

MEDICAL CONTESTED CASE HEARING NO. 13063

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.

ISSUE

A benefit contested case hearing was held on February 7, 2013, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Petitioner / Claimant is not entitled to a lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner / Claimant appeared and was assisted by IF, ombudsman. Respondent / Carrier appeared and was represented by BJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Petitioner / Claimant: Petitioner / Claimant.

For Respondent: NT, M.D.

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 and HO-2.

Petitioner / Claimant's Exhibits C-1 through C-4.

Respondent's Exhibits R-A through R-I.

BACKGROUND INFORMATION

Petitioner / Claimant worked for the employer, (Employer). On (Date of Injury), while working, she was injured. This resulted in Petitioner / Claimant sustaining injuries to the physical structure of her body. In October 2012, SKH, M.D., a board certified neurosurgeon, sought approval for spinal surgery in the form of a lumbar laminectomy L4, L5, and S1 CPT 63047,

22114, 20926, 63048. Such requested treatment underwent utilization review on November 5, 2012 and was denied. Dr. H sought reconsideration and such denial was upheld on December 4, 2012. Petitioner / Claimant then appealed the denial to an Independent Review Organization (hereinafter "IRO") and the IRO reviewer, a neurosurgeon, upheld the previous adverse determinations based on the following sources: DWC – Division of Workers' Compensation Policies or Guidelines and *ODG - Official Disability Guidelines & Treatment Guidelines* (hereinafter "ODG"). Consequently, Petitioner / Claimant appealed the IRO decision and this is the reason for the present discussion and decision.

DISCUSSION

Medical Necessity

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. TEX. LAB. CODE § 408.021. "Health care reasonably required" is defined 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. TEX. LAB. CODE § 401.011 (22a). Health care under the Texas Workers' Compensation system must be consistent with evidence-based medicine if that evidence is available. "Evidence-based medicine" means 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. TEX. LAB. CODE § 401.011 (18a). 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. TEX. LAB. CODE § 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with the Texas Labor Code. TEX. LAB. CODE § 413.017(1).

In accordance with the above statutory guidance, the Division has adopted treatment guidelines by rule. 28 Tex. Admin. Code § 137.100 (Division Rule 137.100). This Rule directs health care providers to provide treatment in accordance with the current edition of the ODG and that 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.

The pertinent provisions of the ODG applicable to this case are as follows, to wit:

LAMINECTOMY/ LAMINOTOMY:

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

DISCECTOMY/LAMINECTOMY:

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) (BlueCross BlueShield, 2002) (Buttermann, 2004) 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, although discectomy seemed to be associated with a more rapid initial recovery, and discectomy was superior to conservative treatment when the herniation was at L4-L5. (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) A recent RCT compared decompressive surgery with nonoperative measures in the treatment of patients with lumbar spinal stenosis, and concluded that, although patients improved over the 2-year follow-up regardless of initial treatment, 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) According to a major recent trial, early surgery (microdiscectomy) in patients with 6-12 weeks of severe sciatica caused by herniated disks 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. The authors concluded, "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. Although both strategies have similar outcomes after 1 year, early surgery remains a valid treatment option for well-informed patients." (Peul-NEJM, 2007) (Deyo-NEJM, 2007) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and

single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. (Hallett, 2007) A recent 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) There is consistent evidence that for patients with a herniated disk, discectomy is associated with better short-term outcomes than continued conservative management, although outcomes begin to look similar after 3 to 6 months. This is a decision to be made with the patients, discussing the likelihood that they are going to improve either way but will improve faster with surgery. Similar evidence supports the use of surgery for spinal stenosis, although the outcomes look better with surgery out to about 2 years. (Chou, 2008) Standard open discectomy is moderately cost-effective compared with nonsurgical treatment, a new Spine Patient Outcomes Research Trial (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) 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. Lumbar disc herniation level and type should be considered in preoperative outcomes

counseling. Smokers had a significantly lower return to work rate. In the carefully screened patient, lumbar microdiscectomy for symptomatic disc herniation results in an overall high success rate, patient satisfaction, and return to physically demanding activities. (Dewing, 2008) Workers' comp back surgery patients are at greater risk for poor lumbar discectomy outcomes than noncompensation patients. (DeBerard, 2008) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (DeBerard, 2011)

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.

