

MEDICAL CONTESTED CASE HEARING 16063

**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 Claimant is not entitled to exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy for the compensable injury of (Date of Injury).

**STATEMENT OF THE CASE**

On March 15, 2017, 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 Independent Review Organization's (IRO's) determination that Claimant is not entitled to exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Claimant appeared and was assisted by ER, ombudsman. Carrier appeared and was represented by RT, attorney.

**EVIDENCE PRESENTED**

The following witnesses testified:

For Claimant: Claimant and 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-3.

Carrier is Exhibits CR-A through CR-I.

**DISCUSSION**

Claimant sustained a compensable injury on (Date of Injury) and has had multiple cervical surgeries for her compensable injury. The most recent, performed on April 27, 2015 involved a

C3-T2 posterior cervical fusion with removal of a left C3 lateral mass screw, a right C5 hemilaminectomy, and C5-6 foramintomy. Due to Claimant's continued symptoms, Dr. JS, Claimant's surgeon referred Claimant for a CT scan and Myelography which showed "Extensive postop change at C2-T2" as well as "trace lucency around the T2 screws." Because of the finding of trace lucency and the Claimant's clinical signs being concerning for pseudoarthrosis, Dr. S submitted for an exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy. However, the surgery was denied preauthorization, reconsideration, and through the IRO process. Claimant argued that she is entitled to the requested surgery due to the concern that her fusion had not healed. Carrier argued there is insufficient evidence of pseudoarthrosis to justify the surgery and further argued that the IRO reviewer was correct.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury be 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."

The ODG addresses a posterior and anterior cervical fusion in the “Neck/Upper Back” as follows:

#### Patient Selection Criteria for Anterior Spinal Fusion:

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

#### Criteria for Cervical Fusion – Recommended Indications:

- (1) Acute traumatic spinal injury (fracture or dislocation) resulting in cervical spinal instability.
- (2) Osteomyelitis (bone infection) resulting in vertebral body destruction.
- (3) Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression.
- (4) Cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities.
- (5) Spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality or pathologic Babinski sign) and Diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression.
- (6) Spondylotic radiculopathy or nontraumatic instability with all of the following criteria:
  - (a) Significant symptoms that correlate with physical exam findings AND radiologist-interpreted imaging reports.
  - (b) Persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain, despite 8 weeks of conservative therapy with at least 2 of the following:
    - Active pain management with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., an NSAID, muscle relaxant or tricyclic antidepressant);
    - Medical management with oral steroids or injections;
    - Physical therapy, documented participation in a formal, active physical therapy program as directed by a physiatrist or physical

therapist, may include a home exercise program and activity modification, as appropriate.

- (c) Clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities of work or at-home duties.
- (d) Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression, or Diagnostic imaging by X-ray demonstrates Instability by flexion and extension X-rays; Sagittal plane translation >3 mm; OR Sagittal plane translation >20% of vertebral body width; OR Relative sagittal plane angulation >11 degrees.
- (e) Not recommend repeat surgery at the same level.
- (f) Tobacco cessation: Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery.
- (g) Number of levels: When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria above. Fewer levels are preferred to limit strain on the unfused segments. If there is multi-level degeneration, prefer limiting to no more than three levels. With one level, there is approximately an 80% chance of benefit, for a two-level fusion it drops to around 60%, and for a three-level fusion to around 50%. But not fusing additional levels meeting the criteria, risks having to do future operations
- (h) The decision on technique (e.g., autograft versus allograft, instrumentation) should be left to the surgeon.

#### Posterior Cervical Fusion:

Under study.

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

A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. (*Callahan, 1977*) (*Liu, 2001*) (*Sagan, 2005*) Although the addition of instrumentation is thought to add to fusion rate in posterior procedures, a study using strict criteria (including abnormal motion between segments, hardware failure, and radiolucency around the screws) reported a 38% rate of nonunion in patients who received laminectomy with fusion compared to a 0% rate in a group receiving

laminoplasty. (*Heller, 2001*) In a study based on 932,009 hospital discharges associated with cervical spine surgery for degenerative disease, complications and mortality were more common after posterior fusions or surgical procedures associated with a primary diagnosis of cervical spondylosis with myelopathy. The overall percent of cases with complications was 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (*Wang, 2007*)

Patients undergoing occipitocervical fusion or C1–2 (high cervical region) fusion is an absolute contraindication for returning to any type of activity with a risk of re-injury (such as contact sports), because the C-1 arch is relatively fragile and stability depends on the status of the periodontal ligaments. (*Burnett, 2006*)

Dr. S, at the hearing, appeared to reference the ODG regarding spinal fusions for the lumbar spine. The ODG addresses the necessity for a low back spinal fusion in the “Low Back- Lumbar and Thoracic” section as follows:

#### Patient Selection Criteria for Spinal Fusion:

(A) Recommended as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to criteria below:

- (1) Spondylolisthesis (isthmic or degenerative) with at least one of these:
  - (a) instability, and/or
  - (b) symptomatic radiculopathy, and/or
  - (c) symptomatic spinal stenosis;
- (2) Disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level;
- (3) Revision of pseudoarthrosis (single revision attempt);
- (4) Unstable fracture;
- (5) Dislocation;
- (6) Acute spinal cord injury (SCI) with post-traumatic instability;
- (7) Spinal infections with resultant instability;
- (8) Scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity;
- (9) Scheuermann's kyphosis;
- (10) Tumors.

