

**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 28, 2009 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to bilateral L3-S1 radiofrequency thermocoagulation for the compensable injury of \_\_\_\_\_?

**PARTIES PRESENT**

Petitioner/Claimant appeared and was assisted by JT, ombudsman.  
Respondent/Carrier was represented by SB, attorney.

**BACKGROUND INFORMATION**

Claimant was injured during the course and scope of employment on \_\_\_\_\_ when she stepped down from a stool and fell to the floor. Doctors have treated Claimant's lower back, right shoulder, right knee, and right ankle.

Claimant testified that Drs. S and P have given her three previous treatments of radiofrequency thermocoagulation, also known as facet joint radiofrequency neurotomy. She said that the treatments helped her.

The IRO issued a decision on April 24, 2009 upholding a denial for the requested radiofrequency thermocoagulation. The IRO based its decision on failure to comply with the **Official Disability Guidelines** (ODG). The IRO noted that it had not been provided documentation that Claimant had at least 12 weeks of relief rated at greater than or equal to 50% improvement in VAS or that Claimant had an adequate prior diagnostic block performed. The IRO also noted that even though the ODG recommends that no more than 2 levels for radiofrequency thermocoagulation, Claimant's doctor requested that the procedure be performed on 3 levels.

Texas Labor Code §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. §401.011(22-a) defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." "Evidence based medicine" is further defined, by §401.011 (18-a) as the use of the current best qualify 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.

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*.

The ODG provides the following for facet joint radiofrequency neurotomy:

Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.

*Current research:* Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (van Kleef, 1999) (Boswell, 2005) (Leclaire, 2001) (Van Kleef, 1999) (Gallagher, 1994) (van Wijk, 2005) A recent small RCT found that the percutaneous radiofrequency neurotomy treatment group showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacro-iliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment, and it provided relief for only one component of the patients' pain. (Nath, 2008) *Observational Trials:* One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007)

*Systematic reviews:* When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported “sparse evidence” to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiskal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)

*Technique:* There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to

the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.

*Factors associated with failed treatment:* These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery.

*Factors associated with success:* Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)

*Duration of pain relief:* One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)

*Complications:* Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti, 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

#### **Criteria for use of facet joint radiofrequency neurotomy:**

- (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).
- (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.

Claimant failed to present evidence-based medical evidence to overcome the decision of the IRO.

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, who was the employee of (Employer), sustained a compensable injury.
  - C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of \_\_\_\_\_.
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. Bilateral L3-S1 radiofrequency thermocoagulation is not health care reasonably required for the \_\_\_\_\_ compensable 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 bilateral L3-S1 radiofrequency thermocoagulation is not health care reasonably required for the compensable injury of \_\_\_\_\_.

## **DECISION**

Claimant is not entitled to bilateral L3-S1 radiofrequency thermocoagulation for the compensable injury of \_\_\_\_\_.

## **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 **ASSURANCE COMPANY OF AMERICA** and the name and address of its registered agent for service of process is

**LEO F. MALO**  
**12222 MERIT DRIVE SUITE 700**  
**DALLAS, TEXAS 75251**

Signed this 29th day of July 2009.

CAROLYN F. MOORE  
Hearing Officer