mechanism. Specifically the IW has had persistent LBP with clear objective findings per MRI/May 2008 and Pain Mgmt therapies recommended per Dr. Kumar for the above conditions.

{¶16} 6. Following a hearing before a staff hearing officer ("SHO") on March 17, 2008, relator's claim was allowed for the following conditions:

> LUMBAR STRAIN; LEFT SHOULDER STRAIN; LEFT KNEE STRAIN; CERVICAL STRAIN; HERNIATED NUCLEUS PULPOSUS C6-7.

The SHO specifically denied the allowance of the following other conditions:

> AGGRAVATION ARTHRITIS LEFT KNEE; AGGRAVATION LUMBAR DEGENERATIVE DISC DISEASE; and AGGRAVATION CERVICAL DEGENERATIVE DISC DISEASE.

{¶17} 7. In a C-9 dated April 21, 2008, relator's physician, Ralph W. Newman, D.O., requested the authorization for another MRI and a neurological consultation with Dr. White.

{¶18} 8. The MRI dated May 2, 2008 revealed the following findings and impressions:

> FINDINGS: Lumbar alignment is normal. Mild degenerative changes are present at the L2-3, L3-4, L4-5, and L5-S1 levels, where there is slight loss disc space height and signal, annular bulging, and facet arthropathies, which narrow the exit neural foramina bilaterally at L4-5. No focal disc protrusions are seen. An incidental hemangloma is noted in the bodies of T11, L1 and L4. The T12-L1 and L1-2 interspaces are unremarkable.
>
> The conus medullaris is normal. No compression fracture seen.
>
> IMPRESSION:
>
> Mild lumbar spondylosis, most marked at L4-5 where there is mild bilateral neural foraminal narrowing.

{¶19} 9. Relator was examined by Mark A. White, D.O., and, in his May 12, 2008 report, Dr. White noted the following:

> [a] Back pain, most likely facet-mediated pain, aggravation of preexisting facet disease from a traumatic fall at work.
>
> [b] Multilevel degenerative disc disease from L2 to S1 with no significant herniated disc, foraminal stenosis.
>
> [c] Right hip pain, rule out primary hip pathology.
>
> [d] Comorbid factors to include mild obesity and diabetes.

Dr. White opined that relator would benefit from a pain management referral for facet block injections and a formal course of physical therapy. Dr. White also opined that the following additional conditions should be allowed in relator's claim:

> * * * I do feel he needs additional allowances degenerative disc disease (722.52) added to his claim for a chronic condition aggravated by a work injury for L2-3, L3-4 and L4-5, and L5-S1 added to his claim along with facet arthropathy (721.3) added to his claim which is a chronic condition but aggravated by his work injury.

{¶20} 10. Relator was seen by Vasantha Kumar, M.D. at the Olentangy Pain Clinic. In a letter dated June 13, 2008, Dr. Kumar recommended that relator continue with physical therapy, indicated he might benefit from adding low dose of "elavil or neurontin to help with neuropathic pain." Dr. Kumar also recommended a trial of lumbar facet joint injections.

{¶21} 11. In a letter dated July 18, 2008, Dr. White opined that a lumbar discogram was necessary for the following reasons:

> As you recall, his MRI scan shows diffuse degenerative disc disease from L2 to S1 with no significant foraminal stenosis. He does have a small annular protrusion at L4-5 with his worst degenerative disc disease being at L4-5. The only thing I can offer him in the office is to determine where his pain generator is coming from. With workers' compensation denying all diagnostic procedures, this puts this patient in a difficult situation in the hopes of finding his pain generator to

> determine if there is anything from a surgical standpoint to offer him. I am still not overly optimistic given the diffuse nature of his disc disease, facet disease that surgery would be successful unless we can clarify the pain generator. Therefore, I discussed with him in the office today provocative lumbar discography to help clarify the pain generator.

Dr. White also opined that the following additional conditions should be allowed in relator's claim:

> I do feel he needs annular protrusion (724.4) added to his claim which is a direct and proximate result of his work injury and also degenerative disc disease (722.52) which is a chronic condition aggravated by his work injury.

{¶22} 12. On August 23, 2008, Dr. Kumar performed a total of six lumbar facet joint medial branch blocks at L4-5 and L5-S1. Dr. Kumar would repeat the injections on September 6, 2008.

{¶23} 13. In a C-9 dated August 25, 2008, Dr. Newman requested permission to perform the discogram, for follow-up visits and for another MRI.

{¶24} 14. Mark G. Siegel, M.D. examined relator at the request of the employer. In his August 27, 2008 report, Dr. Siegel opined that the lumbar discogram and follow-up MRI were the appropriate diagnostic steps given relator's condition.

{¶25} 15. In an order mailed September 15, 2008, the Bureau of Workers' Compensation ("BWC") denied the requested treatment.

{¶26} 16. In spite of the fact that the requested discogram was refused, the discogram was performed on September 18, 2008.

