MEDICAL CONTESTED CASE HEARING NO. 10166
M6-10-24539-01

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 April 22, 2010 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that Claimant is not entitled to radiofrequency thermocoagulation of the right stellate ganglion for the compensable injury of _____?

PARTIES PRESENT

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

BACKGROUND INFORMATION

Claimant's shoulder injury of _____ resulted in a superior labral tear from anterior to posterior. He had surgery in March of 2004 followed by physical therapy and work hardening. He returned to work in July 2004 with pain. By September of 2004, a magnetic resonance imaging showed he still had the tear. When he underwent a second surgery in March of 2005, he was diagnosed with chondromalacia of the shoulder. He had additional physical therapy but continued to have pain in the shoulder. Claimant had radiofrequency thermocoagulation (RFTC) of the right stellate ganglion six times from 2007 through 2009. Dr. O has recommended that Claimant undergo an additional RFTC to the right stellate ganglion.

Two utilization reviewers denied Dr. O's request for RFTC. They referred to the Official Disability Guidelines (ODG) on stellate ganglion blocks and regional sympathetic blocks. They wrote that there was no indication that the RFTC would be provided in conjunction with active rehabilitation and that there was not sufficient objective evidence of Claimant's functional gains from the past RFTC procedures to justify another one.

The Independent Review Organization reviewer, a doctor of osteopathy who is board certified in anesthesiology upheld the decision of the utilization reviewers. The reviewer's explanation was as follows: the ODG does not support RFTC procedures on the stellate ganglion; there is contradictory documentation of Claimant's relief from previous RFTC procedures; there is a lack of consistent evidence that Claimant obtained significant long-term relief from previous RFTC procedures; there is a lack of objective documentation showing that Claimant had significant functional restoration from any of the RFTC procedures or reduced the use of opiates following the previous RFTC procedures; Claimant's physical examinations did not change from September to December of 2009; and there is a lack of documentation that Claimant received

treatment for chondromalacia of the right shoulder. In addition, the reviewer questioned Claimant's diagnosis of reflex sympathetic dystrophy/complex regional pain syndrome.

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. 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 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are 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."

The ODG provides the following for Stellate Ganglion Block:

> Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks.

The ODG provides the following for CRPS, sympathetic and epidural blocks:

> Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis

of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) *Predictors of poor response:* Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) *Alternatives to regional sympathetic blocks*: may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. *Mixed conduction blocks (central neural blocks*): suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above. *Clonidine* has also been effective epidurally. (Stanton-Hicks, 2006) *Baclofen* has been demonstrated to be effective intrathecally to reduce dystonia. (van Hilten, 2000) *IV regional sympathetic blocks*: controversial due to varying success. Guanethadine was used, but is no longer available in the US. Bretylium and reserpine require daily blocks, and have potential side effects of transient syncope with apnea, orthostatic hypotension, pain with administration, nausea and vomiting. Bretylium provided more than 30% pain relief for a mean of 20 days compared to placebo. (Hord, 1992) Due to modest benefits and the invasiveness of the therapies, epidural clonidine injection and intravenous regional sympathetic block with bretylium should be offered only after careful counseling, and they should be followed by intensive physical therapy. Intravenous regional sympathetic block (Bier's block) with guanethidine and lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in patients suffering from CRPS-I of the hand. (Paraskevas, 2005) Local or systemic parecoxib combined with lidocaine/clonidine IV regional analgesia is an effective treatment for CRPS-I in a dominant upper limb. (Frade, 2005) See also Sympathetically maintained pain (SMP); & Regional sympathetic blocks.

Recommendations (based on consensus guidelines) for use of sympathetic blocks: (1)In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended. (2) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual. (3) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction and increased tolerance of activity and touch (decreased allodynia) in physical

therapy/occupational therapy. (4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase. (5) In acute exacerbations, 1 to 3 blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature). (6) Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain. (Burton, 2006) (Stanton-Hicks, 2004) (Stanton-Hicks, 2006) (International Research Foundation for RSD/CRPS, 2003) (Colorado, 2006) (Washington, 2002) (Rho, 2002)

The ODG provides the following for Regional Sympathetic Blocks (stellate ganglion block, thoracic sympathetic block, and lumbar sympathetic block:

Recommendations are generally limited to diagnosis and therapy for CRPS. See CRPS, sympathetic and epidural blocks for specific recommendations for treatment. Also see CRPS, diagnostic criteria; CRPS, medications; & CRPS.
Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies. The one prospective double-blind study (of CRPS) was limited to 4 subjects. *Anatomy:* Sympathetic flow to the head, neck and most of the upper extremities is derived from the upper five to seven thoracic spinal segments. The stellate ganglion is formed by a fusion of the inferior and first thoracic sympathetic ganglia in 80% of patients. In the other 20%, the first thoracic ganglion is labeled the stellate ganglion. The upper extremity may also be innervated by branches for Kuntz's nerves, which may explain inadequate relief of sympathetic related pain. *Proposed Indications:* This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Pain: CRPS; Herpes Zoster and post-herpetic neuralgia; Frostbite. Circulatory insufficiency: Traumatic/embolic occlusion; Post-reimplantation; Post-embolic vasospasm; Raynaud's disease; Vasculitis; Scleroderma. *Testing for an adequate block:* Adequacy of a sympathetic block should be recorded. A Horner's sign (ipsilateral ptosis, miosis, anhydrosis conjunctival engorgement, and warmth of the face) indicates a sympathetic block of the head and face. It does not indicate a sympathetic block of the upper extremity. The latter can be measured by surface temperature difference (an increase in temperature on the side of the block). Somatic block of the arm should also be ruled out (the incidence of brachial plexus nerve block is ~ 10%). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. Documentation of motor and/or sensory block should occur. *Complications:* Incidental recurrent laryngeal nerve block or superior laryngeal nerve block, resulting in hoarseness and subjective shortness of breathe; Brachial plexus block; Intravascular injection; Intrathecal, subdural or epidural injection; Puncture of the pleura with pneumothorax; Bleeding and hematoma. There appears to be a positive correlation between efficacy and how soon therapy is initiated (as studied in patients with CRPS of the hand). Duration of symptoms greater than 16 weeks before the initial SGB and/or a decrease in skin perfusion of 22% between the normal and affected hands

adversely affected the efficacy of SGB therapy. (Ackerman, 2006) (Sayson, 2004) (Grabow, 2005) (Colorado, 2006) (Price, 1998) (Day, 2008) (Nader, 2005) See also Stellate ganglion block.

Thoracic Sympathetic Blocks: Not recommended due to a lack of literature to support effectiveness. Utilized for sympathetic blocks of the upper extremity in the 20% of individuals with innervation of the upper extremity by Kuntz's nerves (nerves from the 2nd and 3rd thoracic sympathetic ganglia bypass the stellate ganglion and directly join the brachial plexus). *Proposed Indications:* CRPS, peripheral neuropathy, brachial plexalgia, sympathetically maintained pain and vascular disorders. (Day, 2008) *Complications:* neuraxial injection; intravascular injection; nerve injury; pnuemothorax.

Lumbar Sympathetic Blocks: There is limited evidence to support this procedure, with most studies reported being case studies. *Anatomy:* Consists of several ganglia between the L1 and L5 vertebra. *Proposed Indications:* Circulatory insufficiency of the leg: (Arteriolsclerotic disease; Claudication: Rest pain; Ischemic ulcers; Diabetic gangrene; Pain following arterial embolus). Pain: Herpes Zoster; Post-herpetic neuralgia; Frostbite; CRPS; Phantom pain. These blocks can be used diagnostically and therapeutically. *Adjunct therapy:* sympathetic therapy should be accompanied by aggressive physical therapy to optimize success. *Complications:* Back pain; Hematuria; Somatic block; Segmental nerve injury; Hypotension (secondary to vasodilation); Bleeding; Paralysis: Renal puncture/trauma. Genitofemoral neuralgia can occur with symptoms of burning dysesthesia in the anteromedial upper thigh. It is advised to not block at L4 to avoid this complication. *Adequacy of the block:* This should be determined, generally by measure of skin temperature (with an increase noted on the side of the block). Complete sympathetic blockade can be measured with the addition of tests of abolition of sweating and of the sympathogalvanic response. (Day, 2008) (Sayson, 2004) (Nader, 2005)

Claimant presented several letters from Dr. O into evidence. In the March 1, 2010 letter Dr. O wrote that he recommended another RFTC for Claimant because the RFTC had been the best procedure to help Claimant. In another letter, which was not dated, Dr. O wrote that Claimant needed the RFTC before having any surgery. He enclosed several articles to support his recommendation but did not discuss the articles. The articles included information on radiofrequency lesioning of the stellate ganglion, reflex sympathetic dystrophy, and complex regional pain syndrome. Claimant argued that since the ODG did not list RFTC as a procedure to be performed on the stellate ganglion, the articles submitted by Dr. O justified the requested procedure. Claimant's argument was not persuasive as Claimant's evidence did not address the issues presented by the IRO.

Claimant argued that the IRO was incorrect in questioning whether Claimant actually had reflex sympathetic dystrophy/complex regional pain syndrome. The argument was persuasive as there was not an issue to be resolved at this hearing concerning that diagnosis. However, Claimant did not present sufficient evidence based medical evidence to overcome the determination made by the IRO reviewer that the requested procedure was not reasonable and necessary health care for 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, who was the employee of (Employer), sustained a compensable injury.

   C. The Independent Review Organization determined that the requested service was not a reasonable and necessary health care service 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. Radiofrequency thermocoagulation of the right stellate ganglion is not 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 radiofrequency thermocoagulation of the right stellate ganglion is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to radiofrequency thermocoagulation of the right stellate ganglion 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 **NEW HAMPSHIRE 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, TEXAS 78701-3218

Signed this 30th day of April, 2010.

CAROLYN F. MOORE
Hearing Officer