

MEDICAL CONTESTED CASE HEARING NO. 19003

DECISION AND ORDER

This case is decided pursuant to the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Administrative Law Judge determines that Claimant is not entitled a lumbar left hemilaminectomy L3-L4.

STATEMENT OF THE CASE

A contested case hearing was held on January 23, 2019, to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a lumbar left hemilaminectomy L3-L4 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

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

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: (Claimant).

For Carrier: None.

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-14.

Carrier's Exhibits CR-A and CR-H.

DISCUSSION

Claimant, a dialysis nurse, sustained a compensable injury on (Date of Injury) when she abruptly stood up and turned to walk. According to the record, the compensable injury of (Date of Injury) extends to and includes a left hip labral tear and lumbar spine disc protrusion at L3-L4. Claimant

received hip surgery, physical therapy, medications and a lumbar injection. Claimant testified that the lumbar pain has persisted. Treating doctor, JW, MD, opined that the L3-L4 protrusion impinged the nerve and caused some radicular pain. He noted that the lumbar injection failed to provide relief and he recommended a lumbar left hemilaminectomy L3-L4.

On July 26, 2018, Dr. W requested a lumbar left hemilaminectomy L3-L4. A Utilization Review was conducted by physician reviewer, MG, MD. Dr. G considered the Official Disability Guidelines (ODG) when he reviewed the necessity of the lumbar left hemilaminectomy L3-L4 and he denied authorization. Dr. G noted that the MRI studies of the lumbar spine did not identify any pathology at L3-L4 of any type and there were no specific physical examination findings consistent with any ongoing radiculopathy in the left lower extremity. Dr. G stated that these factors do not meet ODG recommendations. Claimant requested reconsideration and on August 2, 2018 JH, MD, physician reviewer, upheld Dr. G's decision.

Claimant appealed the denial and an Independent Review Organization (IRO) was appointed by the Texas Department of Insurance in accordance with Rule 133.308. After consideration of the information provided, in IRO Case # 227137, the IRO upheld Carrier's denial of the lumbar left hemilaminectomy L3-L4. Claimant thereafter filed a request for a contested case hearing as provided for by Rule 133.308(s). The contested case hearing was held on January 23, 2019.

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 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 about the care of 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 adopted treatment guidelines by Division Rule 137.100. The rule directs health care providers to

provide treatment in accordance with the current edition of the 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 the Department and the Division are not considered parties to an appeal. In a contested case hearing, the party appealing the IRO decision has the burden of overcoming the decision issued by the IRO by a preponderance of the evidence-based medical evidence. (Rule 133.308 (s).)

For the lumbar left hemilaminectomy L3-L4, the ODG lists the following criteria:

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

Required symptoms/findings; imaging studies; and 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. 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 2. 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 3. 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. MRI (magnetic resonance imaging)
2. CT (computed tomography) scanning
3. Myelography
4. CT myelography and 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).

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 approximately 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. (*Weinstein, 2008*) In general, the risk of surgical complications is fairly small, approximately 3% for readmission and reoperation (*Pugely, 2014*), and 0.10% for death. (*HCUP, 2011*) 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 approximately 33, and the *NNT* (number needed to treat) for short-term improvement is approximately 1.2, but the *NNT* for long-term improvement is well over 10, compared to conservative treatment.

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, 2000*) (*Malter, 1996*) (*Stevens, 1997*) (*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*) (*Weinstein, 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, 2007*) (*Deyo, 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 non-operatively 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. (*Weinstein, 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 non-operatively 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 ligament 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*.

Claimant appealed the denial of the lumbar left hemilaminectomy L3-L4. Dr. G and Dr. H with Utilization Review Agent (URA) opined that Claimant did not meet the ODG criteria for the lumbar left hemilaminectomy L3-L4. According to Dr. H, there was a lack of documentation indicating conservative treatments such as activity modification (not bed rest) after patient education and there was a lack of documentation of Claimant's dates and number of sessions and response to physical therapy. Additionally, it was reported that Claimant had no pain on straight leg raising and Claimant's sensation to touch was normal L1-S1.

Claimant requested that an IRO be appointed to review the URA denial. The Division appointed RYCO Med Review (RYCO) as the IRO. RYCO submitted the review of the request to a licensed orthopedic surgeon. In IRO Case No. 227137, the physician reviewer upheld the denial of the request for the lumbar left hemilaminectomy L3-L4. According to the physician reviewer, Claimant has no objective evidence of a left L3 or L4 radiculopathy on physical exam or on the EMG/NCV and no evidence of nerve root compression on the MRI; therefore, the proposed lumbar left hemilaminectomy L3-L4 is not medically necessary per evidence-based medicine guidelines, including the ODG.

Claimant argued that the recommendations of the ODG regarding the lumbar left hemilaminectomy L3-L4 should not be allowed. According to Claimant, she has ongoing pain. There is, however, no persuasive expert medical evidence that would tend to show that the recommendations contained in the ODG do not apply to Claimant or that the treatment requested by Dr. W is reasonably required for the compensable injury of (Date of Injury).

Based on a careful review of the evidence presented in the hearing, Claimant failed to meet her burden of overcoming the IRO decision. The IRO decision in this case is based on the ODG and

the evidence revealed that Claimant failed to meet all the necessary criteria for the lumbar left hemilaminectomy L3-L4. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, Claimant is not entitled to the lumbar left hemilaminectomy L3-L4.

The Administrative Law Judge 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. The Texas Department of Insurance, Division of Workers Compensation has jurisdiction over this matter.
 - B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
 - C. On (Date of Injury), Claimant was the employee of (Employer), Employer.
 - D. On (Date of Injury), Employer provided workers compensation insurance with Farmington Casualty Company.
 - E. Claimant sustained a compensable injury on (Date of Injury).
 - F. The IRO determined that the lumbar left hemilaminectomy L3-L4 for the compensable injury of (Date of Injury) is not medically necessary.
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 Administrative Law Judge's Exhibit Number 2.
3. The preponderance of the evidence is not contrary to the decision of the IRO that lumbar left hemilaminectomy L3-L4 is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.

3. Claimant is not entitled to a lumbar left hemilaminectomy L3-L4 for the compensable injury on (Date of Injury).

DECISION

Claimant is not entitled to a lumbar left hemilaminectomy L3-L4 for the compensable injury on (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 **FARMINGTON CASUALTY COMPANY**, and the name and address of its registered agent for service of process is

**CORPORATION SERVICE COMPANY
d/b/a CSC-LAWYERS INCORPORATING COMPANY
211 EAST 7th STREET
SUITE 620
AUSTIN, TEXAS 78701-3218**

Signed this 28th day of January, 2019

Early Moyer
Administrative Law Judge