MEDICAL CONTESTED CASE HEARING NO. 13064

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.

ISSUES

A contested case hearing was held on February 21, 2013 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay for the compensable injury of (Date of Injury)?

For good cause an issue was added as follows:

2. Was Claimant's appeal timely filed?

PARTIES PRESENT

Claimant appeared and was assisted by JT, ombudsman. Carrier appeared and was represented by KM, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable low back injury on (Date of Injury), when she slipped and fell on snow and ice. Dr. KJ requested pre-authorization for inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay. The IRO doctor, a neurosurgeon, upheld the previous denials. Claimant appealed.

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 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is 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 provides the following concerning low back 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 radiculopahy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamental 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).

The ODG provides the following patient selection criteria for lumbar spinal fusion:

Patient Selection Criteria for Lumbar Spinal Fusion:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include:

(1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia.
(2) Segmental Instability (objectively demonstrable) - Excessive motion, as in 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 20 degrees. (Andersson, 2000) (Luers, 2007)]
(3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria

includes lumbar inter-segmental movement of more than 4.5 mm. (Andersson, 2000)

(4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. 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.

(5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.

(6) After failure of two discectomies on the same disc, 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.)

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following:

(1) All pain generators are identified and treated; &

(2) All physical medicine and manual therapy interventions are completed; &

(3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology correlated with symptoms and exam findings; &

(4) Spine pathology limited to two levels; &

(5) Psychosocial screen with confounding issues addressed.

(6) 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)

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

The IRO doctor thought the requested procedure was not medically necessary, noting the ODG criteria were not met because the lumbar pathology identified on imaging studies did not warrant the extensive decompression and fusion surgery proposed.

Dr. J testified that Claimant needed the requested surgery to address a herniated disc at L5-S1 with radiculopathy. He said she needed the laminectomy to decompress the L5-S1 area, and she would then need the fusion because the laminectomy would create spinal instability.

Dr. J said the procedure met the ODG guidelines for lumbar fusion. He did not discuss the ODG guidelines for laminectomy. The ODG entry for lumbar laminectomy makes clear that the procedure is appropriate for spinal stenosis. Claimant arguably has nerve root impingement at L5-S1. There was no indication she has spinal stenosis at any level.

Concerning the proposed fusion, the requested treatment must meet the ODG guidelines at the time the request is reviewed, not during the requested surgery.

Claimant testified she is in a lot of pain, cannot do much of anything, and wants the surgery recommended by her doctor approved.

Claimant failed to overcome the IRO decision by the preponderance of evidence based medical evidence.

At the point of closing statements Carrier raised the issue of whether the appeal from the IRO was timely. It was not. The IRO decision was sent to Claimant on November 21, 2012. The appeal was received by the Division on December 18, 2012. Rule 133.308(s)(1)(A) requires the appeal to be filed not later than 20 days after the IRO decision is sent to the appealing party.

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) Claimant was the employee of (Employer), Employer.
   C. On (Date of Injury) Claimant sustained a compensable spinal injury.
   D. The Independent Review Organization determined that Claimant should not have spinal surgery.
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. Inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay is not health care reasonably required for the compensable injury of (Date of Injury).
4. The IRO decision was sent to Claimant on November 21, 2012; Claimant's appeal was received by the Division on December 18, 2012.

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 inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days

length of stay is not health care reasonably required for the compensable injury of (Date of Injury).

4. Claimant did not timely appeal the IRO decision.

DECISION

Claimant is not entitled to inpatient anterior/posterior fusion and bilateral laminectomy at L5-S1 with possible two to three days length of stay 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 Section 408.021 of the Act.

The true corporate name of the insurance carrier is **STATE FARM FIRE AND CASUALTY COMPANY**, and the name and address of its registered agent for service of process is

SHYAMA TERRY, VPO
8900 AMBERGLEN BOULEVARD
AUSTIN, TEXAS 78729

Signed this 21st day of February, 2013.

Thomas Hight
Hearing Officer