MEDICAL CONTESTED CASE HEARING NO 12091
M6-12-37665-01

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 March 20, 2012 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is entitled to one left sided lumbar sympathetic nerve block for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

BACKGROUND INFORMATION

Dr. A requested pre-authorization for up to three left sided lumbar sympathetic nerve blocks as treatment for complex regional pain syndrome (CRPS). The IRO decision partially overturned the previous denials, approving one block. Carrier appealed. Claimant appeared at the pre-hearing in this case and announced she had received the approved injection and saw no reason to proceed. Dr. A did not appeal the IRO decision and did not appear at the pre-hearing.

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 entry for CRPS, diagnostic criteria, provides:

> Recommend using a combination of criteria as indicated below. There are no objective gold-standard diagnostic criteria for CRPS I or II. A comparison between three sets of diagnostic criteria for CRPS I concluded that there was a substantial lack of agreement between different diagnostic sets. (Perez, 2007)
> **A. CRPS-I (RSD):**
> *The IASP (International Association for the Study of Pain)* has defined this diagnosis as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. (Stanton-Hicks, 1995) Diagnostic criteria defined by IASP in 1995 were the following: (1) The presence of an initiating noxious event or cause of immobilization that leads to development of the syndrome; (2) Continuing pain, allodynia, or hyperalgesia which is disproportionate to the inciting event and/or spontaneous pain in the absence of external stimuli; (3) Evidence *at some time* of edema, changes in skin blood flow, or abnormal sudomotor activity in the pain region; & (4) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain or dysfunction. Criteria 2-4 must be satisfied to make the diagnosis. These criteria were found to be able to pick up a true positive with few false negatives (sensitivity 99% to 100%), but their use resulted in a large number of false positives (specificity range of 36% to 55%). (Bruehl, 1999) (Galer, 1998) Up to

37% of patients with painful diabetic neuropathy may meet the clinical criteria for CRPS using the original diagnostic criteria. (Quisel, 2005) To improve specificity the IASP suggested the following criteria: (1) Continuing pain disproportionate to the inciting event; (2) A report of one *symptom* from each of the following four categories and one *physical finding* from two of the following four categories: (a) Sensory: hyperesthesia, (b) Vasomotor: temperature asymmetry or skin color changes or asymmetry, (c) Sudomotor/edema: edema or sweating changes or sweating asymmetry, or (d) Motor/trophic: reports of decreased range of motion or motor dysfunction (weakness/tremor or dystonia) or trophic changes: hair, nail, skin. This decreased the number of false positives (specificity 94%) but also decreased the number of true positives (sensitivity of 70%). (Bruehl, 1999)
The Harden Citeria have updated these with the following four criteria: (1) Continuing pain, which is disproportionate to any inciting event; & (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); & (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry (>1°C) and/or skin color changes and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); & 4. There is no other diagnosis that better explains the signs and symptoms (Harden, 2007)
The Washington State Department of Labor and Industries guidelines include the presence of four of the following physical findings: (1) Vasomotor changes: temperature/color change; (2) Edema; (3) Trophic changes: skin, hair, and/or nail growth abnormalities; (4) Impaired motor function (tremor, abnormal limb positioning and/or diffuse weakness that can't be explained by neuralgic loss or musculoskeletal dysfunction); (5) Hyperpathia/allodynia; or (6) Sudomotor changes: sweating. Diagnostic tests (only needed if four physical findings were not present): 3-phase bone scan that is abnormal in pattern characteristics for CRPS. (Washington, 2002)
The State of Colorado Division of Workers' Compensation Medical Treatment Guidelines adopted the following diagnostic criteria in 2006: (1) The patient

complains of pain (usually diffuse burning or aching); (2) Physical findings of at least vasomotor and/or sudomotor signs, allodynia and/or trophic findings add strength to the diagnosis; (3) At least two diagnostic testing procedures are positive and these procedures include the following: (a) Diagnostic imaging: Plain film radiography/triple phase bone scan, (b) Injections: Diagnostic sympathetic blocks, (c) Thermography: Cold water stress test/warm water stress test, or (d) Autonomic Test Battery. The authors provide the following caveat: Even the most sensitive tests can have false negatives, and the patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate. (Colorado, 2006) Other authors have questioned the usefulness of diagnostic testing over and above history and physical findings. (Quisel, 2005) (Yung, 2003) (Perez2, 2005) A negative diagnostic test should not question a clinically typical presentation of CRPS and should not delay treatment. (Birklein, 2005)

