MEDICAL CONTESTED CASE HEARING NO 12004
M6-11-32246-01

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 June 28, 2011 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 a cervical epidural steroid injection (ESI) at C5-6 for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

BACKGROUND INFORMATION

The Claimant sustained a compensable injury to her cervical spine on (Date of Injury) while working for (Employer). Prior to this injury, on March 8, 2008, the Claimant underwent a posterior cervical laminectomy and foraminotomy at C6-7 and C7-T1, as well as an anterior cervical fusion at C4-5. Because of the Claimant's symptoms after the (Date of Injury) injury, including neck pain radiating into both shoulders and headaches, she was referred to Dr. R, who is board certified in anesthesiology and pain management, for treatment. On November 16, 2010, Dr. R performed a cervical ESI at levels C2-3, C3-4 and C4-5 upon the Claimant, which initially provided good relief of her pain. Within two weeks, however, much of her pain had returned, such that she only had 15 to 20% relief of her pain as of November 29, 2010. Thereafter, Dr. R sought pre-authorization to perform a second cervical ESI upon the Claimant. This request was denied by two Carrier utilization review agents, and the denials were upheld by an IRO. The IRO, who is also board certified in anesthesiology in addition to having a Certificate of Added Qualifications in pain medicine according to the IRO decision, reasoned that the Claimant does not meet the Official Disability Guidelines (ODG) requirements for a second ESI because she has no clinical evidence of radiculopathy, and because in order to meet the guidelines for a second ESI, she must have had at least 50% relief of pain for six to eight weeks from the initial ESI.

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(t), "[a] decision issued by an IRO is not considered an agency decision and neither the Department nor the Division [is] considered [a party] 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."

ODG Recommendations:

> **Cervical ESI**
> Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-*Cochrane*, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of

management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) See the Low Back Chapter for more information and references.

Criteria for the use of Epidural steroid injections, therapeutic:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) for guidance
(4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.

(7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

(8) Repeat injections should be based on continued objective documented pain and function response.

(9) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.

Criteria for the use of Epidural steroid injections, diagnostic:
To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;

(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;

(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

Dr. R's testimony showed that Claimant has credible complaints of pain, but that the IRO is correct in stating that Dr. R's physical examinations of Claimant were normal and showed no clinical signs of radiculopathy. The normal physical examinations are in contrast to an EMG preformed on March 30, 2010, that had findings consistent with chronic C7 radiculopathy. Dr. R was adamant in his testimony that the ODG represents only guidelines, and that he recommended the first and second ESIs for the Claimant because she had failed conservative treatment. He testified that the use of narcotics for the Claimant's pain have provided no real relief for her. Dr. R testified that while a second ESI for the Claimant is not medically necessary, it is "medically indicated" for her condition. He testified that he is aware of studies that would support a second ESI as legitimate treatment for the Claimant's symptoms under the circumstances, but he could not name any at the time that he gave his testimony.

Dr. T testified at the request of the Carrier after having reviewed the Claimant's medical records. Dr. T testified that Claimant does not meet the criteria in the ODG for a cervical ESI because

there is no clinical evidence of radiculopathy on examination and the lack of relief from the first ESI would make a second one unwarranted.

The evidence in the record demonstrates that the Claimant does not meet the first and the seventh criteria in the ODG for the performance of a second cervical ESI. The Claimant failed to provide an evidence-based medical opinion sufficient to overcome the determination of the IRO; therefore, the preponderance of the evidence-based medical evidence is not contrary to the IRO decision that Claimant is not entitled to a cervical ESI at C5-6 for the compensable injury of (Date of Injury).

Even though all the evidence presented may not have been discussed in detail, 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 was 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.

   C. On (Date of Injury), Employer had workers' compensation insurance coverage with Texas Mutual Insurance Co., Carrier.

   D. Claimant sustained a compensable cervical injury on (Date of Injury) while in the course and scope of her employment with (Employer).

   E. The IRO upheld the Carrier's denial of the treatment sought herein in a decision dated January 28, 2011.

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 does not meet the requirements of the ODG for a cervical ESI at C5-6 and she failed to present other evidence-based medicine sufficient to overcome the determination of the IRO.

4. A cervical ESI at C5-6 was not health care reasonably required for Claimant's 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that a cervical ESI at C5-6 was not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a cervical ESI at C5-6 for her compensable injury of (Date of Injury).

ORDER

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:

RON WRIGHT, PRESIDENT
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TX 78723

Signed this 1st day of August, 2011.

Patrice Fleming-Squirewell
Hearing Officer