MEDICAL CONTESTED CASE HEARING NO. 13088

## 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.

## ISSUES

A contested case hearing was held on April 24, 2013, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to an inpatient surgery for a C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring (63075, 63076, 22554, 22585, 22551, 22552, 22845, 20938, 20937, 95920, and 95925) for the compensable injury of (Date of Injury)?

## PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by KW, ombudsman.

Respondent/Carrier appeared and was represented by BS, attorney.

## BACKGROUND INFORMATION

Claimant was injured when he fell off his bicycle while on patrol. His doctor requested a C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring. It was denied by both Carrier utilization reviews. It was then denied by the IRO board-certified orthopedic surgeon. Claimant requested the CCH for this spinal surgery.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-

based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. (Texas Labor Code Section 413.011(e).) Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence. (Division Rule 133.308 (t).)

Under the Official Disability Guidelines in reference to an inpatient surgery for C5/6 and C6/7 anterior cervical discectomy fusion, the following pertinent recommendation is made:

> Recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. (See Discectomy/laminectomy/laminoplasty.) Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. (Bambakidis, 2005) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (Wieser, 2007) This evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below:
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> (1) *Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute:* Three of the six randomized controlled studies discussed in the 2004 Cochrane review

found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. (Jacobs-Cochrane, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Ragab, 2006) (Eck, 2002) (Matsunaga, 1999) (Katsuura, 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alrahman, 1999)

(2) *Fusion with autograft versus allograft:* The Cochrane review found limited evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference between biocompatible osteoconductive polymer or autograft (limited evidence). (Jacobs-*Cochrane*, 2004) (McConnell, 2003) A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. (Younger, 1989) (Sawin, 1998) (Sasso, 2005) Autograft is thought to increase fusion rates with less graft collapse. (Deutsch, 2007). See Decompression, myelopathy.

(3) *Fusion with autograft with plate fixation versus allograft with plate fixation, Single level:* A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients. (Samartzis, 2005)

(4) *Fusion with different types of autograft:* The Cochrane review did not find evidence that a vertebral body graft was superior to an iliac crest graft. (McGuire, 1994)

*(5) Fusion with autograft versus fusion with autograft and additional instrumentation:*

*Plate Fixation:* In single-level surgery there is limited evidence that there is any difference between the use of plates and fusion with autograft in terms of union rates. For two-level surgery, there was moderate evidence that there was more improvement in arm pain for patients treated with a plate than for those without a plate. Fusion rate is improved with plating in

multi-level surgery. (Wright, 2007) See Plate fixation, cervical spine surgery.

(6) *Fusion with allograft alone versus with allograft and additional instrumentation:*
*Plate Fixation:* Retrospective studies indicate high levels of pseudoarthrosis rates (as high as 20% for one-level and 50% for two-level procedures) using allograft alone. In a recent comparative retrospective study examining fusion rate with plating, successful fusion was achieved in 96% of single-level cases and 91% of two-level procedures. This could be compared to a previous retrospective study by the same authors of non-plated cases that achieved successful fusion in 90% of single-level procedures and 72% of two-level procedures. (Kaiser, 2002) (Martin, 1999) See Plate fixation, cervical spine surgery.

*Complications:*
*Anterior versus posterior fusion:* In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007)
*Predictors of outcome of ACDF:* Predictors of good outcome include non-smoking, a pre-operative lower pain level, soft disc disease, disease in one level, greater segmental kyphosis pre-operatively, radicular pain without additional neck or lumbar pain, short duration of symptoms, younger age, no use of analgesics, gainful employment, higher preoperative NDI and normal ratings on biopsychosoical tests such as the Distress and Risk Assessment Method (DRAM). Predictors of poor outcomes include non-specific neck pain, psychological distress, psychosomatic problems and poor general health, litigation and workers' compensation. (Anderson, 2009) (Peolsson, 2006) (Peolsson, 2003) Patients who smoke have compromised fusion outcomes. (Peolsson, 2008)
See Plate fixation, cervical spine surgery. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment.

Under the Official Disability Guidelines in reference to discectomy/laminectomy, the following recommendation is made:

ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures): Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. Note: Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG.
C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.
D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.
E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.

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

A party disputing the IRO decision must present a properly qualified medical expert's report or testimony to overcome the IRO decision based upon "evidence-based medicine." “Evidence-based medicine” means the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.

In this case, Dr. S, Claimant’s orthopedic surgeon, testified he agreed there was a lack of evidence on the EMG or in his orthopedic testing related to this Date of Injury to support a finding of a C7 radiculopathy. He testified it would be debatable between surgeons whether to include the C6/7 level with the C5/6 fusion but that he found it a better practice to perform the C6/7 fusion when there was the type of disc pathology noted at this level on the MRI. In his experience, with this degree of pathology abutting the thecal sac at the adjacent level there would be a strong likelihood of adjacent level disc degeneration requiring a second surgery in the

future. Dr. S testified it was in Claimant's best interest to have both those levels fused now instead of having a second surgery in the future.

Dr. S's testimony is credible and logical. However, when asked about what evidence-based medicine he was relying upon to support his decision, he merely pointed to the MRI and EMG findings. He did not discuss or present any evidence-based medical literature, credible scientific studies, peer-reviewed medical literature and other current scientifically based texts, or treatment and practice guidelines to support his opinion. Under the Act this is required.

Looking at the Official Disability Guidelines, there is a lack of medical criteria at the C6/7 level for performing a fusion. There was no evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved C6/7 level or presence of a positive Spurling test, at least in the medical records admitted into evidence. Dr. S admitted this. Additionally, there was not evidence of motor deficit or reflex changes or positive EMG findings that correlate with the C6/7 level. The Official Disability Guidelines recommends that EMG is optional if there is other evidence of motor deficit or reflex changes but those changes were not found either.

Therefore, under the Official Disability Guidelines and with a lack of other evidence-based medicine, this C6/7 fusion is found not to be reasonably required despite the possibility of future ramifications from performing the fusion at just the C5/6 level. Additionally, as pointed out to the parties at the CCH, these decisions are "all or nothing", i.e. the hearing officer cannot find it medically necessary to do one level and not the other. A decision has to be made on the entire requested procedure. Claimant did not meet his burden of proof.

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 as a Self-Insurer.

   D. On (Date of Injury), Claimant sustained a compensable injury.

   E. The IRO board-certified orthopedic surgeon determined an inpatient surgery for C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring was not health care reasonably required for the compensable injury of (Date of Injury).

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. An inpatient surgery for C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring (63075, 63076, 22554, 22585, 22551, 22552, 22845, 20938, 20937, 95920, and 95925) is not health care reasonably required for the compensable injury of (Date of Injury).

## CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO board-certified orthopedic surgeon that an inpatient surgery for C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring (63075, 63076, 22554, 22585, 22551, 22552, 22845, 20938, 20937, 95920, and 95925) is not health care reasonably required for the compensable injury of (Date of Injury).

## DECISION

Claimant is not entitled to an inpatient surgery for C5/6 and C6/7 anterior cervical discectomy fusion and spinal monitoring 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 **(CITY), SELF-INSURED** and the name and address of its registered agent for service of process is

**(SELF-INSURED)**
**CITY SECRETARY, CITY OF (CITY)**
**(STREET)**
**(CITY), TEXAS (ZIP CODE)**

Signed this 25th day of April, 2013.

KEN WROBEL
Hearing Officer