{¶27} 17. After reviewing the results of the discogram, Dr. White opined that relator's "back pain is due to internal disc derangement L5-S1 due to degenerative disc

disease which is a chronic condition, significantly aggravated by his traumatic injury at work." Dr. White noted the following impressions:

> Mechanical back pain secondary to internal disc derangement due to degenerative disc disease L5-S1 (722.52) which is indirectly related to his work injury, i.e., chronic condition aggravated and significantly aggravated by his work injury.

With regard to further treatment, Dr. White opined that the following treatment was warranted:

> At this juncture, I discussed with him IDET[1] annuloplasty to seal nociceptive fibers in the hopes of alleviating his symptoms. Due to the fact if he had a lumbar fusion he most likely would never be able to return back to the job description he has currently. Therefore, I feel his best option is to pursue IDET annuloplasty.

{¶28} 18. Although the discrogram had initially been denied by the BWC, a hearing was held before a district hearing officer ("DHO") on November 5, 2008. The DHO found that the "requested discogram of the lumbar spine is for diagnostic purposes only" and therefore granted the request on Dr. White's July 18, 2008 report. The DHO's order granting the request for a discrogram would ultimately be affirmed following a hearing before an SHO on January 8, 2009.

{¶29} 19. In a C-9 dated October 8, 2008, Dr. Newman requested authorization for the IDET procedure and post-operative visits. The employer denied the request and the appeal process began.

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[1] Intradiscal electrothermic therapy (IDET) is a relatively new, minimally invasive treatment for spinal disc-related chronic low back pain. This type of persistent disc pain is thought to be caused by nerve fibers that have grown from their normal location in the outer layers of the disc, reaching into the disc interior. This is related to the breakdown (degeneration) of the tough outer layers (annulus) of the disc. The pain may also be from injury to the disc, causing the material in the center (nucleus) of the disc to move into the outer layers of the disc. This material from the nucleus is irritating to the outer layers, where the nerves are, and causes pain. (footnote omitted.)

{¶30} 20. On January 26, 2009, relator filed a motion seeking to have his claim additionally allowed for certain conditions and, in an order mailed February 17, 2009, the BWC allowed relator's claim for the following additional conditions: "721.3 FACET ARTHROPATHY L2-S1, 722.10 LUMBAR DISC DISPLACEMENT, and 724.4 LUMBOSACRAL NEURITIS NOS." The BWC based its order on the February 2, 2008 report by Dr. Riddiford.

{¶31} 21. The employer appealed and had relator examined by Walter H. Hauser, M.D., F.A.C.S. On March 15, 2009, Dr. Hauser opined that relator's current condition was "certainly consistent with the natural aging process, and considering his age group and his weight, they do not demonstrate any significant signs of aggravation." Ultimately, Dr. Hauser concluded that the disputed conditions of aggravation of preexisting facet arthropathy L2-S1, and annular tear L5-S1 were part of the natural aging process, that there was no evidence that there was a substantial aggravation and that those conditions should not be allowed. Further, Dr. Hauser opined that the annular tear at L5-S1 had "no clinical significance."

{¶32} 22. In response, Dr. White authored a letter, dated March 30, 2009, expressing his disagreement with Dr. Hauser's opinion and opining that the requested conditions were the result of the February 7, 2007 work injury**.**

{¶33} 23. Apparently a hearing was held before a DHO, and relator's request that his claim be allowed for additional conditions was denied.[2]

[2] There is no DHO order regarding this issue. However, there is an SHO order which references a DHO order on this issue.

{¶34} 24. The appeal from the DHO order was held before an SHO on May 13, 2009. The SHO initially noted that relator's claim was "neither allowed nor disallowed for the condition of lumbosacral neuritis [inasmuch as] the Injured Worker did not request the recognition of this condition in the C-86 motion at issue today." Thereafter, the SHO determined that relator's claim should be additionally allowed for the following conditions: "SUBSTANTIAL AGGRAVATION OF PRE-EXISTING FACET ARTHROPATHY L2-S1 and for ANNULAR TEAR L[2]-S1 as causally related to the allowed industrial injury." The SHO's order was based on the following evidence:

> [T]he report of Dr. Riddiford, dated 02/05/2008; the MRI dated 05/02/2008 and 09/25/2007; the discogram dated 09/18/2008; the reports of Dr. White dated 05/12/2008 and 07/18/2008; the reports of Dr. Kumar dated 06/13/2008, 08/23/2008, and 09/06/2008.

{¶35} 25. In a letter dated May 26, 2009, Dr. White reviewed relator's treatment options and explained his rationale for requesting the IDET procedure. Thereafter, Dr. White addressed the treatment options available to relator if the IDET procedure was refused:[3]

> I am seeing Mr. Wilson. As you know, he has mechanical back pain due to internal disc derangement secondary to annular tear (724.4). We have exhausted all measures to try to get IDET annuloplasty or percutaneous lumbar disc decompression approved, to no avail. Therefore, I brought Mr. Wilson in to discuss other options. He has failed all conservative measures to include multiple rounds of physical therapy, epidural injections, facet blocks and he is still having to take Percocet for pain. Therefore, I discussed with him artificial disc replacement versus anterior lumbar fusion. The fact that he does have adjacent level degenerative disc disease at L4-5 and small annular protrusion, I would opt to pursue artificial disc replacement to keep and maintain his

[3] At this time, the procedure had not yet been authorized and was in the appeal process.

