MEDICAL CONTESTED CASE HEARING NO. 08080

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 contested case hearing was held on May 29, 2008, to decide the following disputed issues:

1. Is destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral nerve healthcare reasonably required in accordance with Texas Labor Code Section 408.021?

2. Are the prescriptions for Oxycontin 40 mg. 1 PO QID quantity of 90 day supply, Oxy IR 5 mg. 1-2 PO up to a maximum of QID as needed for breakthrough pain quantity of 90 day supply, Medrol Dosepak quantity of 2 packs, Neurontin 300 mg. 1 PO BID quantity of 90 day supply, Mobic 15 mg. on PO BID quantity of 90 day supply, Effexor 150 mg. PO one BID quantity of 90 day supply, and Rozarem 8 mg. PO qHS quantity of 90 day supply healthcare reasonably required in accordance with Texas Labor Code 408.021?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by BO, Ombudsman.

Respondent/Carrier appeared and was represented by RJ, Attorney.

Also present were KJ and MV.

BACKGROUND INFORMATION

Claimant worked as a school teacher and was injured on _____. She stepped in a hole or low spot in the lawn and tripped. Claimant developed pain in her low back and hip following the tripping incident. Claimant had a prior low back injury, but had recovered sufficiently to return to work.

Claimant has been under the care of Dr. D from 2000 through the present. He has provided a diagnosis of:

> **"ASSESSMENT/DIAGNOSIS:**
> **LUMBAR SPONDYLOSIS W/MYELOPATHY** (721.42), Chronic
> **SACROILIITIS NEC** (720.2), Chronic.
> Adhesive Capsulitis/Arthropathy: Bilateral, lumbar, facet arthropathy, joint arthropathy
> Degenerative Disc Disease: Lumbar

Facet Syndrome: Lumbar, spondylosis w/myleopathy
Musculoskeletal: Osteoarthritis, sacroilitis bilateral
Spinal Nerve Root: Bilateral, lumbar, sacral, multiple, neuritis, neuropathy"

The medical records introduced at this hearing show that Claimant had 32 interventional pain procedures from 2000 through 2007. In addition, Claimant's treatment has included what Dr. D refers to as rational polypharmacy.

Claimant had 3 pain intervention procedures in 2007. These were lumbar facet joint nerve rhizotomies at L4, L5 and S1. Claimant testified that these procedures were typical of the treatment she has received in the past and is the same treatment that has been denied by the Carrier resulting in the present medical dispute.

The medical records show that Claimant had a lumbar facet joint rhizotomy at L4, L5 and S1 on February 6, 2007. A March 30, 2007 medical report states that the patient reports dramatic improvement. The patient reports 90% improvement continuous. Pain level prior to procedure is 6/10 and post procedure is 3/10. The same medical record notes that on March 30, 2007 her pain level was 6/10.

On June 14, 2007, Claimant had a lumbar facet joint rhizotomy at L4, L5 and S1 on the left side. On June 20, 2007, Claimant had the same procedure on the right side. A follow-up exam on July 6, 2007 states that the patient reports dramatic improvement. The patient reports 75% improvement continuous. Pain level prior to procedure 6/10 and post procedure 3/10. The pain level on July 6, 2007 was listed as 4/10. A follow-up exam on July 20, 2007 noted the pain level to be 6/10, the same level as prior to the latest procedure.

On October 29, 2007, Claimant had lumbar facet joint nerve rhizotomies at L4, L5 and S1 on the left side. On the following day, Claimant had the same procedure on the right side. On November 15, 2007, a follow-up exam stated that the patient reports dramatic improvement. The patient reports 80% improvement continuous. Pain level prior to procedure 6/10 and post procedure 3/10. Claimant was noted to be in moderate distress on November 15, 2007 with a pain level of 5/10.

In February 2008, Dr. D requested Carrier approval for lumbar facet joint rhizotomies at L4, L5 and S1. This is the same procedure that had been approved and performed 3 times in 2007. In addition, Dr. D requested approval for prescription medication under a 90-day treatment plan. This was a similar drug treatment plan to what Claimant has been taking for the past several years. The specific drugs are listed in the second issue statement.

The Carrier denied approval for both, the lumbar rhizotomy and the drug treatment request. Claimant requested review by an Independent Review Organization (IRO).

