MEDICAL CONTESTED CASE HEARING NO. 15032

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. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence is not contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to an anterior cervical discectomy fusion with instrumentation at C6-C7 for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

On March 9, 2015, Virginia Rodriguez-Gomez, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to an anterior cervical discectomy fusion with instrumentation at C6-C7 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was represented by LD, attorney.
Respondent/Carrier appeared and was represented by BJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant and Dr. MA.

For Carrier: Dr. TS.

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits: HO-1 (set notice) and HO-2.

Claimant's Exhibits C-1 through C-16.

Carrier's Exhibits CR-A through CR-K.

DISCUSSION

Claimant sustained a compensable injury to the cervical spine. Claimant now requests authorization for an anterior cervical discectomy fusion with instrumentation at the C6-C7 level

of the cervical spine. Upon the initial utilization review and again upon reconsideration, the requested procedure was denied by the Carrier's utilization review agent. The basis for the denial was that Claimant failed to show that there was an abnormal imaging study which showed positive findings that correlated with nerve root involvement found with previous objective physical and/or diagnostic findings. This criterion, along with other criteria, is set out in the Official Disability Guidelines (ODG). An independent review organization (IRO) also denied this request citing similar reasoning.

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 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 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. 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 nor the Division are (sic) 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."

Regarding discectomy/laminectomy, the neck and upper back chapter of the ODG states as follows:

> Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following:
> (1) Progression of myelopathy or focal motor deficit;
> (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or
> (3) Presence of spinal instability when performed in conjunction with stabilization.
> (See Fusion, anterior cervical.) Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. In addition, although surgery for spondylosis and radiculopathy may offer some short term benefit, non-operative treatment with PT can provide similar improvement in pain and function at 12-16 months for patients without progressive neurologic deficits or instability. (Persson, 1997) The American Academy of Orthopaedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniations with predominate arm pain and for caudal lesions in large, short-necked individuals. (Albert, 1999) The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. (Jacobs-*Cochrane*, 2004) (Dowd, 1999) (Colorado, 2001) In terms of posterior procedures, there does not appear to be sufficient evidence to support the use of laminoplasty versus laminectomy based on outcomes or post-operative morbidity. Research has indicated that as many as 60% of patients who received laminoplasty had posterior neck and shoulder girdle pain post-operatively (versus 25% in the laminectomy group). (Hosono, 1996) (Heller, 2001) Some authors continue to prefer laminoplasty to anterior spinal decompression and fusion (for myelopathy due to disc herniation) as they feel the risk of chronic neck pain is less troublesome than the risk of bone graft complications and/or adjacent spondylosis that can be found with the fusion procedure. (Sakaura, 2005) It is not clear from the evidence that long-term outcomes are improved with the surgical treatment of cervical radiculopathy compared with nonoperative measures. However, relatively rapid and substantial relief of pain and impairment in the short term (6-12 weeks after surgery) after surgical treatment appears to have been reliably achieved. (Haldeman, 2008) *Late deterioration:* Has been found with both anterior and posterior approaches. (Rao, 2006) With the anterior approach, recurrent symptoms have been found secondary to deterioration of the adjacent segment, inadequate decompression at the time of the initial surgery, pseudoarthrosis, graft or implant failure, and/or

continued growth of osteophytes. With the posterior approach, recurrent symptoms have been found secondary to development of kyphosis, instability, spread of ossification of the posterior longitudinal ligament, and development of stenosis at new levels. In a study based on 932,009 hospital discharges associated with cervical spine surgery, anterior fusions were shown to have a much lower rate of complications compared to posterior fusions, with the overall percent of cases with complications being 2.40% for anterior decompression, 3.44% for anterior fusion, and 10.49% for posterior fusion. (Wang, 2007)

Pre-operative evaluation:

MRI: This is a very sensitive test for radicular disorders but has a lower negative predictive value. Disc bulges have been found in one study in 52% of subjects and protrusions in 27% without back pain. At age 60 years, 93% of subjects in one study had disc degeneration/bulges on MRI. (Boden, 1990)

EMG: Optional for cervical surgery. See Electromyography.

Surgery versus nonoperative care: Cervical radiculopathy will likely improve with surgery or nonoperative care, but surgery can lead to a greater degree of improvement faster, at the cost of increased risks and the recovery period. Patients with cervical radiculopathy, related to disc herniation or spinal stenosis, improved with or without neck surgery, according to this RCT. The patients who underwent surgery recovered more rapidly and had a modest advantage at 12 months in the percent who rated their condition as better/much better, 87% in the surgical group compared with 62% in the nonsurgical group. The surgical group also had an advantage in neck pain scores at 12 months, but the differences declined by the two-year follow-up. According to the authors, structured physical therapy should be tried before surgery is chosen. (Engquist, 2013)

ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. (Washington, 2004) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

A. There must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
B. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. *Note:* Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are

unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see EMG.

C. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.
D. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.
E. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.

The ODG sets out its criteria A through E for undertaking cervical discectomies and laminectomies. The IRO decision noted that Claimant failed to meet criterion C in setting out its reasoning for its denial of the requested procedure. Claimant presented the medical opinion of his surgeon, Dr. MA, in support of his contention that the requested procedure should be approved. However, when asked whether Claimant's MRI of the cervical spine revealed an abnormal imaging study which showed positive findings that correlated with nerve root involvement, he stated it did not. Dr. A added that he was requesting approval of the procedure only because he did not know what other surgical intervention to offer Claimant to afford him relief of his pain. In fact, the evidence reflected that Claimant's cervical spine MRI findings revealed no involvement of the exiting right or left nerve roots at C6-C7. Claimant has failed to show that he met the patient selection criteria listed in the ODG as noted by the IRO in its report. Claimant did not present the written or oral opinion of a medical doctor which would state why the ODG should not apply in this case or present other evidence-based medical evidence to overcome the IRO's decision. Thus, the preponderance of the evidence is not contrary to the IRO's decision that the Claimant is not entitled to the requested procedure.

The Hearing Officer 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 and sustained a compensable injury.

   C. On (Date of Injury), Employer provided workers' compensation insurance with Texas Mutual Insurance Company, Carrier.

2. Carrier delivered to Claimant and Provider 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. Claimant has failed to show that he meets the patient selection criteria listed in the ODG for the requested procedure.

4. Claimant did not present an opinion from a medical doctor, which stated why the ODG should not apply in this case or present other evidence-based medical evidence to overcome the IRO's decision that Claimant is not entitled to the requested procedure.

5. An anterior cervical discectomy fusion with instrumentation at C6-C7is 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 an anterior cervical discectomy fusion with instrumentation at C6-C7 is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to an anterior cervical discectomy fusion with instrumentation at C6-C7 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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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

Signed this 13th day of March, 2015.

Virginia Rodriguez-Gomez
Hearing Officer