> motion at L5-S1 to avoid adjacent level disc degeneration progression. I reviewed with him on a plastic model how the surgery is performed. He is a candidate due to the fact he has minimal facet arthropathy, he has already had facet blocks which would not alleviate his pain, so therefore, the majority of his symptoms seem to be of discogenic etiology. Therefore, again, I reviewed with him how the surgery is performed.
>
> We obtained an updated MRI of his lumbar spine dated May 26, 2009, again showing annular tear at L5-S1. I disagree with the radiologist's interpretation, there is not a significant right foraminal disc herniation at L4-5 or L3-4. His discogram showed concordant pain at L5-S1 due to annular tearing (724.4), and again, I feel his best option in the hopes of getting sustained relief in his back pain is to undergo anterior artificial disc replacement with ProDisc L. * * *

{¶36} 26. Relator's file was reviewed by Mark G. Siegel, M.D. to determine whether the requested IDET procedure was reasonably necessary for the allowed condition. In his June 3, 2009 letter, Dr. Siegel concluded that, while controversial, the IDET procedure should be allowed.

{¶37} 27. The managed care organization approved the IDET surgery.

{¶38} 28. The employer appealed and obtained the June 19, 2009 file review of Oscar F. Sterle, M.D., A.A.O.S., F.A.A.D.E.P. At the outset of Dr. Sterle's report, he specifically noted that relator's claim had been specifically disallowed for "724.4 radiculitis--lumbosacral." Thereafter, Dr. Sterle opined that "[t]he use of IDET is not supported as a form of treatment in low back pain issues" as "[t]he procedure is suggested for discogenic pain that is non-radicular and that has not responded to conservative treatment as an alternative to a fusion procedure." Dr. Sterle referenced various other medical studies indicating that the effectiveness of the IDET procedure remained unproven and concluded that the need for these services was not reasonably

related to the industrial injury, nor were they reasonably necessary or appropriate for treatment of the allowed conditions, and that the requested cost of the services was not medically reasonable.

{¶39} 29. In an order mailed July 17, 2009, the BWC determined that the IDET procedure should not be authorized based on the report of Dr. Sterle.

{¶40} 30. Relator appealed.

{¶41} 31. Because the request to perform the IDET procedure had, thus far, been denied, Dr. White completed a C-9 dated August 10, 2009, requesting authorization to perform ALIF surgery at L5-S1.[4] Dr. White's May 26, 2009 report (Finding of Fact No. 25) supported this request. In that report, Dr. White had recommended lumbar fusion if the IDET procedure was denied.

{¶42} 32. In response to relator's current request for authorization of ALIF surgery, Dr. Siegel offered an additional report dated August 12, 2009. As in his first report, Dr. Siegel again indicated that relator's claim had physically been disallowed for lumbar radiculitis. Dr. Siegel's report clearly indicates that he was aware that the request for the IDET procedure had been denied. In opining that the ALIF procedure should be denied, Dr. Siegel stated:

> A new request is made by Dr. White for an ALIF with hospital bed, walker and three day admission.
>
> This request is denied as Dr. White clearly indicates the need for surgery is the allowed annular disc tear and the radiculopathy. The worker is disallowed for this condition of radiculopathy or lumbar radiculitis.

[4] Anterior Lumbar Interbody Fusion (ALIF) is a type of back surgery used to fuse the disc space of the spine through entering the front of the body through the abdomen.

Additionally, a review of the medical literature finds that an ALIF for lumbar disc pain is indicated only for intractable pain that has failed other less invasive procedures.

What is particularly disturbing is that this more aggressive and more invasive approach is being offered as Dr. Sterle has denied the lesser IDET.

As noted in the review of 6-3-09, the IDET is reasonable and supported by multiple medical literatures. Dr. Sterle, in his denial, simply reproduces the ODG/BWC web site literature, ignoring new and recent documentation supporting this procedure as a less invasive technique.

What ODG does note is that IDET may be performed if:
• Unremitting, persistent low back pain of at least 6 months continuous duration;
• Other potential structural causes of chronic low back pain have been excluded;
• There is no evidence of primary radicular pain or radiculopathy;
• A MRI has been performed demonstrating disc pathology of the posterior annulus at no more than two levels without evidence of a neural compressive-disorder or prior surgery at that level;
• No more than two discs are involved and reduction of disc height is no more than 50%;
• There is evidence of lack of satisfactory improvement with a comprehensively applied non-operative care program, including: back education, activity modification, progressive intensive exercise, a trial of manual physical therapy, and oral anti-inflammatory medication[.]

In summary, the requested surgery by Dr. White is denied as being directed at radiculitis that is not allowed. The annular tear is allowed and such surgery may be warranted. However, prior to such a procedure, the IDET should be performed as a less invasive and dangerous procedure.

Dr. Sterle's denial is flawed and is not supportable by current medical literature. The procedure is clearly approved and allowed by ODG for specific conditions that have been defined.

> As such, Dr. Siegel again reiterated that the proper procedure to be performed at this time was the IDET surgery and that the request for ALIF surgery should be denied because Dr. White indicated the need for such surgery is due to radiculopathy and the annular disc tear.

