MEDICAL CONTESTED CASE HEARING NO. 10051
M6-09-21103-01

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 September 22, 2009, 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 bilateral facet joint injections at L4-5 and L5-S1 or facet rhizotomy at L5-S1 for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by TM, ombudsman.
Respondent/Carrier appeared and was represented by TW, attorney.

BACKGROUND INFORMATION

Claimant is a firefighter for the (Self-Insured) and sustained multiple injuries while fighting a fire on _____, when a balcony collapsed, causing him to fall more than 30 feet to the ground. Among his injuries is a low back injury. His doctor, Dr. D, MD, diagnosed his low back problems as facet mediated pain and provided facet injections on February 18, 2008, to treat that condition. Claimant received "profound" relief from the injections until September 28, 2008, when his low back pain was reported to flare. In early December of 2008, Dr. D recommended that Claimant have a facet rhizotomy and referred him to Dr. R.

The request for preauthorization of a facet rhizotomy was denied and the denial was ultimately upheld by an IRO in late March of 2009. After the denial of the facet rhizotomy, Dr. D recommended another facet injection. The request for an injection was also denied. In a letter dated April 27, 2009, Dr. D stated that his recommendations for care had "come full circle" since the facet rhizotomy had been denied because there had been no follow up facet injections and that the request for facet injections had been denied because a facet rhizotomy was recommended rather than repeat injections. Frustrated, Dr. D wrote:

> [H]aving first referred the patient to Dr. R, a superb interventional pain specialist on December 8, 2008, for facet rhizotomy, we have now moved through a multitude of sets of pre-certification request, (sic) and the obtainment of unnecessary diagnostic studies, to only be told that facet joint injections are being denied as there is a plan to move forward with facet joint rhizotomy anyway, the exact procedure, (sic) which was denied in the first place as requested by Dr. R.

Dr. D also said that he had discussed the case and the "disturbing delay in appropriate treatment" with CG, the nurse case manager assigned to Claimant. After discussing the case with Dr. D, Ms. CG reportedly suggested that he make a single preauthorization request for either facet injections or a facet rhizotomy and then discuss the matter with the peer review doctor to see which would be approved.

The first utilization review doctor recommended that neither procedure be authorized, citing provisions of the Official Disability Guidelines (ODG) that say that only one set of facet joint injections should be done and noting that Claimant had already had bilateral facet joint injections at L5 that had brought temporary relief. The utilization review agent found that there was no clear documentation of a sufficient response to the facet joint injections to warrant a facet rhizotomy.

The second utilization review doctor also recommended that the request for facet injections and facet rhizotomy be denied because there was no documentation of evidence based guidelines to support more than one set of facet injections and the documentation provided to him failed to show sufficient pain relief from the facet injections to warrant a rhizotomy.

After the request was reconsidered and denied, Claimant appealed Carrier's denial to an IRO. The Texas Department of Insurance appointed (Independent Review Organization) as the IRO. The IRO referred the appeal to an MD board certified in physical medicine and rehabilitation with a subspecialty certification in pain management. The IRO physician reviewer stated that Claimant had requested a series of repeat facet injections at "[t]wo bilateral (or 4) levels". He noted that the ODG "does not allow a series of repeat facet injections." He also stated that radiofrequency neurotomy (another name for facet rhizotomy) is not an established procedure in the ODG and that, when approved, the ODG requires that the diagnostic facet injection provide at least 12 weeks of a 50% reduction in pain. The IRO physician reviewer stated that, although Dr. D had documented the existence of pain relief, "[n]o specific duration of the pain relief was provided."

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 (Texas Labor Code §408.021). "Health care reasonably required" is defined 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, generally accepted standards of medical practice recognized in the medical community (Texas Labor Code §401.011(22-a)). "Evidence based medicine" means 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 (Texas Labor Code §401.011 (18-a)). In accordance with the above statutory guidance, Rule 137.100 directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be reasonably required.

