MEDICAL CONTESTED CASE HEARING NO. 13119

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 July 30, 2013, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that lumbar laminectomy and foraminectomy and foraminotomy at L5-S1 with a 23 hour hospitalization is not reasonably required health care for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was represented by LP, attorney. Respondent/Carrier appeared and was represented by JL, attorney. Petitioner, KB, MD appeared as a witness only.

BACKGROUND INFORMATION

Claimant sustained a compensable injury on (Date of Injury). On November 18, 2011, KB, MD, performed a lumbar laminectomy and microdiscectomy at L5-S1. Although Claimant experienced some improvement after the surgery, he continued to report low back pain near the same levels as before the operation. After the surgery, Claimant began to complain of numbness in his right foot and paresthesias in the bottom of the right foot. Dr. B ordered post-operative physical therapy.

On April 16, 2012, Claimant reported that he had experienced increased low back pain with right lower extremity discomfort that began during physical therapy a week to a week and a half before. Dr. B ordered an MRI. The MRI was done on May 24, 2012. It revealed 2mm redundant bulging and facet hypertrophy at L3-4; a broad 3-4mm disc protrusion and facet hypertrophy at L4-5; and a 2mm redundant bulging annulus and facet hypertrophy at L5-S1; enhancing right anterolateral and right lateral epidural scar formation surrounding the L5 and S1 nerve roots; and right anterolateral and subarticular recess narrowing with impingement upon the right S1 and exiting right L5 nerve roots. Dr. B submitted a request for preauthorization of a laminectomy and foraminotomy at L5-S1 with a 23 hour hospitalization.

Carrier submitted the request for preauthorization to a utilization review agent (URA). The URA recommended that the request be denied, citing the Official Disability Guidelines (ODG). The URA noted that the ODG criteria for discectomy/laminectomy required the presence of

radiculopathy and that Claimant's symptoms appeared to be related to post-operative epidural fibrosis and not to a recurrent or residual herniated disc. The URA stated that it is not clear that the proposed procedure would benefit Claimant since repeat surgery would only enhance the epidural fibrosis scarring and potentially increase Claimant's symptoms.

Reconsideration of the denial was requested and the preauthorization was submitted to another URA. The request was again denied. In the reconsideration report, the URA stated that he would not recommend the procedure because there was no evidence of a recurrent or residual disc herniation and that the proposed surgery is directed at disc pathology which is not documented by radiology as opposed to the epidural fibrosis. Carrier's refusal to preauthorize the surgery requested by Dr. B was then appealed to an Independent Review Organization (IRO).

The Texas Department of Insurance appointed Applied Assessments LLC as the IRO in this matter. The IRO submitted the request to a physician reviewer identified as being board certified in orthopedic surgery. The physician reviewer stated that his determination was based upon the provisions of the ODG and the physician reviewer's medical judgment, clinical experience and expertise in accordance with accepted medical standards. In recommending that Carrier's denial of the proposed procedure be upheld, the physician reviewer stated that although the exam findings are consistent with persistent nerve root irritation to the right at L5 and S1 secondary to epidural scar formation, the MRI findings suggest that further surgical procedures would, within reasonable medical probability, only increase the amount of epidural scar tissue noted in the MRI and worsening symptoms would occur following the repeat surgery at L5-S1.

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 in making decisions for the treatment 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 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 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 neither the Department nor the Division is considered a party 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. (Division Rule 133.308 (s).)

Dr. B testified. He disagrees with the URA doctors and the IRO physician reviewer that surgery is not indicated in this instance. He asserts that Claimant's condition is consistent with the findings to support laminectomy in the ODG. He testified that the scarring that has been implicated in Claimant's nerve root irritation will necessarily be removed in the surgery and that the other doctors' concern over worsening Claimant's condition through additional surgery is unfounded.

With regard to laminectomy/laminotomy, the ODG provides as follows:

> 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. (sic) 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).

Surgical indications for laminectomy, found under the discectomy/laminectomy section, are as follows:

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 (>= 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).

The ODG provides that the best target for a hospital stay after a laminectomy is one day.

Carrier presented the testimony of Dr. CC. Dr. C disagrees with Dr. B and testified that the proposed surgery is not reasonably necessary and is not likely to lead to an improvement in Claimant's condition. He explained that the most likely cause of the nerve root impingement is the scar tissue from the prior surgery because the imaging studies do not reflect the existence of a recurrent herniation of the disc. He agreed with the URA doctors and the IRO physician reviewer that additional surgery would most likely cause additional problems rather than providing any lasting relief.

Dr. B testified that Claimant meets the ODG requirements for surgery because an MRI demonstrates lateral nerve root compression at L5-S1; Claimant has had activity modification; drug therapy has been provided; and Claimant has been referred to physical therapy. In his opinion, Claimant qualifies for surgery under the indications for surgery set forth in the ODG and the proposed laminectomy/laminotomy should be approved. It is noted, however that the medical records in evidence do not show that Claimant has undergone patient education and does not show that Claimant has been taught home exercise and stretching in conjunction with the physical therapy. Dr. B testified that all surgeries involve the formation of scar tissue, and Dr. C agreed with the proposition. However, Dr. B failed to address the concerns shared by both URA doctors and the IRO doctor that scar tissue from the additional surgery would make Claimant's condition worse, not better.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See* Black vs. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999); E.I. Du Pont De Nemours and Company, Inc. v. Robinson, 923 S.W.2d 549 (Tex. 1995). Evidence is considered in terms of the general acceptance of the theory and technique by the relevant scientific community; the expert's qualifications; the existence of literature supporting or rejecting the theory; the technique's potential rate of error; the availability of other experts to test and evaluate the technique; and 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). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. Black v. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999).

The ODG recommendation for laminectomies states that it is useful in cases of 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 and trauma. Stenosis due to post-surgical scar tissue is not one of the conditions listed, although it is not necessarily ruled out, by the ODG. In order to evaluate the potential efficacy of laminectomy and laminotomy in this specific situation, both the ODG and generally accepted standards of medical practice recognized in the medical community as reflected in the recommendations of four out of five of the orthopedic surgeons whose opinions are available are considered. It is the consensus of the medical professionals that the surgery proposed by Dr. B is not reasonably calculated to lead to lasting improvement in Claimant's condition but, rather, is likely to lead to a worsening in Claimant's condition. The hearing officer finds the consensus opinion of the URA doctors, the IRO doctor and Dr. C to be persuasive. The preponderance of the evidence based medicine is not contrary to the IRO decision in this matter and it will be upheld.

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), Employer provided workers' compensation insurance with Old Republic Insurance Company, Carrier.

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

   E. The Division appointed Applied Assessments LLC as the Independent Review Organization in this matter.

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. Laminectomy and foraminectomy and foraminotomy at L5-S1 to treat post surgical scar tissue at L5-S1 after microdiscectomy and laminectomy is not health care clinically appropriate and considered effective for the injured employee's injury and is not health care provided in accordance with best practices consistent with evidence based medicine and generally accepted standards of medical practice recognized in the medical community.

CONCLUSIONS OF LAW

The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case. Venue is proper in the (City) Field Office. The preponderance of the medical evidence is not contrary to the IRO's determination that laminectomy, foraminectomy and foraminotomy at L5-S1 with a 23 hour outpatient hospital stay is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to laminectomy, foraminectomy and foraminotomy at L5-S1 with a 23 hour outpatient hospital 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 §408.021.

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

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TX 78701-3232

Signed this 1st day of August, 2013,

KENNETH A. HUCHTON
Hearing Officer