

MEDICAL CONTESTED CASE HEARING NO. 14015

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 October 09, 2013, to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to a laminectomy decompression at left L4/5, L5/S1, and possibly L3/4 with a 2 day inpatient stay for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by DM, ombudsman.
Respondent/Carrier appeared and was represented by GS, attorney.

BACKGROUND INFORMATION

On (Date of Injury), Claimant was getting out of his 18-wheeler. The next thing he remembers is he was lying on the ground with his left leg wrapped underneath him. Since then, Claimant has had six surgeries – three to treat MRSA, one was a lumbar fusion from L1 to S1 in 2003, one was to remove hardware that had broken and the last one was for a spinal cord stimulator. Claimant's surgeon, SL, M.D., has requested to perform a laminectomy decompression at left L4/5, L5/S1, and possibly L3/4. He described that this was not a fusion because everything is already fused. He will remove the hardware on the left and perform the laminectomies in order to free up the L4, L5, and S1 nerves. He opines this will help with Claimant's weakness in his left leg that is causing him to fall and maybe it will help with some of Claimant's low back pain. The surgery was denied twice by the Carrier. The IRO neurosurgeon agreed with the denial.

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. 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 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."

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to a laminectomy decompression:

Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopathy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamentary hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their 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) 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) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. (Weinstein, 2010) Comparative effectiveness evidence from SPORT shows good value for standard posterior laminectomy after an imaging-confirmed diagnosis of spinal stenosis [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011) Decompressive surgery (laminectomy) is more effective for lumbar spinal stenosis than land based exercise, but given the risks of surgery, a self-management program with exercise prior to consideration of surgery is also supported. (Jarrett, 2012) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy.

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to a discectomy/laminectomy surgical indications:

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).

The Official Disability Guidelines recommends a laminectomy for spinal stenosis. The Official Disability Guidelines only defines “Decompression”. It gives the definition as it “may be a surgical procedure that is performed to alleviate pain caused by pinched nerves (neural impingement).” The Official Disability Guidelines then only gives examples of decompressions. The Official Disability Guidelines does not give a recommendation for decompression the way it does for a discectomy, laminectomy or fusion. The IRO doctor states the Official Disability Guidelines requires imaging studies to confirm neurocompressive findings. The IRO doctor

ignores the part where the Official Disability Guidelines says “ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam finding: nerve root compression (L3, L4, L5, or S1), lateral disc rupture or lateral recess stenosis.” There is nothing in the Official Disability Guidelines paragraph above about not supporting laminectomies at previously fused levels.

NT, M.D. provided a peer-review for the Carrier. He recommended denying the surgery. Dr. T’s opinion is not persuasive because he references the Official Disability Guidelines’ recommendations for surgical discectomy. Claimant’s surgeon is recommending a multi-level laminectomy, not a discectomy. GP, M.D., FAAPMR, opined the Official Disability Guidelines does not support additional decompression at previously fused levels. He also opines there is no conclusive electrodiagnostic evidence of chronic multilevel radiculopathy. The Official Disability Guidelines states fusion is recommended for spondylolisthesis but laminectomies were recommended for spinal stenosis. While poly-neuropathies may be masking the poly-radiculopathies as one EMG report states, there is electrodiagnostic evidence, symptomatic complaints and objective testing supporting multilevel radiculopathy. The EMG report states Claimant’s symptoms were more consistent with peripheral poly-neuropathy. As noted above, EMGs are not required when there is clinical evidence of the correlating radiculopathy. Dr. L explained removing the stenosis around the L4, L5, and S1 nerves will help with the radiculopathy and maybe the back pain. That is the focus of the laminectomy procedure. He explained how the imaging studies showed the stenosis. He saw the stenosis on the films when reading them himself at the L3/4 level but he explained he is only going that high to free the L4 nerve as the nerve root comes out between the L3/4 and L4/5 discs. He explained the procedure would not help with the neuropathies so Claimant would not be free of all of his complaints.

Dr. L sent Claimant to IL, M.D. for a second opinion. Dr. L is a spinal deformity specialist. He agrees Claimant has a flatback syndrome and opines he would not do any surgeries. He does not believe surgery would improve his current constellation of symptoms. Dr. L also referred Claimant to MC, EdD, for a psychological evaluation. After performing the pre-surgical evaluation, Dr. C approved Claimant for back surgery.

A peer review was done by RH, M.D. He says that in a claimant who has failed prior lumbar surgeries, the Official Disability Guidelines and other evidence-based guidelines would not support any type of repeat lumbar surgeries. A search in the Low Back Treatment Guidelines does not reveal anything with relation to a “repeat” surgery, especially a laminectomy. A search for “failed” only reveals that a revision surgery for a failed previous operation is one of the reasons to allow for a fusion – which is not being requested in this case so that statement is not relevant.

Claimant’s surgeon explained what he was doing – a decompressive laminectomy at L4/5 and L5/S1 and possibly up to the L3/4 level in order to free up the L4 nerve, which begins as high as the L3/4 disc level. The imaging studies do not show stenosis at that level but he testified he

would look there to make sure the left L4 nerve was free. The Official Disability Guidelines supports laminectomies to treat spinal stenosis. That is what Dr. L testified he was going to address. He was not doing discectomies or fusions. Dr. L disagrees but this is just a difference in medical opinion on how to treat Claimant. Dr. L does not refer to the Official Disability Guidelines. The three carrier doctors and IRO doctor who disagree with Claimant either base their opinions on other procedures listed in the Official Disability Guidelines such as discectomies and do not address “laminectomies” or they make general statements that do not appear to be supported by the Official Disability Guidelines.

The specific surgery Dr. L has recommended is supported by the Official Disability Guidelines and no doctor, including the IRO doctor, addresses the specific surgery Dr. L has requested. The opinions of the other doctors are not based upon the Official Disability Guidelines and are not persuasive. Claimant provided evidence-based medicine sufficient to contradict the determination of the IRO and the preponderance of the credible evidence is contrary to the decision of the IRO.

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), Claimant sustained a compensable injury.
 - D. The Independent Review Organization board certified neurological surgeon determined Claimant should not have a laminectomy decompression at left L4/5, L5/S1, and possibly L3/4 with a 2 day inpatient stay.
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. A laminectomy decompression at left L4/5, L5/S1, and possibly L3/4 with a 2 day inpatient stay is 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 contrary to the decision of the IRO that a laminectomy decompression at left L4/5, L5/S1, and possibly L3/4 with a 2 day inpatient stay is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to a laminectomy decompression at left L4/5, L5/S1, and possibly L3/4 with a 2 day inpatient stay for the compensable injury of (Date of Injury).

ORDER

Carrier is 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 **AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA** and the name and address of its registered agent for service of process is

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

Signed this 11th day of October, 2013.

KEN WROBEL
Hearing Officer