

MEDICAL CONTESTED CASE HEARING NO 12057
M6-12-36410-01

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 November 16, 2011, with the record closing on December 22, 2011, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is entitled to bilateral lumbar sympathetic blocks times three for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by LW, attorney. Respondent/Provider did not appear. Claimant did not appear.

BACKGROUND INFORMATION

Respondent and Claimant failed to appear for the contested case hearing on November 16, 2011, although the Division sent to both notice of the date, time, and place of the hearing. 10 day letters were sent to Respondent and Claimant on November 16, 2011, offering each of them an opportunity to request that the hearing be reset to permit him or her to present evidence on the disputed issue. No response was received from Respondent or Claimant.

Claimant sustained a compensable right shoulder injury on (Date of Injury). She developed symptoms throughout her whole body, which treating doctors diagnosed as CRPS/RSD. Dr. NA requested pre-authorization of bilateral lumbar sympathetic blocks times three. The IRO decision overturned the previous denials, and Carrier appealed.

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 Official Disability Guidelines (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 concerning lumbar facet joint medial branch blocks:

Not recommended except as a diagnostic tool. Minimal evidence for treatment. *Pain Physician 2005*: In 2005 *Pain Physician* published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2½ year study period (8.4 ± 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to *Pain Physician*.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti2, 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus

Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (Boswell2, 2007) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). See also Facet joint intra-articular injections (therapeutic blocks).

The IRO doctor considered the requested treatment using the ODG entry 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 IRO doctor thought that the requested treatment was appropriate for complex regional pain syndrome (CRPS, also referred to as reflex sympathetic dystrophy or RSD), and that Claimant has CRPS. Maybe she does clinically, not legally. After a CCH held on August 24, 2011, the Division determined that the compensable injury does not extend to include "complex regional pain syndrome/reflex sympathetic dystrophy (CRPS/RSD) of the body, bilateral upper extremities and bilateral lower extremities".

There was no showing that the requested treatment was treatment for the compensable injury.

There was no objection to the testimony, reports, or qualifications of any doctor.

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 Carrier stipulated to the following facts:
 - A. Venue is proper in the (City)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 with American Home Assurance Company, Carrier.
 - D. On (Date of Injury) Claimant sustained a compensable injury.
 - E. The Independent Review Organization determined Claimant should have the requested treatment.
2. The Division sent to Respondent and Claimant at their respective addresses of record with the 10 day letters 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. Both Respondent and Claimant failed to appear for the November 16, 2011 medical contested case hearing; neither responded to the Division's letter offering each of them an opportunity to have the hearing rescheduled.
4. There was no showing of good cause for Respondent or Claimant's failure to appear for the medical contested case hearing.
5. The Independent Review Organization determined that Claimant should have the requested treatment because it is appropriate treatment for CRPS.
6. After a CCH held on August 24, 2011, the Division determined that the compensable injury does not extend to include "complex regional pain syndrome/reflex sympathetic dystrophy (CRPS/RSD) of the body, bilateral upper extremities and bilateral lower extremities".
7. Bilateral lumbar sympathetic blocks times three is not health care reasonably required for 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) Office.
3. Bilateral lumbar sympathetic blocks times three is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to bilateral lumbar sympathetic blocks times three for the compensable injury of (Date of Injury).

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 Section 408.021 of the Act.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE 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**

Signed this 22nd day of December, 2011.

Thomas Hight
Hearing Officer