MEDICAL CONTESTED CASE HEARING 20023

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 Administrative Law Judge (ALJ) determines that Claimant is not entitled to TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay.

STATEMENT OF THE CASE

On December 17, 2020, Britt Clark, a Division ALJ, 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 TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay?

PARTIES PRESENT

Claimant appeared and was assisted by BA, ombudsman. Insurance Carrier appeared and was represented by DP, attorney. The hearing took place by video conference due to the COVID-19 pandemic.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant, Dr. JS.

For Insurance Carrier: None.

The following exhibits were admitted into evidence:

ALJ's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-5.

Insurance Carrier's Exhibits CR-A through CR-CC.

DISCUSSION

This case involves a dispute as to the medical necessity of a TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay. Claimant contested the opinion of the IRO and contended that the surgery at issue is medically necessary to treat the compensable injury. Insurance Carrier relied on the opinion of the IRO and the opinions of its Utilization Review agents.

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 of Insurance 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 relevant portions of the ODG indicate the following for a lumbar fusion:

> Recommended as an option for spondylolisthesis, pseudarthrosis, unstable fracture, dislocation, acute spinal cord injury with post-traumatic instability, spinal infections with

resultant instability, scoliosis, Scheuermann's kyphosis, or tumors, as indicated in the Patient Selection Criteria below. Not recommended in workers' compensation patients for degenerative disc disease (DDD), disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or nonspecific low back pain, due to lack of evidence or risk exceeding benefit.

See Adjacent segment disease/degeneration (fusion); Iliac crest donor-site pain treatment; Revision surgery for pseudarthrosis, lumbar; Revision surgery for pseudarthrosis, cervical; Back brace, post-operative (fusion); Physical therapy (PT); Hospital Length of Stay (LOS); Home health services in the Pain Chapter; and Durable medical equipment (DME) in the Knee and Leg Chapter.

Patient Selection Criteria for Lumbar 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) 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 the section "ODG Indications for Surgery™ -- Discectomy/laminectomy" in Discectomy/ laminectomy.)

(E) Pseudarthosis: Revision Surgery for failed previous fusion at the same disc level for pseudarthrosis and hardware breakage/malposition may be recommended if there are ongoing symptoms and functional limitations that have not responded to non-operative care. [(A)(3) above] Imaging confirmation should be obtained, and other causes of persistent pain should be ruled out. Revision 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 pseudarthrosis. (*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. See Revision surgery for pseudarthrosis, lumbar and Revision surgery for pseudarthrosis, cervical.

(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, 2002*)
(6) There should be documentation that the surgeon has discussed potential alternatives, benefits and risks of fusion with the patient;

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

In this case, Dr. AF performed a utilization review and opined the requested procedure was not medically necessary due to a lack of evidence of lumbar instability. Dr. CP also performed a utilization review on reconsideration and agreed that there was no imaging showing instability or spondylolisthesis, with x-rays showing only minimal scoliosis. Claimant appealed these determinations and an IRO reviewer provided an opinion agreeing with the utilization review agents. The IRO reviewer stated that Claimant has symptoms and clinical findings consistent with an L5-S1 radiculopathy but noted that Claimant's imaging had been stable over a period of time. The reviewer stated there was no evidence of instability at L5-S1 based on radiographs and no significant spondylolisthesis at L5-S1. He noted that "current evidence-based guidelines do not recommend consideration of lumbar fusion to address radiculopathy or degenerative disc disease in the lumbar spine." (CR-BB, Page 5).

Claimant disagreed with the determination of these doctors and provided her medical records, which included the opinion of Dr. JS, Claimant's treating surgeon. Dr. S testified at the hearing and opined that the treatment at issue was medically necessary for Claimant's condition. Dr. S opined that spinal instability is not the only determining factor as to whether a fusion is medically necessary. Dr. S believed that Claimant required an L5-S1 fusion because this is the level of the lumbar spine which correlated with her symptoms, discussing the objective evidence and clinical findings in his records. He opined that this surgery is medically necessary per the ODG. He did not provide other evidence-based medical studies and relied on the ODG for his opinion.

After review of the evidence, Claimant failed to meet her burden of proof. The IRO reviewer persuasively explained why Claimant did not meet the ODG criteria for a lumbar fusion. Dr. S's opinion was carefully considered but did not show that the requested procedure was medically necessary per the ODG. Although he stated in his testimony and throughout his notes that there are other criteria for authorization of a fusion, his testimony supported that Claimant did not meet any of the "Patient Selection Criteria for Lumbar Spinal Fusion" discussed in the ODG. (cited above, (A)(1-10)). Dr. S's analysis focuses on subsection (F) of the ODG criteria, which

is pre-operative surgical indications for spinal fusion. He failed to address that Claimant does not appear to meet the patient selection criteria for a fusion in the ODG. While Dr. S documents that Claimant has corroborating physical findings and imaging with failure of non-operative treatment, the ODG specifies that these requirements are "subject to" the selection criteria for a fusion, which his testimony did not support that Claimant met. Furthermore, per his testimony, Dr. S appears to disagree with the portion of the ODG that states the requested surgery is not recommended for degenerative disc disease, disc herniation, or spinal stenosis without degenerative spondylolisthesis and instability. The ODG notes that there are significant risks associated with lumbar fusion for non-recommended conditions. Dr. S's opinion was not persuasive in rebutting the opinion of the IRO.

Claimant has the burden of proof on this case to show by the preponderance of evidence-based medical evidence that the surgery requested is clinically appropriate and considered effective for her injury. As Claimant did not overcome the IRO decision by a preponderance of the evidence-based medical evidence, she has accordingly failed to meet her burden of proof.

The ALJ 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 as a self-insured Insurance Carrier.

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

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

3. TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay 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 TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay.

DECISION

Claimant is not entitled to TLIF L5-S1 post spinal fusion L5 to S1 laminectomy L5, S1, and spinal monitoring-inpatient X 3 day stay.

ORDER

Insurance 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 **(SELF-INSURED)**, and the name and address of its registered agent for service of process is

(NAME)
(STREET ADDRESS)
(CITY, STATE, ZIPCODE)

Signed this 22nd day of December, 2020.

BRITT CLARK
Administrative Law Judge