

MEDICAL CONTESTED CASE HEARING NO. 13018

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 contested case hearing was held on October 30, 2012, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a microlumbar discectomy, L4-5 bilaterally, and microlumbar discectomy, L5-S1 left, is not reasonably required health care for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by CM, ombudsman. Respondent/Carrier appeared and was represented by SB, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: KT, MD, DC

For Carrier: None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 and HO-2.

Claimant's Exhibits C-1 through C-18.

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

BACKGROUND INFORMATION

Claimant sustained a compensable injury on (Date of Injury), while lifting a container of soft drink syrup at (Employer), a convenience store. Claimant's treating doctor is K T, MD, DC. Dr. T treated Claimant with medication and physical therapy for a time, and then referred her to Dr. W, MD in October of 2011. Dr. L noted that Claimant complained of low back and bilateral leg-thigh pain, but had normal heel and toe walk and normal, pain-free lumbar range of motion. Dr. L administered a sacroiliac injection that provided no relief. He then administered bilateral epidural steroid injections at L4-L5 on November 17, 2011. Claimant received some relief from the November 17, 2011, injections, but it lasted only a short time.

Dr. T then referred Claimant to J M Randle, MD for a surgical consultation. Dr. R saw Claimant on May 22, 2012. He noted that she complained of significant low back pain, bilateral gluteal pain, bilateral posterior thigh pain and bilateral lower leg pain from the date of injury through the date of his consultation. He reviewed an MRI taken on October 11, 2011, and recommended bilateral microdiscectomy at L4-L5 and microdiscectomy on the left at L5-S1 for “disk herniations at L4-5 and L5-S1 with annular tear at each level.”

A request for preauthorization was submitted. The first utilization review agent (URA) to address the request was P W, MD. Dr. W is a board certified neurosurgeon. He recommended that the request be denied. In his report, Dr. W wrote that the MRI did not reveal central canal, lateral recess or neural foraminal stenosis at L5-S1 and, although there was moderate stenosis of the inferior aspect of the left neural foramen at L4-L5, there was no evidence of central canal, lateral recess or right neural foraminal stenosis. He noted that he had not received notes from the physical therapy or from Dr. L, and concluded that not only had conservative treatment not been shown, but the imaging studies and physical findings were not consistent. He found that the request did not meet Official Disability Guidelines (ODG) indications for surgery.

Carrier denied preauthorization and reconsideration was requested. Carrier submitted the preauthorization request to K T, MD. Dr. T is also a board certified neurosurgeon. The request submitted to Dr. T also failed to include objective evidence of significant current conservative care (such as physical therapy notes, chiropractic notes, or massage therapy notes) or interventional injection therapy notes. Dr. T wrote that there was “no MRI report ... to objectively correlate physical findings with imaging studies.” She also recommended that the request for surgery be denied.

An Independent Review Organization review was requested and MedReviews was appointed as the IRO. The physician reviewer for the IRO was identified as board certified in orthopedic surgery with fellowship training as a spine surgeon. The physician reviewer upheld Carrier’s denial of preauthorization. The IRO physician reviewer noted that a trial of conservative care, including pharmacotherapy, physical therapy and injections was administered with minimal relief. He reviewed the findings of the MRI and of an EMG that suggested possible right L4 radiculopathy. In upholding Carrier’s denial, the IRO physician reviewer stated that the decompression requested does not correlate with the MRI findings and there was minimal neurogenic compression evident from the MRI “to suggest any decompression at L4-L5 or L5-S1 would achieve any meaningful surgical outcome.” “Essentially,” he said, “there is scant evidence of frank neural compression based on the diagnostic MRI findings.” The IRO physician reviewer cited the ODG in making his recommendation.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011

(22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines in making decisions regarding individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. Health care providers are directed to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be reasonably required. 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 (s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered a party 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 ODG provides the following recommendations regarding lumbar discectomy:

Discectomy/ laminectomy

Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004) For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (Bigos, 1999) While there is evidence in favor of discectomy for prolonged symptoms of lumbar disc herniation, in patients with a shorter period