Recent Research: Four-year results for the Dartmouth Spine Patient Outcomes Research Trial (SPORT, n= 1244) 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. Consequently, for patients who don't want an operation no matter how bad their pain is, this study suggests that they will improve and they will not have complications (e.g., paralysis) 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 with surgery than without surgery, and the risks are extremely low. (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. 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) For radiculopathy with herniated lumbar disc, there is good evidence that 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) According to a new study, surgery provides better results than non-surgical treatment for most patients with back pain related to a herniated disk, but not for those receiving workers' compensation. (Atlas, 2010) 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)

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)

In the instant case, both parties relied on the ODG in support of their respective positions for or against the requested treatment. When both parties cite the ODG in support of their respective positions, such positions must be supported by sufficient medical evidence to justify application of the ODG in the manner promulgated. The IRO reviewer, a neurosurgeon, reviewed the records and upheld the adverse determination of the utilization review doctors. Essentially, the

IRO reviewer opined that because there was no evidence that the ODG criteria was met in this case, the requested treatment should not be approved. Thereafter, the IRO reviewer cited the ODG in upholding the denial of the requested treatment.

Petitioner / Claimant contended that she complied with the ODG criteria for the requested treatment. She argued that the requested treatment would help her in her recovery. As such, Petitioner / Claimant asserted that the ODG was met in this case and that the requested treatment was medically necessary. She relied upon the medical records presented as well as her own testimony to support her position

Respondent / Carrier contended that Petitioner / Claimant did not comply with the ODG criteria for the requested treatment. It argued that there was no medical evidence that the ODG criteria was met in this case. Respondent / Carrier declared that the ODG was not met and that the requested treatment was not medically necessary. It relied upon its documentary evidence as well as the testimony of NTs, M.D., a board certified orthopedic surgeon, to support its position.

When weighing expert testimony, the hearing officer must first determine whether the doctor rendering an expert opinion is qualified to offer such. In addition, the hearing officer must determine whether the opinion is relevant to the issues at bar and whether it is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See Black v. Food Lion, Inc.*, 171 F.3d 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *See Black*, 171 F.3d 308. In determining reliability of the evidence, the hearing officer must consider the evidence in terms of

- (1) general acceptance of the theory and technique by the relevant scientific community;
- (2) the expert's qualifications;
- (3) the existence of literature supporting or rejecting the theory;
- (4) the technique's potential rate of error;
- (5) the availability of other experts to test and evaluate the technique;
- (6) the clarity with which the theory or technique can be explained to the trial court; and
- (7) the experience and skill of the person who applied the technique on the occasion in question.

Kelly v. State, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990) *aff'd*, 824 S.W.2d 568 (Tex. Crim. App. 1992).

Additionally, "[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." *See* Division Rule 133.308 (t).

"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." *Id.*

Accordingly, Petitioner / Claimant, as the party appealing the IRO decision, had the burden by a preponderance of evidence-based medical evidence to establish that the requested treatment was medically necessary. Claimant's testimony was found to be very credible, consistent, and persuasive with regard to the mechanism of injury and her subsequent symptoms and there was no doubt that she was injured as a result of the incident that occurred on (Date of Injury). However, there was insufficient evidence-based medical evidence explaining how the ODG criteria for the requested treatment was met and to establish that the requested treatment was medically necessary. Therefore, after carefully reviewing and considering the conflicting evidence, the preponderance of the evidence is not contrary to the decision of the IRO that Petitioner / Claimant is not entitled to a lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 for the compensable injury of (Date of Injury).

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), Petitioner / Claimant was an employee of (Employer)., the Employer.
 - C. On (Date of Injury), Employer provided workers' compensation insurance with Texas Mutual Insurance Company.
 - D. On (Date of Injury), Petitioner / Claimant sustained a compensable injury.
2. Respondent / Carrier delivered to Petitioner / Claimant a single document stating the true corporate name of Respondent / Carrier, and the name and street address of Respondent / Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. The IRO determined that Petitioner / Claimant is not entitled to a lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 for the compensable injury of (Date of Injury).
4. A lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 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 a lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Petitioner / Claimant is not entitled to a lumbar laminectomy L4, L5, and S1 CPT 63047, 22114, 20926, 63048 for the compensable injury of (Date of Injury).

ORDER

Respondent / Carrier is not liable for the benefits at issue in this hearing. Petitioner / Claimant remains entitled to medical benefits for the compensable injury in accordance with § 408.021.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RICHARD J. GERGASKO
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 15th day of February 2013.

Julio Gomez, Jr.
Hearing Officer