{¶43} 33. Stephen W. Diritsch, M.D., examined relator on August 17, 2009. In his report of the same day, Dr. Diritsch noted that relator's claim had been disallowed for radiculitis but also indicated that, during his examination, relator "describes back pain radiating distally to his left leg more than his right" and "[h]e has thigh numbness." Dr. Diritsch opined that artificial disc displacement was not recommended for the allowed conditions in the claim.

{¶44} 34. Mark W. Cooper, D.O., F.A.A.D.E.P., examined the record as part of an alternative dispute resolution process. In his report dated August 21, 2009, Dr. Cooper also indicated that relator's claim had been disallowed for lumbosacral radiculitis. Thereafter, Dr. Cooper identified the medical records and reports which he reviewed, and concluded that the request for ALIF at L5-S1 should be denied for the following reasons:

> * * * Fusion surgery per Official Disability Guidelines is allowed only for objectively demonstrated severe structural instability or acute/progressive neurological compromise. ODG indicates fusion surgery may be recommended for degenerative disc disease with spinal segment collapse with or without neurological compromise after six months of compliance with recommended conservative therapy. Severe structural instability, acute neurological dysfunction, and spinal segment collapse has not been demonstrated in this case. Official Disability Guidelines do not recommend discography and do not allow for surgery based only on a positive discogram. Official Disability Guidelines go on to state; "insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis."

> * * * The claims 721.3; substantial aggravation of preexisting facet arthropathy L2-S1 and 722.10, lumbar strain are nonspecific conditions and not an indication for fusion surgery per ODG.

{¶45} 35. Based on Dr. Cooper's opinion, the ADR Coordinator offered a letter dated August 31, 2009, indicating that relator would not be reimbursed for the ALIF procedure.

{¶46} 36. Relator's appeal from the July 17, 2009 BWC order denying the requested IDET procedure was heard before a DHO on September 3, 2009. The DHO determined that the IDET procedure should be permitted stating:

> The Injured Worker is authorized to undergo an IDET procedure at L5-S1, with pre/post op visits with four view x-rays, as set forth on the 06/02/2009 C-9 of Dr. White. The District Hearing Officer finds that the request is reasonably necessary and appropriate for the allowed conditions. This is based on the multiple reports of Dr. White in file and the 09/18/2008 lumbar diskography report.

{¶47} 37. Apparently an appeal had been taken from the decision of the ADR Coordinator to refuse to reimburse relator for the expense of the ALIF procedure. This appeal was referred to the BWC for consideration and, in an order mailed September 17, 2009, the BWC administrator denied the request as follows:

> Per Dr. Cooper, the requested services are not reasonably related to or reasonably necessary for the treatment of the industrial injury. He states "Fusion surgery per Official Disability Guidelines (ODG) is allowed only for objectively demonstrated severe structural instability or acute/progresssive neurological compromise. ODG indicates fusion surgery may be recommended for degenerative disc disease with spinal segment collapse with or without neurological compromise after 6 months of compliance with recommended conservative therapy. Severe structural instability, acute neurological dysfunction, & spinal segment collapse has not been demonstrated in this case. ODG do[es] not recommend discog-

> raphy & do[es] not allow for surgery based only on a positive discogram. ODG go[es on] to state- 'insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis.' "

{¶48} 38. In a letter dated September 18, 2009, Dr. White indicated that he met with relator to discuss proceeding with the IDET annuloplasty which had been approved by the DHO.

{¶49} 39. That same day, September 18, 2009, Dr. Hauser was asked to review other records along with his original file review from March 13, 2009 (opining that the requested conditions of lumbosacral neuritis, facet arthropathy and annular tear at L5-S1 were part of the natural aging process and should not be allowed) to determine whether the ALIF procedure should be authorized. Dr. Hauser opined that it should not, stating:

> In answer to your question as far as the request for ALIF procedure as Dr. White has requested on 08/10/2009, it is my opinion, that this procedure is warranted only for significant degenerative disk disease with, at least, partial collapse of the disk. Mr. Wilson's claim has been specifically disallowed for lumbosacral disk degeneration. It is my opinion that the annular tear at L5-S1 is of no clinical significance, and the interbody fusion or the ALIF procedure as requested by Dr. White is first of all, a rather aggressive procedure for a complaint of pain on a discogram when his several MRI's of the lumbar spine have not confirmed the need for any surgical procedures.
>
> To summarize, it is my opinion that there is insufficient objective evidence to justify the ALIF procedure as recommended by Dr. Mark White and, beyond that, there is no indication based on his current allowed conditions in this claim.

