

MEDICAL CONTESTED CASE HEARING NO. 16000

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence is not contrary to the decision of the IRO that claimant is not entitled to revision right L5/S1 foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring.

STATEMENT OF THE CASE

On September 8, 2015, Britt Clark, a Division hearing officer, held a contested case hearing 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 revision right L5/S1 foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring?

PARTIES PRESENT

Claimant appeared and was assisted by DM, ombudsman. Carrier appeared and was represented by SC, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Dr. JS.

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-10.

Carrier's Exhibits CR Exhibits Page 1 through 97.

DISCUSSION

It is undisputed that Claimant sustained a compensable injury to his low back on (Date of Injury). Claimant's neurosurgeon, Dr. JS, requested preauthorization for revision right L5/S1

foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring. Carrier's URA doctors denied the request. The IRO doctor agreed with the denial. Claimant is disputing the IRO decision and relied on the opinion of Dr. S to establish that the preponderance of the evidence is contrary to the decision of the IRO.

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 lumbar discectomy/laminectomy, which the parties agreed applied to the foraminotomy:

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) (Buttermann, 2004) (Chou, 2008) 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. (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) In the treatment of patients with lumbar spinal stenosis, patients improved over the 2-year follow-up regardless of initial treatment, and 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 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) Although both surgery and nonsurgery have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients. (Peul-NEJM, 2007) (Deyo-NEJM, 2007) There is no obvious additional benefit was noted by combining decompression with instrumented fusion. (Hallett, 2007) A 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) Discectomy is moderately cost-effective compared with nonsurgical treatment, according to a 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) Four-year results for the Dartmouth Spine Patient

Outcomes Research Trial 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. (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. (Hansson, 2008) Both 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) 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) Carefully selected patients who underwent surgery for a lumbar disc herniation (standard open discectomy) achieved greater improvement than nonoperatively treated patients (active physical therapy, education/counseling with home exercise instruction, and NSAIDs), and there was little to no degradation of outcomes in either group (operative and nonoperative) from 4 to 8 years. (Lurie, 2014) 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. (Dewing, 2008) Workers' comp back surgery patients are at greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 2008) (DeBerard, 2011) Overweight and obese patients demonstrated an increased risk of postoperative complications after lumbar spine surgery, but these are not associated with a greater risk of mortality. (Marquez-Lara, 2014)

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. (See Indications below.) 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) 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.

Risk versus benefit: The primary tradeoff is whether to undergo the risks of surgery, which are fairly small in this case, to achieve good short-run improvement of symptoms (success rate > 80%) faster than could also be achieved from conservative treatment alone. Minor pain and discomfort may not be worth the risks of surgery and the recovery time from surgery, depending on the patient's tolerance for risk, and there is no downside in delaying surgery. 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. There is good evidence that discectomy is moderately superior to nonsurgical therapy for improvement in pain and function through 2 to 6 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) (Chou, 2008) Similar evidence supports the use of surgery for spinal stenosis, but the outcomes look better with surgery out to about 2 years. (Malmivaara, 2007) In this trial, early surgery 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. (Peul, 2007) (Deyo, 2007) Consequently, for patients who don't want surgery no matter how bad their pain is, they will likely improve and they will not have complications 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 in the short-term with surgery, and the risks are extremely low. (Weinstein2, 2008) In general, the risk of surgical complications is fairly small, about 3% for readmission and reoperation (Pugely, 2014), and 0.10% for death. (HCUP, 2012) For those receiving workers' compensation, surgery may not be better than non-surgical treatment for most patients, even in the short-run. (Atlas, 2010) (DeBerard, 2008) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (DeBerard, 2011) Obese patients have an increased risk of postoperative complications after lumbar spine surgery, but these are not associated with a greater risk of mortality. (Marquez-Lara, 2014) Smokers have much worse outcomes from lumbar decompression than nonsmokers, with an odds ratio for reoperation over 11. (Bydon, 2015) (Dewing, 2008)

NNH/NNT: Without taking into account specific risk factors, like smoking, obesity, or workers' comp, the NNH (number needed to harm) is about 33, and the NNT (number needed to treat) for short-term improvement is about 1.2, but the NNT for long-term improvement is well over 10, compared to conservative treatment.