The ODG provides the following information regarding facet joint injections other than an initial set of diagnostic injections:

> Facet joint injections, multiple series
>
> Not recommended.

Diagnostic blocks: One set of medial branch blocks is recommended prior to a neurotomy. Intra-articular blocks are not recommended as the diagnostic procedure. Confirmatory blocks, while recommended for research studies, do not appear to be cost effective or to prevent the incidence of a false positive response to the neurotomy procedure itself. See Facet joint diagnostic blocks (injections).
Therapeutic injections: With respect to facet joint intra-articular therapeutic injections, no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). See Facet joint intra-articular injections (therapeutic blocks). There is no peer-reviewed literature to support a "series" of therapeutic fact blocks.

and, in part:

Facet joint intra-articular injections (therapeutic blocks)

Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid (combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006)

Dr. D testified on behalf of Claimant. He agreed that the ODG does not provide for more than one set of facet joint injections, but testified that if another set of facet injections was the only thing that Carrier would approve, it would be better for Claimant than simply continued use of narcotic medication for pain relief.

With regard to facet rhizotomy, the ODG provides:

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) (Niemesto-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 ≥ 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.

and, in part:

<u>Facet joint diagnostic blocks (injections)</u>

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to

provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy.

In a Contested Case Hearing, 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. (Rule 133.308(t)). Dr. D testified that Claimant experienced significant relief from the facet injection in February of 2008 and, based upon the results of that injection including the extent and duration of the relief provided, he believes that Claimant meets the provisions of the ODG for a facet rhizotomy. Dr. D's opinion that the successful facet joint injection in February of 2008 should be followed up with a facet rhizotomy at L5-S1 is consistent with the foregoing sections of the ODG. Carrier offered no medical opinions other than those of the URA doctors and the IRO doctor as set forth above.

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 (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; and (7) 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). Dr. D has been treating Claimant and has first hand knowledge of the effects of the initial facet joint injection. He observed the degree of relief afforded by the February 2008 facet injection and the duration of that relief. His opinion that Claimant should undergo a facet rhizotomy is based upon his observations, his medical judgment, and the provisions of the ODG.

In light of the medical substantiation of Dr. D's opinion, the provisions of the ODG that support his opinion, and his rebuttal of the bases for denial by the URA doctors and the IRO doctor, the hearing officer finds that the preponderance of the evidence based medicine is contrary to the decision of the IRO and that a facet rhizotomy at L5-S1 is health care reasonably required for the treatment of the _____, compensable injury.

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 the (Self-Insured), Employer, a self-insured.

C. Claimant sustained a compensable injury on _____.

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. Claimant had a diagnostic facet joint injection on February 18, 2008.

4. Claimant experienced profound relief from the diagnostic facet joint injection of February 18, 2008.

5. Claimant continued to experience significant relief from his pain after the February 18, 2008, facet joint injection until late September of 2008.

6. Claimant meets the standards set forth in the ODG for facet rhizotomy at L5-S1 because the facet joint injection at L5-S1 provided profound relief for more than 12 weeks.

7. Bilateral facet joint injections at L4-5 and L5-S1 is not health care reasonably required for the compensable injury of _____.

8. Facet rhizotomy at L5-S1 is health care reasonably required for the compensable injury of _____.

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 facet joint injections at L4-5 and L5-S1 is not health care reasonably required for the compensable injury of _____.

4. The preponderance of the evidence is contrary to the decision of the IRO that facet rhizotomy at L5-S1 is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to bilateral facet joint injections at L4-5 for the compensable injury of _____. Claimant is entitled to facet rhizotomy at L5-S1 for the compensable injury of _____.

ORDER

Carrier is liable for 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 **(SELF-INSURED)** and the name and address of its registered agent for service of process is

HG, MAYOR
(STREET ADDRESS, FLOOR)
(CITY), TEXAS (ZIP CODE)

Signed this 23rd day of September, 2009

KENNETH A. HUCHTON
Hearing Officer