{¶50} 40. The employer's appeal from the DHO order authorizing the IDET procedure was heard before an SHO on October 30, 2009. The SHO affirmed the prior DHO order authorizing the IDET procedure as follows:

> The order of the District Hearing Officer is affirmed. It is the order of the Staff Hearing Officer that the C-9 dated 06/02/2009 requesting authorization of an IDET procedure is granted and the C-9 dated 05/15/2009 which requested cervical facet injections is dismissed in the manner specified by the District Hearing Officer.
>
> More specifically, the Staff Hearing Officer agrees with the District Hearing Officer's rationale and conclusion in authorizing an IDET procedure at L5-S1 with pre/post op visits with four view x-rays, as set forth on the 06/02/2009 C-9 of Dr. White. The Staff Hearing Officer relies upon the 06/03/2009 review opinion of Dr. Si[e]gel, M.D., in reaching this decision. Dr. Si[e]gel opines that this procedure is appropriate and reasonably necessary for treatment of conditions that are currently recognized under this claim.

{¶51} 41. That same day, October 20, 2009, the same hearing officer who, while sitting as an SHO, authorized the IDET procedure, also heard relator's appeal, sitting as a DHO, from the order of the administrator dated September 17, 2009, which had denied relator's request for the ALIF procedure. The DHO affirmed the order of the administrator and denied the request for the ALIF procedure. **(At this point in time, the IDET procedure had been authorized by SHO order dated 10/30/09 and the ALIF procedure had been denied by DHO order dated 10/30/09.)**

{¶52} 42. Dr. White performed the IDET annuloplasty on November 12, 2009.

{¶53} 43. In a follow-up visit on December 4, 2009, Dr. White noted that relator's back pain was stable, and he did describe numbness and tingling in his right leg. Dr. White did note that relator did not describe any severe radicular symptoms, weakness, or other neurogenic symptoms. Dr. White indicated that he would follow up with relator in six weeks, noting that it could take up to six months for the disc to heal. If the disc did not

heal, Dr. White indicated that another MRI should be done, at which time lumbar fusion would be discussed.

{¶54} 44. Dr. White examined relator again on January 15, 2010, and indicated that relator "had approximately 30% improvement in his mechanical back pain. His leg pain has resolved." In that report, Dr. White did note that the IDET annuloplasty failed, and that relator would need the ALIF procedure at L5-S1.

{¶55} 45. In a follow-up visit on February 12, 2010, Dr. White indicated that relator's back pain was beginning to worsen and he was having some right lateral high thigh pain, which was slightly different than before the IDET procedure was performed. Dr. White recommended an updated MRI.

{¶56} 46. The MRI was taken March 5, 2010, and revealed the following impressions:

> [a] L4-5 shallow disc bulge/protrusion eccentric right encroaching upon right paracentral dural sac and right L5 nerve root. Mild spinal stenosis.
>
> [b] L5-S1 shallow posterior disc bulge/protrusion eccentric right with annular rent effacing right S1 nerve root.
>
> [c] Facet arthropathies multilevel with low-grade facet joint fluid from L2-3 to L5-S1.

{¶57} 47. After reviewing the most recent MRI, Dr. White authored a letter dated March 5, 2010, recommending that relator proceed with the ALIF procedure. Dr. White stated his reasons:

> [H]e has had previous IDET annuloplasty due to internal disc derangement L5-S1 (722.10). Unfortunately, he is still having mechanical back pain despite aggressive post IDET physical therapy and still having occasional right lateral thigh pain and tingling. I had him repeat his MRI scan dated March 4,

> 2010, I do not have the radiologist's dictated report, but it shows continued annular tear at L5-S1 with mild foraminal narrowing on the right.
>
> * * * My rationale for performing this is he has significant internal disc derangement at L5-S1 due to his work injury that the IDET annuloplasty has not taken and now he has continued to be narcotic-dependent taking Nucynta, Flexeril and Lyrica for his symptoms and has failed all conservative measures and has failed IDET annuloplasty * * *.

{¶58} 48. Dr. Siegel considered the record again and, in a report dated March 15, 2010, Dr. Siegel recommended that the ALIF procedure be denied for the following reasons:

> A requested IDET was approved based on a Medline review documenting the benefits of this procedure.
>
> * * *
>
> A new request is made by Dr. White for an ALIF with hospital bed, walker and three day admission.
>
> This request is denied as Dr. White clearly indicates the need for surgery is the allowed annular disc tear and the radiculopathy. The worker is disallowed for this condition of radiculopathy or lumbar radiculitis.
>
> Additionally, a review of the medical literature finds that an ALIF for lumbar disc pain is indicated only for intractable pain that has failed other less invasive procedures.
>
> An IDET was approved and performed on 11-12-09.
>
> A follow up note dated 3-5-10 from Dr. White indicates that the IDET annuloplasty has not taken and that the worker has continued narcotic dependent pain and is on Mucynta, Flexeril and Lyrica.
>
> Dr. White opines that an ALIF is needed to improve the pain of the annular tear at the L5-S1 level.

> That MRI on 3-5-10 finds at L5-S1 an annular rent with effacement of the right S1 nerve root.
>
> A review by Dr. Hauser on 9-18-09 specifically notes that, "there is insufficient objective evidence to justify the ALIF by Dr. White. …it is a rather aggressive procedure for a complaint of pain on a discogram when his several MRI's of the lumbar spine have not confirmed the need for any surgical procedure."
>
> Dr. Cooper further opines on 8-21-09 that the surgery is indicated only for structural instability or progressive neurological compromise and/or DDD with spinal segmental collapse. As the worker has none of these conditions, the surgery is not appropriate.
>
> What is apparent is that the surgery is directed at the condition of an annular rent tear. This is noted by Dr. White, Hauser and Dr. Cooper.
>
> What is clear is that the medical literature, ODG and a review of Medline literature does not support the procedure. However, there are single reported cases and anecdotal confirmation that this procedure is, at times, performed for this condition.
>
> Accordingly, the request is denied as not being supported by ODG or a Medline review.