B. CRPS-II (causalgia):

Nerve damage can be detected by EMG but pain is not contained to that distribution. (Stanton-Hicks, 1995) CRPS I and II appear to be clinically similar. (Bruehl, 1999) CRPS-II is defined by the IASP as: (1) The presence of continuing pain, allodynia, or hyperalgesia after a nerve injury, not necessarily limited to the distribution of the injured nerve; (2) Evidence at some time of edema, changes in skin blood flow, and/or abnormal sudomotor activity in the region of pain; & (3) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction. The state of Colorado also uses the above criteria but adds that there must be documentation of peripheral nerve injury with pain initially in the distribution of the injured nerve. (Colorado, 2006)

C. Differential Diagnoses of CRPS

These need to include local pathology, peripheral neuropathies, infectious processes, inflammatory and vascular disorders. (Quisel2, 2005) (Stanton-Hicks, 2006) Also include the following conditions: pain dysfunction syndrome; cumulative trauma syndrome; repetitive strain syndrome; overuse syndrome; tennis elbow; shoulder-hand syndrome; nonspecific thoracic outlet syndrome; fibromyalgia; posttraumatic vasoconstriction; undetected fracture; post-herpetic neuralgia; diabetic neuropathy. (Stanton-Hicks, 2004) Others have suggested that likely differential diagnoses should include: (1) Disuse; (2) Somatoform disorder (symptoms related to psychological factors); & (3) Factitious disorder (deliberately feigning symptoms). (Barth, 2009) See also Treatment for CRPS; Sympathetically maintained pain (SMP); CRPS, medications; CRPS, prevention; CRPS, sympathetic and epidural blocks.

The ODG entry for treatment of CRPS concerning sympathetic nerve blocks provides:

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)

Claimant received in the past six lumbar sympathetic nerve blocks performed by Dr. A. In September 2011 Claimant had a flare up in symptoms with increased pain and swelling. Dr. A requested approval of up to three additional sympathetic nerve blocks.

The IRO doctor, board certified in anesthesiology and pain management, cited part of the ODG guidelines for treatment of CRPS indicating that anywhere from one to three sympathetic nerve blocks can be given therapeutically as an adjunct to physical therapy, apparently referring to criterion (5) above: “In acute exacerbations, 1 to 3 blocks may be require for treatment”. The IRO doctor thought the appropriate and necessary procedure would be to proceed with one lumbar sympathetic nerve block, assess the results, then decide whether to proceed with another sympathetic nerve block based on “the merit of the previous injection”. Accordingly, the IRO doctor approved one but not more than one of the requested blocks.

Carrier argued no injection should have been approved and offered a report and testimony from Dr. C, also board certified in anesthesiology and pain management. Dr. C did not base his opinions in support of Carrier’s case on the criteria for use of sympathetic nerve blocks. He testified the ODG diagnostic criteria were not met in that there was no documented physical examination performed in connection with the flare up in symptoms and request for approval of

additional blocks. In other words, the documentation failed to establish that the flare up in symptoms in September 2011 was due to CRPS.

Carrier did not dispute the injection approved by the IRO on the ground it was not treatment for the compensable injury. Carrier failed to overcome the IRO by the preponderance of evidence based medical evidence.

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) 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 with Zurich American Insurance Company, Carrier.

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

   E. The Independent Review Organization determined Claimant should have the requested treatment to the extent of one injection.

2. Carrier delivered to Claimant Respondent 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. One left sided lumbar sympathetic nerve block is 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) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that one left sided lumbar sympathetic nerve block is health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to one left sided lumbar sympathetic nerve block 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 Section 408.021 of the Act.

The true corporate name of the insurance carrier is **ZURICH AMERICAN 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

Signed this 20th day of March, 2012.

Thomas Hight
Hearing Officer