of symptoms but no absolute indication for surgery, there are only modest short-term benefits, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. (Osterman, 2006) The SPORT studies concluded that both lumbar discectomy and nonoperative treatment resulted in substantial improvement after 2 years, but those who chose discectomy reported somewhat greater improvements than patients who elected nonoperative care. (Weinstein, 2006) (Weinstein2, 2006) A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability, but the relative benefit of initial surgical treatment diminished over time while still remaining somewhat favorable at 2 years. (Malmivaara, 2007) Patients undergoing lumbar discectomy are generally satisfied with the surgery, but only half are satisfied (sic) with preoperative patient information. (Ronnberg, 2007) If patients are pain free, there appears to be no contraindication to their returning to any type of work after lumbar discectomy. A regimen of stretching and strengthening the abdominal and back muscles is a crucial aspect of the recovery process. (Burnett, 2006) According to a major recent trial, early surgery (microdiscectomy) in patients with 6-12 weeks of severe sciatica caused by herniated disks is associated with better short-term outcomes, but at 1 year, disability outcomes of early surgery vs conservative treatment with eventual surgery if needed are similar. The median time to recovery was 4.0 weeks for early surgery and 12.1 weeks for prolonged conservative treatment. The authors concluded, "Patients whose pain is controlled in a manner that is acceptable to them may decide to postpone surgery in the hope that it will not be needed, without reducing their chances for complete recovery at 12 months. Although both strategies have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients." (Peul-NEJM, 2007) (Deyo-NEJM, 2007) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. (Hallett, 2007) A recent British study found that lumbar discectomy improved patients' self-reported overall physical health more than other elective surgeries. (Guilfoyle, 2007) Microscopic sequestrectomy may be an alternative to standard microdiscectomy. In this RCT, both groups showed dramatic improvement. (Barth, 2008) There is consistent evidence that for patients with a

herniated disk, discectomy is associated with better short-term outcomes than continued conservative management, although outcomes begin to look similar after 3 to 6 months. This is a decision to be made with the patients, discussing the likelihood that they are going to improve either way but will improve faster with surgery. Similar evidence supports the use of surgery for spinal stenosis, although the outcomes look better with surgery out to about 2 years. (Chou, 2008) Standard open discectomy is moderately cost-effective compared with nonsurgical treatment, a new Spine Patient Outcomes Research Trial (SPORT) study shows. The costs per quality-adjusted life-year gained with surgery compared with nonoperative treatment, including work-related productivity costs, ranges from \$34,355 to \$69,403, depending on the cost of surgery. It is wise and proper to wait before initiating surgery, but if the patient continues to experience pain and is missing work, then the higher-cost option such as surgery may be worthwhile. (Tosteson, 2008) Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures: discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone). Discectomy is the surgical removal of herniated disc material that presses on a nerve root or the spinal cord. A laminectomy is often involved to permit access to the intervertebral disc in a traditional discectomy.

Patient Selection: Microdiscectomy for symptomatic lumbar disc herniations in patients with a preponderance of leg pain who have failed nonoperative treatment demonstrated a high success rate based on validated outcome measures (80% decrease in VAS leg pain score of greater than 2 points), patient satisfaction (85%), and return to work (84%). Patients should be encouraged to return to their preinjury activities as soon as possible with no restrictions at 6 weeks. Overall, patients with sequestered lumbar disc herniations fared better than those with extruded herniations, although both groups consistently had better outcomes than patients with contained herniations. Patients with herniations at the L5-S1 level had significantly better outcomes than did those at the L4-L5 level. Lumbar disc herniation level and type should be considered in preoperative outcomes counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities. (Dewing, 2008) Workers' comp back surgery patients are at greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 2008) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (DeBerard, 2011)

Spinal Stenosis: For patients with lumbar spinal stenosis, standard posterior decompressive laminectomy alone (without discectomy) offers a significant advantage over nonsurgical treatment. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy (sic). (See Indications below.) Laminectomy may be used for spinal stenosis secondary to degenerative processes (sic) exhibiting ligamentum hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements (sic) of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) See also Laminectomy.

Recent Research: Four-year results for the Dartmouth Spine Patient Outcomes Research Trial (SPORT, n= 1244) indicated that patients who underwent standard open discectomy for a lumbar disc herniation achieved significantly greater improvement than nonoperatively treated patients (using recommended treatments - active physical therapy, home exercise instruction, and NSAIDs) in all primary and secondary outcomes except work status (78.4% for the surgery group compared with 84.4%). Although patients receiving surgery did better generally, all patients in the study improved. Consequently, for patients who don't want an operation no matter how bad their pain is, this study suggests that they will improve and they will not have complications (e.g., paralysis) from nonoperative treatment, but those patients whose leg pain is severe and is limiting their function, who meet the ODG criteria for discectomy, can do better with surgery than without surgery, and the risks are extremely low. (Weinstein2, 2008) In most patients with low back pain, symptoms resolve without surgical intervention. (Madigan, 2009) This study showed that surgery for disc herniation was not as successful as total hip replacement but was comparable to total knee replacement in success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) For radiculopathy with herniated lumbar disc, there is good evidence that standard open discectomy and microdiscectomy are moderately superior to nonsurgical therapy for improvement in pain and function through 2 to 3 months, but patients on average experience improvement either with or without surgery, and benefits associated with surgery decrease with long-term follow-up. (Chou, 2009) According to a new study, surgery provides better results than non-surgical treatment for most