{¶59} 49. On March 24, 2010, the BWC denied relator's request seeking authorization of the ALIF procedure as follows:

> Peer review by Mark Cooper, D.O., (report on file), dated 8/21/09 opines that the requested services are not reasonably related to or reasonably necessary for the treatment of the industrial injury. He states "Fusion surgery per Official Disability Guidelines (ODG) is allowed only for objectively demonstrated severe structural instability or acute/progressive neurological compromise. ODG indicates fusion surgery may be recommended for degenerative disc disease with spinal segment collapse with or without neurological compromise after 6 months of compliance with recommended conservative therapy. Severe structural instability, acute neurological dysfunction, & spinal segment

> collapse has not been demonstrated in this case. ODG do[es] not recommend discography & do[es] not allow for surgery based only on a positive discogram. ODG go[es on] to state- insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis." * * *

{¶60} 50. An independent medical examination was performed by Alvin J.D. Gallanosa, M.D. In his April 23, 2010 report, Dr. Gallonosa concluded that relator had reached maximum medical improvement ("MMI") for all of his back conditions except:

> * * * He has not yet reached MMI for 722.10 L5-S1 tear or 721.3 facet arthropathy at L2-S1. He has undergone some minimally invasive procedures for these, but he continues to have significant pain in the low back and in the lower limbs. Ongoing followup with a neurosurgeon would be required so he can reach MMI for these conditions.

When asked for his recommendation for any proposed plan of treatment, Dr. Gallonosa responded:

> * * * Recommendations would be for continuing followup with his neurosurgeon. Ongoing opioid analgesic use is recommended, although efforts should be made to wean this down to the lowest effective dose. Expected length of treatment would depend on whether he will undergo a more invasive procedure/surgery. Expected results would be a decrease in pain and an increase in ability to perform functional activities and eventually return to work at a light to medium level.

{¶61} 51. In response to Dr. Siegel's most recent report where he opined that the ALIF procedure should be denied because the ODG and medical literature did not support the procedure for use for the condition of annular rent tear, Dr. White indicated that Dr. Siegel **had mistakenly** opined that the requested ALIF surgery was for the annular rent tear. Instead, Dr. White referenced his March 5, 2010 letter (Finding of Fact

No. 47) and, in this most recent report, dated May 7, 2010, Dr. White reiterated his rationale for proceeding with the ALIF procedure at this time:

> * * * [T]he anterior lumbar interbody fusion is to treat his internal disc derangement (722.10) in the hopes of alleviating his mechanical back pain. This is well-documented in the literature. I am unsure of what Medline review he is talking about, but clearly, the North American Spine Society and American College of Surgeons along with the Congress of Neurological Surgeons have documented that lumbar fusion in appropriate selected individuals with mechanical back pain, internal disc derangement due to annular herniation, which the patient has (722.10), has shown to improve functional outcome and also help return patients back to the workplace and avoid narcotic-dependency.
>
> Medical necessity for the surgery is to remove the annular herniation, remove the disc and to fuse it to remove the painful segment. In my hands, anterior lumbar interbody fusion in a workers' compensation patient has a 70% success rate with 65% of the patients returning to work. I do feel this meets all three Miller criteria, he also meets ODG guidelines, as stated, that the patient has failed six months of conservative care, has had extensive physical therapy, injections and still has mechanical back pain due to annular herniation and internal disc derangement (722.10).

{¶62} 52. Following a hearing before a DHO on May 14, 2010, the request for the ALIF surgery was denied as follows:

> The District Hearing Officer affirms the denial of the two C-9's Physician's Request for Medical Services from Dr. White, both dated 03/10/2010, requesting authorization of surgery in the form of anterior lumbar intervertebral fusion (ALIF) at L5-S1, with a three-day stay at St. Ann's, various CPT codes, pre-admission testing, pre and post-operative visits with x-rays, bone growth stimulator, hospital bed for three months, and a wheeled walker for four months. Based on the file review reports from Dr. Cooper dated 08/21/2009 and from Dr. Siegel dated 03/10/2010, along with the addendum report from Dr. Hauser dated 09/18/2009, the District Hearing Officer finds that the proposed hospitalization and

> treatment, testing, devices, and equipment are not necessary or appropriate for the allowed conditions of the claim.
>
> All evidence, including Dr. White's 05/07/2010 report, was reviewed and evaluated.

