MEDICAL CONTESTED CASE HEARING NO 12034
M6-12-36323-01

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 October 24, 2011, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a second bilateral SI joint injection is not reasonably required health care for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Provider appeared as a witness only and was not represented. Claimant appeared and was assisted by RH, ombudsman. Respondent/Carrier appeared and was represented by MST, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable injury on (Date of Injury), when she slipped and fell while pulling chicken to be used in the course and scope of her employment with (Employer), Employer. Claimant has undergone spinal fusion at L4-5 and L5-S1. KB, MD performed a bilateral sacroiliac (SI) epidural steroid injection on January 6, 2011. On July 5, 2011, Dr. B requested preauthorization to perform a second bilateral SI.

Carrier's first Utilization Review Agent (URA), was Joseph L. Braun, MD, who determined that the request should not be preauthorized. In his report, Dr. Braun stated that the request did not meet the Official Disability Guidelines (ODG) criteria for repeat epidural steroid injections because the results of the January 6, 2011, injections had not been fully documented to show that Claimant had 70% pain relief or more for at least 6 weeks after the injections. A request for reconsideration was made and the request was submitted to a second URA, CSC, MD. Dr. C also referenced the ODG requisites for repeat epidural steroid injections and opined that Claimant did not meet the ODG criteria because there was no mention of the duration of pain relief; the visual analog scale (VAS) did not show that Claimant had a 70% reduction in pain; and the diagnostic evaluation did not show that other pain generators had been ruled out. Carrier's denial was appealed to an Independent Review Organization (IRO).

Professional Associates was appointed as the IRO and it submitted the case to a physician reviewer who is board certified in orthopedic surgery. The IRO physician reviewer upheld Carrier's denial of the request for a second bilateral SI epidural steroid injection, citing the ODG and his medical judgment, clinical experience and expertise in accordance with accepted medical standards. The physician reviewer utilized the entry on SI joint blocks in the hip and pelvis chapter of the ODG in evaluating the request. He stated that the interval of relief from the first epidural steroid injection was not clear from Dr. B records. He also stated that Claimant has a migratory pain pattern and her relief from pain cannot be attributed to the SI joint.

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 are (sic) considered parties (sic) 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 entry for sacroiliac joint injections refers the reader to intra-articular steroid hip injection; sacroiliac joint blocks; and sacroiliac joint radiofrequency neurotomy. The entry for sacroiliac joint blocks states:

> Sacroiliac joint blocks
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> Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint.
> *Innervation:* The anterior portion is thought to be innervated by the posterior rami of the L1-S2 roots and the posterior portion by the posterior rami of L4-S3.although the actual innervation remains unclear. Anterior innervation may also be supplied by the obturator nerve, superior gluteal nerve and/or lumbosacral trunk. (Vallejo, 2006) Other research supports innervation by the S1 and S2 sacral dorsal rami.
> *Etiology:* includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma.
> *Diagnosis:* Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). (Schwarzer, 1995) There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. (Yin, 2003)
> *Treatment:* There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a

clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy.
Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009) The latest AHRQ Comparative Effectiveness Report, covering Pain Management Interventions for Hip Fracture, concluded that nerve blockade was effective for relief of acute pain; however, most studies were limited to either assessing acute pain or use of additional analgesia and did not report on how nerve blockades may affect rehabilitation such as ambulation or mobility if the blockade has both sensory and motor effects. (Abou-Setta, 2011)

Criteria for the use of sacroiliac blocks:

1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above).
2. Diagnostic evaluation must first address any other possible pain generators.
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management.
4. Blocks are performed under fluoroscopy. (Hansen, 2003)
5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed.
6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period.
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.
8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.
9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these

should be limited to maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

In addition to the lack of clarity in the duration of Claimant's relief from pain, the IRO physician reviewer stated that the medical records indicated that Claimant had a migratory pain pattern and the relief of her pain could not be ascribed to the SI joint.

Dr. B testified at the hearing. He pointed out that in chart notes on January 20, 2011, Claimant had reported a 70% relief of pain, that on April 21, 2011, she had reported an 80% relief with greater function, and that it was only during the office visit of June 9, 2011, that Claimant reported recurrent back pain. Claimant confirmed that she had received relief from the SI epidural steroid injection in January, that she had significant relief from her usual low back pain until sometime in May, and that her low back pain had become increasingly debilitating since that time. Dr. B testified that he could have specifically stated in his reports that Claimant had more than six weeks of relief, but he had documented ongoing relief through April 21, 2011, after the January 6, 2011, injections and it seemed that the URA doctors and the IRO doctor were simply ignoring the evidence of more than three months of pain relief. Dr. B also testified that he had performed a number of orthopedic tests that tended to confirm Claimant's primary pain generator was her sacroiliac joint, that problems with the sacroiliac joint were not uncommon in light of the two fused levels above, and that the efficacy of the January 6, 2011, epidural steroid injections confirmed that Claimant's pain came from the sacroiliac level. Medical records offered into evidence report that a shear test, Faber test, Flamingo Test and Fortin (incorrectly transcribed as "foreign") Finger Test were all indicative of sacroiliac pain.

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. B is a board certified orthopedic surgeon and is qualified by skill and experience to provide an opinion on whether a second sacroiliac block is an effective treatment for Claimant's compensable injury. He has explained how Claimant meets the ODG criteria for additional

sacroiliac blocks and has rebutted the objections made by the URA doctors and the IRO physician reviewer. The repeat sacroiliac injection, performed in compliance with the ODG recommendations, is presumed to be reasonable. Claimant has shown by a preponderance of the evidence that a second bilateral SI joint injections is health care reasonably required for the compensable injury in this matter.

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 (Date of Injury), Claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), Employer provided workers' compensation insurance through Association Casualty Insurance Company, Carrier.

   D. Claimant sustained a compensable injury on (Date of Injury).

   E. The Texas Department of Insurance appointed Professional Associates as the Independent Review Organization (IRO) in this matter.

   F. The IRO determined that the requested for a second bilateral SI joint injection should be denied.

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 received a bilateral SI joint injection on January 6, 2011.

4. Claimant obtained at least 70% pain relief from the bilateral SI joint injection of January 6, 2011, and that relief lasted until the middle of May of 2011, a period of approximately 18 weeks.

5. Claimant's SI joint dysfunction has been shown to be a cause of Claimant's pain complaints by more than three clinical tests and the success of the January 6, 2011, bilateral SI joint injection.

6. Claimant meets the criteria set forth in the ODG for sacroiliac joint blocks.

7. A second bilateral SI joint injection is health care reasonable required to alleviate the effects of the 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that a second bilateral SI joint injection is not reasonably required medical care for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to a second bilateral SI joint injection for the compensable injury of (Date of Injury).

ORDER

Carrier is 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 **ASSOCIATION CASUALTY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

DIANE MORRIS, PRESIDENT
3420 EXECUTIVE CENTER DRIVE
SUITE 200
AUSTIN, TEXAS 78766

Signed this 26th day of October, 2011.

KENNETH A. HUCHTON
Hearing Officer