patients with back pain related to a herniated disk, but not for those receiving workers' compensation. (Atlas, 2010) Use of appropriateness criteria to guide treatment decisions for each clinical situation involving patients with low back pain and/or sciatica, with criteria based upon literature evidence, along with shared decision-making, was observed in one prospective study to improve outcomes in low back surgery. (Danon-Hersch, 2010) An updated SPORT trial analysis confirmed that outcomes of lumbar discectomy were better for patients who have symptoms of a herniated lumbar disc for six months or less prior to treatment. Increased symptom duration was related to worse outcomes following both operative and nonoperative treatment, but the relative increased benefit of surgery compared with nonoperative treatment was not dependent on the duration. (Rihn, 2011) Comparative effectiveness evidence from SPORT shows good value for standard open discectomy after an imaging-confirmed diagnosis of intervertebral disc herniation [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011)

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

- I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

- B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

- C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education (≥ 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 1. NSAID drug therapy
 2. Other analgesic therapy
 3. Muscle relaxants
 4. Epidural Steroid Injection (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
 1. Physical therapy (teach home exercise/stretching)
 2. Manual therapy (chiropractor or massage therapist)
 3. Psychological screening that could affect surgical outcome
 4. Back school (Fisher, 2004)

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

Dr. T testified on Claimant's behalf. He stated that Claimant is an outlier and that the ODG fails to adequately address her condition because she has bilateral symptoms and the ODG is predicated on lesions to only one side of the spine. Dr. T acknowledged that Claimant does not

meet the requisites under the ODG for discectomy and agreed that the MRI does not confirm nerve root impingement at L4-L5 or L5-S1 or neuroforaminal stenosis at L5-S1. He testified that the MRI and EMG are consistent with high intensity findings, but it was difficult to determine whether the EMG and MRI findings correlate. While Dr. T agreed that Claimant would not be a candidate for surgery under the ODG, he testified that he believed that the surgery should be approved and that he hoped that Dr. R is correct and Claimant would get some relief from the proposed surgery.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See Black vs. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). Evidence is considered in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; and (6) the experience and skill of the person who applied the technique on the occasion in question. *Kelly v. State*, 792 S.W.2d 579 (Tex.App.-Fort Worth 1990). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *Black v. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999).

Dr. T is not a surgeon and testified that he is not qualified to comment on the purpose of microdiscectomy. He did not provide evidence of scientific studies or other sources to support his contention that Claimant is an outlier, that the ODG is not an appropriate guide to treatment of patients with broad-based pathology that affects the bilateral nerve roots, and the recommended bilateral microlumbar discectomy at L4-5 and microlumbar discectomy on the left at L5-S1 would be efficacious for Claimant's disc bulges and annular tears. His opinion is contrary to the opinions of three board-certified neurosurgeons and, under the circumstances, is not persuasive.

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.

- C. On (Date of Injury), Employer provided workers' compensation insurance with Mercantile Trust of Texas, Carrier.
 - D. Claimant sustained a compensable injury on (Date of Injury).
 - E. MedReviews was appointed by the Texas Department of Insurance to act as the independent review organization to review Carrier's denial of the requested procedure.
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 2.
 3. The IRO determined that Carrier's denial of the requested bilateral microdiscectomy at L4-5 and microdiscectomy on the left at L5-S1 should be upheld.
 4. Claimant's physical findings, including but not limited to the left sided symptoms, does not correlate to the findings of the MRI.
 5. The requested bilateral microlumbar discectomy at L4-5 and microlumbar discectomy on the left at L5-S1 is not is recognized under the ODG as clinically appropriate and effective for injuries such as Claimant's and in accordance with best practices consistent with evidence based medicine.
 6. Dr. T's opinion that the surgery should be approved was not supported by evidence of scientific studies, peer-reviewed medical literature, or other current scientifically based texts and treatment and practice guidelines.

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 IRO that bilateral microlumbar discectomy at L4-5 and microlumbar discectomy on the left at L5-S1 is not reasonably required health care for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to bilateral microlumbar discectomy at L4-5 and microlumbar discectomy on the left at L5-S1 for the compensable injury of (Date of Injury).

ORDER

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

The true corporate name of the insurance carrier is **MERCANTILE TRUST OF TEXAS** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
350 N. ST. PAUL ST.
DALLAS, TX 75201**

Signed this 2nd day of November, 2012.

KENNETH A. HUCHTON
Hearing Officer