(B) Not recommended in workers' compensation patients for the following conditions:

- (1) Degenerative disc disease (DDD);
- (2) Disc herniation;
- (3) Spinal stenosis without degenerative spondylolisthesis or instability;

(4) Nonspecific low back pain.

(C) Instability criteria: Segmental Instability (objectively demonstrable) - Excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria include lumbar inter-segmental translational movement of more than 4.5 mm. (*Andersson, 2000*) (*Luers, 2007*) (*Rondinelli, 2008*)

(D) After failure of two discectomies on the same disc [(A)(2) above], fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)

(E) Revision Surgery for failed previous fusion at the same disc level [(A)(3) above] if there are ongoing symptoms and functional limitations that have not responded to non-operative care; there is imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and significant functional gains are reasonably expected. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. Workers compensation and opioid use may be associated with failure to achieve minimum clinically important difference after revision for pseudoarthrosis (*Djurasovic, 2011*) There is low probability of significant clinical improvement from a second revision at the same fusion level(s), and therefore multiple revision surgeries at the same level(s) are not supported.

(F) Pre-operative clinical surgical indications for spinal fusion should include all of the following:

- (1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.);
- (2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings;
- (3) Spine fusion to be performed at one or two levels;
- (4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery;
- (5) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing; (*Colorado, 2001*) (*BlueCross BlueShield, 2002*)

- (6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient;
- (7) For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

The proposed treatment was denied at the initial utilization review level and the reconsideration level, and the IRO reviewer agreed with the denial. The IRO reviewer noted that the ODG states that complications from a cervical fusion include pseudoarthrosis with the treatment options to include a surgical revision. The IRO reviewer was able to review the opinion of Dr. S, regarding his position that trace lucency found on the CT scan and myelography were sufficient to show pseudoarthrosis. However, the IRO reviewer did not believe there were sufficient findings to support the proposed treatment. The reviewer on reconsideration, Dr. RW, addressed the trace lucency of the T2 pedicle screw, and believed the objective evidence did not show distinct imaging signs of pseudoarthrosis, dynamic instability, hardware failure, etc.

Dr. S testified at the hearing that Claimant requires the surgery due to the indication of pseudoarthrosis, i.e., a non-healed spinal fusion. He cited the trace lucency at the T2 pedicle screw, which he indicates in his report “could indicate that the posterior cervical spine is not fixed.” Dr. S admitted that Claimant did not have instability per the ODG, but he believed the fusion was indicated by ODG due to a non-healed fusion. He opined that the suspicion of pseudoarthrosis was sufficient to perform a spinal fusion, noting the objective evidence of trace lucency at T2 coupled with his clinical findings. While he is correct that instability is not required for the ODG to recommend spinal fusion as referenced in the low back chapter, his analysis regarding the suspicion of pseudoarthrosis does not appear to be supported. The ODG requires that there is “imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition.” This reference is specific to the lower back, and not the cervical/upper back section of the ODG. For the cervical and upper back, the ODG reflects that a fusion surgery is used in cases where there has been insufficient anterior stabilization. Dr. W more persuasively explained that the finding of trace lucency was insufficient to confirm pseudoarthrosis, spinal instability, or the lack of fusion, especially considering Dr. S indicated in his records that the finding was not significant. Moreover, Dr. S’s medical records indicate the surgery, in part, is to ascertain whether pseudoarthrosis is present, and those records do not support imaging confirmation of the condition. The current imaging studies and clinical findings contained in the record did not support the assertion that the prior anterior stabilization was unsuccessful. Based upon the evidence presented, there was insufficient evidence-based medical evidence presented to rebut the IRO’s determination that Claimant is not entitled to the disputed procedure.

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 (Employer), Employer.
  - C. On (Date of Injury), Employer provided workers' compensation insurance through Utica Mutual Insurance Company, 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. Exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy 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 IRO's determination that Claimant is not entitled to exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy for the compensable injury of (Date of Injury).

## **DECISION**

Claimant is not entitled to exploration spinal fusion C7-T1, C7-T2 post spinal fusion and spinal monitoring, three day inpatient stay, and T1-T2 foraminotomy 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 **UTICA MUTUAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is

**BRIAN K. McCULLOCH**  
**2435 NORTH CENTRAL EXPRESSWAY, SUITE 400**  
**RICHARDSON, TX 75080**

Signed this 15<sup>th</sup> day of March, 2017.

BRITT CLARK  
Hearing Officer