MEDICAL CONTESTED CASE HEARING NO. 12130
M6-12-38877-01

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 August 13, 2012 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to O/P lumbar radiofrequency ablation at L5-S1 outpatient for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant's presence was excused. Representing Claimant was Manual Gonzales, attorney. Petitioner/Provider Dr. KB appeared telephonically. Respondent/Carrier appeared and was represented by Bryan Jones, attorney.

BACKGROUND INFORMATION

On (Date of Injury) Claimant sustained injuries to his neck, low back, and right shoulder in a motor vehicle accident. For his lumbar injury, Claimant received conservative treatment that consisted of physical therapy and medications, which produced temporary relief. On September 20, 2011 Dr. KB performed lumbar medial blocks at L4-5 and L5-S1. As part of the operative report, Dr. B reported that Claimant has significant relief immediately afterwards, On September 21, 2011 Dr. GW indicated that Claimant reported mild increase of Claimant's back pain since the injection. Dr. B recommended proceeding with radiofrequency ablation at L5-S1. Two utilization reviews (URAs) were conducted. Both URAs denied the request. The first URA found that there was a lack of objective information regarding the efficacy of the medial back blocks. The reconsideration of the URA found that long term functional improvement from radiofrequency ablation had not been established by large randomized controlled studies. Dr. B appealed the Carrier's decision to an IRO. The IRO upheld the Carrier's denial and noted that:

> The extent of relief was not quantified nor was the duration of relief from the medial lumbar blocks. Per *ODG* guidelines, there should be response of at least 70% pain relief.

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 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. 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. (Division Rule 133.308 (t)).

With regard to facet joint radiofrequency neurotomy, the section of the *ODG* for "Low Back Problems" provides as follows:

> "Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.

Criteria for use of facet joint radiofrequency neurotomy:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at ≥ 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function.

(4) No more than two joint levels are to be performed at one time.

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy"

Also, pursuant to the *ODG,* the recommendations for facet blocks are as follows:

"Criteria for the use of diagnostic blocks for facet "mediated" pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of ≥ 70%. The pain response should be approximately 2 hours for Lidocaine.

2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.

3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.

4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).

5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.

6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.

7. Opioids should not be given as a "sedative" during the procedure.

8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.

9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.

10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)

11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level."

Claimant's requesting doctor, KB, M.D., a board certified orthopedic surgeon, testified that Claimant had "significant" improvement" from the previous block, while still under the effect of Lidocaine. Dr. B interpreted "significant" as 90-100% relief. Therefore, Dr. B testified that Claimant meets the criteria outlined in the ODG regarding facet joint radiofrequency neurotomy.

The ODG recommends a radiofrequency ablation provided the patient meets specific criteria to include a positive response from a previous medical branch block. The IRO reviewer should not have referenced the September 21, 2011 report of Dr. W that noted a mild increase of pain after the lumbar medial blocks since the ODG requirement only references documentation of a pain response for approximately 2 hours while Claimant is still under the effects of Lidocaine. But Dr. B acknowledged that Claimant's pain relief was not quantified, since this operative report was done before Dr. B was aware of the need to report actual numbers. Thus Claimant and Dr. B failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision regarding the requested procedure. Therefore, it is concluded that Claimant and Dr. B have not met the requisite evidentiary standard required to over the IRO decision and the preponderance of the evidence is not contrary to the IRO decision that the Claimant is not entitled to O/P lumbar radiofrequency ablation at L5-S1 outpatient for the compensable injury of (Date of 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 (Date of Injury), Claimant was the employee of (Employer), Employer.

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

   D. The Independent Review Organization (IRO) determined that the Claimant should not have O/P lumbar radiofrequency ablation at L5-S1 outpatient.

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. Dr. B and Claimant failed to prove that Claimant meets the requirements in the ODG for O/P lumbar radiofrequency ablation at L5-S1 outpatient and the requested procedure is not consistent with the recommendations in the ODG.

4. The requested O/P lumbar radiofrequency ablation at L5-S1 outpatient 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) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that O/P lumbar radiofrequency ablation at L5-S1 outpatient is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to O/P lumbar radiofrequency ablation at L5-S1 outpatient 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 §408.021.

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:

MR. RON WRIGHT, PRESIDENT
6210 E. HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 13th day of August, 2012.

Judy L. Ney
Hearing Officer