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 (\geq 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)

The request was also for a neuroplasty, which the ODG references as an Adhesiolysis, states the following:

Not recommended due to the lack of sufficient literature evidence (risk vs. benefit, conflicting literature). Also referred to as epidural neurolysis, epidural neuroplasty, or lysis of epidural adhesions, percutaneous adhesiolysis is a treatment for chronic back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space. Lysis of adhesions is carried out by catheter manipulation and/or injection of saline (hypertonic saline may provide the best results). Epidural injection of local anesthetic and steroid is also performed. It has been suggested that the purpose of the intervention is to eliminate the effect of scar formation, allowing for direct application of drugs to the involved nerves and tissue, but the exact mechanism of success has not been determined. There is a large amount of variability in the technique used, and the technical ability of the physician appears to play a large role in the success of the procedure. In addition, research into the identification of the patient who is best served by this intervention remains largely uninvestigated. Adverse reactions include dural puncture, spinal cord compression, catheter shearing, infection, excessive spinal cord compression, hematoma, bleeding, and dural puncture. Duration of pain relief appears to range from 3-4 months. Given the limited evidence available for percutaneous epidural adhesiolysis it is recommended that this procedure be regarded as investigational at this time. (Gerdesmeyer, 2003) (Heavner, 1999) (Belozzer, 2004) (BlueCross BlueShield, 2004) (Belozzer, 2004) (Boswell, 2005) (Boswell, 2007) (The Regence Group, 2005) (Chopra, 2005) (Manchikanti1, 2004) (Epter, 2009) This recent RCT found that after 3 months, the visual analog scale (VAS) score for back and leg pain was significantly reduced in the epidural neuroplasty group, compared to to conservative treatment with physical therapy, and the VAS for back and leg pain as well as the Oswestry disability score were significantly reduced 12 months after the procedure in contrast to the group that received conservative treatment. (Veihelmann, 2006)

Adhesiolysis is Not Recommended by ODG.

Turning first to the neuroplasty, Claimant did not meet his burden of proof. As noted above, the above procedure is not recommended by the ODG, which is reflected in the opinions of the IRO doctor and the Utilization Review doctors. Claimant provided the testimony of Dr. JS, his treating surgeon. Dr. S opined that if there is an MRI which correlates with the physical exam findings which showed evidence of nerve root compression, the ODG provides for this procedure. His testimony was inconsistent with the ODG, and he did not cite evidence-based medical evidence to justify this procedure. After reviewing all of the evidence, the preponderance of the evidence is not contrary to the IRO regarding this procedure.

Concerning the foraminotomy, the IRO reviewer and Utilization Review doctors believed there was insufficient evidence confirming nerve root compression or radiculopathy. The IRO doctor reviewed the MRI which showed an osteophyte/disc complex contacting the exiting right L5 nerve root and opined that there was insufficient evidence of objective findings or symptoms consistent with the distribution of the nerve root. While Dr. S disputed these findings with citation to his records, the IRO doctor and the URA doctors more persuasively explain the basis of their respective opinions as their opinions appear to be more consistent with the objective medical evidence. 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. Rule 133.308(s). In this case, Claimant failed to do so.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

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 the City of (City), Employer.
 - C. On (Date of Injury), Employer provided workers compensation insurance as a self-insured Carrier.
 - D. On (Date of Injury), Claimant sustained a compensable 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. Revision right L5/S1 foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring 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 that claimant is not entitled to revision right L5/S1 foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring.

DECISION

The preponderance of the evidence is not contrary to the decision of the IRO that claimant is not entitled to revision right L5/S1 foraminotomy, neuroplasty right L5/S1 nerve roots and spinal monitoring.

ORDER

Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. 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 OF (CITY), TEXAS**, and the name and address of its registered agent for service of process is

**MARY J. KAYSER
CITY SECRETARY, CITY OF (CITY)
1000 THROCKMORTON
(CITY), TX 76102**

Signed this 16th day of September, 2015.

BRITT CLARK
Hearing Officer