{¶63} 53. Relator's appeal was heard before an SHO on June 23, 2010, and was denied as follows:

> The C-9's dated 03/10/2010 remain unauthorized. These requests are from Dr. White and are for surgery (ALIF), a three day hospital stay, a hospital bed for three months, a wheeled walker, and other pre and post operative procedures and items. This claim has some significant allowed conditions, but also some significant disallowed conditions. It has not been shown that the requests are necessary and appropriate to deal with the allowed conditions of this claim. The Hearing Officer, here, relies on the 09/18/2009 report from Dr. Hauser, the 03/17/2010 report from Dr. Siegel and the 08/21/2009 report from Dr. Cooper. It is noted that virtually identical requests in that of C-9's dated 08/10/2009 were refused authorization per the District Hearing Officer order of 10/30/2009.

{¶64} 54. Relator's further appeal was refused by order of the commission mailed July 21, 2010.

{¶65} 55. Thereafter, relator filed the instant mandamus action in this court.

Conclusions of Law:

{¶66} In this mandamus action, relator alleges that the commission abused its discretion by denying his request for proceeding with the ALIF procedure based on the August 21, 2009 report from Dr. Hauser, the September 18, 2009 report of Dr. Cooper, and the March 15, 2010 report of Dr. Siegel. Relator argues that the reports of Drs. Hauser and Cooper pre-date the IDET procedure and do not consider the failure of this procedure in opining that the ALIF procedure is not warranted. Relator argues that Dr.

Siegel's report cannot constitute some evidence because he erroneously contends that Dr. White's reason for the ALIF procedure was annular tear and radiculopathy.

{¶67} The Supreme Court of Ohio has set out a three-prong test to determine whether requested medical services should be allowed. Specifically, in *State ex rel. Miller v. Indus. Comm.*, 71 Ohio St.3d 229, 1994-Ohio-204, provides that medical services be authorized provided that the medical evidence demonstrates that the requested medical services are: (1) reasonably related to the allowed conditions, (2) reasonably necessary for treatment of the allowed conditions, and (3) the cost of the proposed services are medically reasonable.

{¶68} Relator is correct to point out that the reports of Drs. Hauser and Cooper were written prior to the IDET surgery. However, relator is incorrect to argue that these reports cannot constitute some evidence upon which the commission could rely in denying his request for the ALIF procedure. To the extent that their opinions are based on relator's actual condition, their reports constitute some evidence in spite of the fact that their reports pre-date the IDET procedure and its subsequent failure.

{¶69} At the time of his March 15, 2009 report, Dr. Hauser examined relator and opined that relator's conditions were part of the natural aging process and that those conditions were neither caused by nor aggravated by the February 20, 2007 injury. Dr. Hauser did note the annular tear at L5-S1 (which was later added as an allowed condition), but opined that it had "no clinical significance" and that there was "no evidence of any nerve root compression at the L5-S1 level."

{¶70} On September 18, 2009, Dr. Hauser issued an addendum, which is the subject of this mandamus action. This report was authored after relator's claim had been

allowed for additional conditions but before the IDET procedure was performed, and it addressed the issue of whether or not the ALIF procedure was medically appropriate. Dr. Hauser opined that the ALIF procedure was "warranted only for significant degenerative disk disease with, at least, partial collapse of the disk." After noting that relator's claim had "been specifically disallowed for lumbosacral disk degeneration" and reiterating that the "annular tear at L5-S1 was of no clinical significance," Dr. Hauser opined that there was "insufficient objective evidence to justify the ALIF procedure."

{¶71} While Dr. Hauser's report was written before the relator's IDET surgery, the conditions under which Dr. Hauser opined ALIF surgery would be appropriate do not exist. Relator's claim was specifically denied for aggravation of lumbar disk disease. Further, the fact that Dr. Hauser opined that the annular tear had no clinical significance does not remove it from consideration. It was Dr. Hauser's opinion that the annular tear was not responsible for relator's condition. Relator's criticisms go to the weight to be given the evidence and not its admissibility.

{¶72} Relator further challenges Dr. Hauser's report because he notes that relator's claim had not been allowed for radiculitis. The magistrate finds that this is not significant and does not warrant the removal of his report from evidentiary consideration. Further, several reports in the record mention that, at certain times, relator has had radicular symptoms while other reports note that, at other times, he has not had radicular symptoms. Dr. Riddick's February 5, 2008 report indicates that radiculitis should be an allowed condition in the claim. Dr. White's May 12, 2008 report indicates that relator has no true radicular symptoms. The June 13, 2008 report from the Olentangy Pain Clinic to Dr. Newman indicates that relator has pain radiating down his legs occasionally

associated with tingling. On March 13, 2009, Dr. Hauser examined relator and noted that relator "complained of numbness in both legs." In his report of the same date, Dr. Hauser references a report from Dr. Gerwitz, who reviewed the MRIs and found no "signs or symptoms consistent with radiculopathy." The May 5, 2009 SHO order specifically states that relator's claim is "neither allowed nor disallowed for lumbosacral neuritis." All of these reports pre-date Dr. Hauser's September 18, 2009 report. Given all the references to radicular symptoms in the record, and because Dr. Hauser opines that the ALIF procedure is warranted only under certain conditions, none of which exist, the magistrate finds that Dr. Hauser's references to radiculitis should not remove it from evidentiary consideration.