On April 6, 2008, the IRO decision upheld the Carrier's denial of the lumbar rhizotomy. The IRO decision is based, in part, on an incorrect, but understandable, reading of Dr. D's progress notes. Dr. D has computer-generated notes that start with a category listed as history of present illness. It reports the lowest pain level to be 6/10 and the highest pain level to be 9/10. It notes the patient has pain all the time. These statements are the same on every report of Dr. D in 2007 and 2008. Dr. D explains in an April 29, 2008 response that the statement relied on by the IRO doctor concerns Claimant's overall evaluation and is not a post procedure evaluation. He

notes that the post procedure evaluation is stated later in the report. However, even if Dr. D's explanation of his medical records is accepted, the provision he quotes as reporting the post procedure evaluation is confusing and fails on its face to comply with the requirements set out in the ODG or any other evidence-based medicine guidelines. In the progress notes under "Last ACPSC Treatment:" there is a statement that Claimant received either 90%, 80% or 75% improvement. This is followed by a statement that the pain level prior to procedure 6/10 and post procedure 3/10. This appears to equate to a 50% pain relief which conflicts with the percentage reported in the same paragraph. There was no explanation offered by Dr. D in regard to this conflict. In addition, each progress report states the pain level as of that date. This pain level does not match up with the narrative percentage report. For example, Claimant has a rhizotomy treatment on October 30, 2007. She returned for follow exam on November 15, 2007. That report states that Claimant had 80% improvement continuously. It also reports pain level prior to procedure 6/10 and post procedure 3/10. It further notes that pain level on November 15, 2007 to be 5/10.

The ODG discusses the use of lumbar rhizotomies under the heading of facet joint radiofrequency neurotomy. It lists 6 criteria for the use of facet joint radiofrequency neurotomy:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above.
(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at $\geq$50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.
(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
(4) No more than two joint levels are to be performed at one time.
(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

Dr. D has failed to provide documentation as to how the Claimant meets the above criteria set out in the ODG. A conclusionary statement that the Claimant meets the ODG requirements is not sufficient.

Dr. D presented separate guidelines for the management of chronic spinal pain. He has a right to do this. The ODG criteria are not the only procedures to justify medical treatment under the Texas Workers' Compensation Act. The requirement is that the treatment must be based on

the use of current best qualified scientific and medical evidence formulated from credible scientific studies. The specific guidelines provided are titled "Interventional Techniques: Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain." These guidelines are published by the American Society of International Pain Physicians. These guidelines are dated January 2007 and several of the authors are the same authors and scientific studies relied on by the ODG. There is no question that these guidelines are based on scientific studies and meet the evidence-based standards required by the Texas Workers' Compensation Act.

Paragraph 8.2 of the Pain Physician Guideline sets out the criteria for repeat lumbar rhizotomies that are in question in this case. It states:

- The suggested frequency would be 3 months or longer (maximum of 3 times per year) between each procedure, provided that greater than 50% relief is obtained for 10 to 12 weeks.
- The therapeutic frequency for medical branch neurotomy should remain at intervals of at least 3 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.

Dr. D provided no explanation as to how Claimant may have complied with the above procedures. As already discussed, Claimant's medical records are confusing and conflicting. In a May 28, 2008 letter, Dr. D provided a 105-page copy of the Chronic Spinal Pain Guidelines with the only explanation being that Claimant has been treated by the most compassionate and advance care possible for her chronic pain condition based by the standard care in pain medicine across the United States. This conclusionary statement may be true, but the medical records fail to document compliance with these guidelines.

Another unusual feature of this case is that the Claimant testified very credibly at the hearing that she, indeed, received greater than 50% pain relief from the rhizotomies over a 12-week period following the procedure. She testified that she has had lumbar rhizotomies about 4 months apart for several years. The pain relief begins to wear off after 3 to 4 months. She explained that the nerve endings heal and the pain returns. Claimant stated with her lumbar rhizotomies her need for pain medication was reduced and she had improvement in her daily activities. She was able to function as a housewife, performing household chores. More importantly, she was able to return to work full-time as a school teacher, which is the ultimate goal of the workers' compensation act. None of this improved function information is documented in the medical records. This information provided in her testimony was not provided to the Carrier in the pre-certification process. It was not available to the IRO doctor for his decision. This information surfaced for the first time at the Medical Contested Case Hearing (MCCH). However, Claimant's credible testimony cannot cure the documentation problems set out in this case. To do so would subvert the entire medical review process. One of the basic functions of the treating doctor is to fully and accurately document Claimant's medical condition and treatment. This information should be provided to the Carrier on an ongoing basis. When a medical pre-certification request is made to the Carrier, information concerning compliance with the ODG or other evidence-based guidelines needs to provide it. At each step of the review process, the treating doctor needs to show compliance with the treatment guidelines. In Dr. D's

request for lumbar facet joint nerve rhizotomies in this case, he fails to mention any treatment guidelines, much less compliance with such guidelines. For example, in his request dated February 25, 2008 (CR EX F), he provides a grossly inaccurate medical history stating that Claimant had 75 - 80% pain relief for 8 months. It completely left out the rhizotomy treatment 3 months earlier.