{¶73} Turning now to Dr. Cooper's August 21, 2009 file review, he likewise indicates that relator's claim has been disallowed for radiculitis. However, for the same reasons expressed above, the magistrate does not find this to be fatal. Relator also challenges Dr. Cooper's report because it too pre-dates the failure of the IDET surgery. However, similarly to Dr. Hauser's report, Dr. Cooper provided his opinion as to what conditions warrant the ALIF surgery. He specifically stated as follows:

> * * * Fusion surgery per Official Disability Guidelines is allowed only for objectively demonstrated severe structural instability or acute/progressive neurological compromise. ODG indicates fusion surgery may be recommended for degenerative disc disease with spinal segment collapse with or without neurological compromise after six months of compliance with recommended conservative therapy. Severe structural instability, acute neurological dysfunction, and spinal segment collapse has not been demonstrated in this case. Official Disability Guidelines do not recommend discography and do not allow for surgery based only on a positive discogram. Official Disability Guidelines go on to state; "insufficient evidence to recommend fusion for chronic

> low back pain in the absence of stenosis and spondylolisthesis."
>
> * * * The claims 721.3; substantial aggravation of preexisting facet arthropathy L2-S1 and 722.10, lumbar strain are nonspecific conditions and not an indication for fusion surgery per ODG.

There is no evidence presented that relator suffers from either severe structural instability, acute neurological dysfunction or spinal segment collapse. As such, his report is not removed from evidentiary consideration. Relator's complaints go to the weight to be given the evidence.

{¶74} Relator's last challenge is to the March 15, 2010 report of Dr. Siegel. As above indicated, the magistrate finds Dr. Siegel's references to radiculits are explained by the record and do not present a reason to remove his report from evidentiary consideration. Dr. Siegel points to Dr. Hauser's September 18, 2009 report and agrees with Dr. Hauser's conclusion that "there is insufficient objective evidence to justify the ALIF * * * when his several MRI's of the lumbar spine have not confirmed the need for any surgical procedure." He also quotes from Dr. Cooper's report and agrees with his assessment that ALIF surgery "is indicated only for structural instability or progressive neurological compromise and/or DDD with spinal segmental collapse. As the worker has none of these conditions, the surgery is not appropriate." Further, the fact that Dr. Siegel indicates that "there are single reported cases and anecdotal confirmation that this procedure is, at times, performed" for annular rent tear does not conflict with his statement that in this case, the ALIF is not warranted.

{¶75} In *State ex rel. Eberhardt v. Flxible Corp.* (1994), 70 Ohio St.3d 649, 657, the Supreme Court of Ohio summarized the distinction between the ambiguous, equivocal and repudiated reports as follows:

> * * * [E]quivocal medical opinions are not evidence. See, also, *State ex rel. Woodard v. Frigidaire Div., Gen. Motors Corp.* (1985), 18 Ohio St.3d 110 * * *. Such opinions are of no probative value. Further, equivocation occurs when a doctor repudiates an earlier opinion, renders contradictory or uncertain opinions, or fails to clarify an ambiguous statement. Ambiguous statements, however, are considered equivocal only while they are unclarified. [*State ex rel. Paragon v. Indus. Comm.* (1983), 5 Ohio St.3d 72.] Thus, once clarified, such statements fall outside the boundaries of [*State ex rel. Jennings v. Indus. Comm.* (1982), 1 Ohio St.3d 101], and its progeny.
>
> Moreover, ambiguous statements are inherently different from those that are repudiated, contradictory or uncertain. Repudiated, contradictory or uncertain statements reveal that the doctor is not sure what he means and, therefore, they are inherently unreliable. Such statements relate to the doctor's position on a critical issue. Ambiguous statements, however, merely reveal that the doctor did not effectively convey what he meant and, therefore, they are not inherently unreliable. Such statements do not relate to the doctor's position, but to his communication skills. If we were to hold that clarified statements, because previously ambiguous, are subject to *Jennings* or to commission rejection, we would effectively allow the commission to put words into a doctor's mouth or, worse, discount a truly probative opinion. Under such a view, any doctor's opinion could be disregarded merely because he failed on a single occasion to employ precise terminology. In a word, once an ambiguity, always an ambiguity. This court cannot countenance such an exclusion of probative evidence.

Dr. Siegel's report is neither internally inconsistent nor ambiguous. The fact that Dr. Siegel indicated that the ALIF procedure is, at times, performed for annular tear, does not render his report equivocal as relator suggests. Dr. Siegel agreed with the opinions of

Drs. Hauser and Cooper (whose reports do constitute some evidence) and further opined that medical literature and the ODG do not support the procedure.

{¶76} There is some evidence in the record indicating that the requested procedure is not reasonably related to the allowed conditions, nor is it reasonably necessary to treat the allowed conditions. The evidence upon which the commission relied establishes that relator did not meet the three-prong test of *Miller.*

{¶77} Based on the foregoing, it is this magistrate's decision that this court should deny relator's request for a writ of mandamus.

___/S/ Stephanie Bisca Brooks
STEPHANIE BISCA BROOKS
MAGISTRATE

NOTICE TO THE PARTIES

Civ.R. 53(D)(3)(a)(iii) provides that a party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion as required by Civ.R. 53(D)(3)(b).