The basic requirement is for the requesting doctor to document compliance with some evidence-based medicine guidelines. The requesting doctor's opinion that a medical procedure is reasonable and necessary or that it was approved in the past does not meet the above standard.

I find that Claimant's doctor has failed to show compliance with either the ODG, or in the alternative, the Pain Physician's Guidelines. Therefore, the destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral nerve is not healthcare reasonably required in accordance with Texas Labor Code Section 408.021.

In regard to the second issue, Dr. D has requested 7 prescription drugs. The requested prescription drugs are not listed in the medical records. Most of the medical records contain a statement that Claimant was instructed to take medication as prescribed. In a response letter to the Carrier dated April 3, 2008, Dr. D states that the medications listed are needed to control Claimant's pain. There was no mention of the ODG or any other evidence-based medicine guidelines.

The Carrier denied Dr. D's request for prescription drugs and that decision was reviewed by an IRO on April 29, 2008. The Carrier's denial was upheld. In a May 14, 2008 letter by Dr. D, he states that it is his professional medical opinion that Claimant meets the ODG guidelines. In addition, by letter dated May 28, 2008, Dr. D provided alternate guidelines to support his request for the 7 prescription drugs. This is a 7-page document entitled "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain." These guidelines were adopted by the House of Delegates of the Federation of State Medical Boards of the United State, Inc. These model guidelines may very well meet the standard of evidence-based medicine. However, there is nothing showing that the Claimant has complied with the requirement set out in the guidelines. Evidence that the requested prescription drugs were authorized under the ODG or the alternative model guidelines was not provided. Claimant has failed to establish that the prescription drugs are healthcare reasonably required in accordance with the Texas Workers' Compensation Act.

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 _____, Claimant was the Employee of (Employer).

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. In February 2008, Dr. D requested approval for destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral nerve (lumbar rhizotomy).

4. On April 6, 2008, the IRO decision upheld Carrier's denial of the requested medical procedure (Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar and sacral nerve).

5. The preponderance of the medical evidence is not contrary to the IRO decision that the medical procedure requested (Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar and sacral nerve) is not healthcare reasonably required.

6. In February 2008, Dr. D requested approval for 7 prescription drugs to control pain for the Claimant.

7. On April 29, 2008, the IRO decision upheld Carrier's denial of the requested 7 prescription drugs.

8. The preponderance of the medical evidence is not contrary to the IRO decision that the requested 7 prescription drugs are not healthcare reasonably required.

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. Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral nerve is not healthcare reasonably required in accordance with Texas Labor Code Section 408.021.

4. The prescriptions for Oxycontin 40 mg. 1 PO QID quantity of 90 day supply, Oxy IR 5 mg. 1-2 PO up to a maximum of QID as needed for breakthrough pain quantity of 90 day supply, Medrol Dosepak quantity of 2 packs, Neurontin 300 mg. 1 PO BID quantity of 90 day supply, Mobic 15 mg. on PO BID quantity of 90 day supply, Effexor 150 mg. PO one BID quantity of 90 day supply, and Rozarem 8 mg. PO qHS quantity of 90 day supply are not healthcare reasonably required in accordance with Texas Labor Code Section 408.021.

DECISION

Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral nerve is not healthcare reasonably required in accordance with Texas Labor Code Section 408.021. The prescriptions for Oxycontin 40 mg. 1 PO QID quantity of 90 day supply, Oxy IR 5 mg. 1-2 PO up to a maximum of QID as needed for breakthrough pain quantity of 90 day supply, Medrol

Dosepak quantity of 2 packs, Neurontin 300 mg. 1 PO BID quantity of 90 day supply, Mobic 15 mg. on PO BID quantity of 90 day supply, Effexor 150 mg. PO one BID quantity of 90 day supply, and Rozarem 8 mg. PO qHS quantity of 90 day supply are not healthcare reasonably required in accordance with Texas Labor Code Section 408.021.

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 **LIBERTY INSURANCE CORPORATION**, and the name and address of its registered agent for service of process is:

CT CORPORATION SYSTEMS
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201

Signed this 25th day of June, 2008.

Donald E. Woods
Hearing Officer