MEDICAL CONTESTED CASE HEARING NO. 13101

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 May 30, 2013 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to an outpatient left sacroiliac joint injection for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

BACKGROUND INFORMATION

Claimant sustained a compensable low back injury while lifting and stacking heavy boxes on (Date of Injury). He described his treatment to date, which has included injections, physical therapy, and a home exercise program; it has now been recommended that he undergo a left sacroiliac joint injection in the hope and expectation that it will ease his symptoms.

NT, MD, Carrier's Medical Director, testified describing his education and training. He described the proposed treatment, and indicated that the Official Disability Guidelines (ODG) are considered evidence-based medicine, as required by the Division.

The witness described Claimant's medical condition and treatment *vis-à-vis* the ODG, and noted that Claimant has not undergone the recent aggressive physical therapy and does not display the three or more positive examination findings that the ODG considers prerequisites to the contemplated sacroiliac joint injection.

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. Section 401.011(22-a) defines health care reasonably required 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 (A) evidence-based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

Evidence-based medicine is medicine that is firmly supported by 1) credible scientific studies, including peer-reviewed medical literature and other current, scientifically based texts, and/or 2) treatment and practice guidelines, such as the treatment portion of the Official Disability Guidelines (ODG). **Texas Labor Code Section 401.011 (18-a).**

The Division of Workers' Compensation has adopted treatment guidelines under Division Rule 137.100. That rule requires that health care providers provide treatment in accordance with the current edition of the ODG, and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the Texas Labor Code. The initial inquiry in any dispute regarding medical necessity is whether the proposed care is consistent with the ODG.

With regard to a sacroiliac joint injection, the ODG reads as follows:

> 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.
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> *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.
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> *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.
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> *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 a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

A review of Claimant's medical records in light of the content of the ODG reveals that Claimant's proposed injection does not comport with the first criterion enumerated therein. Specifically, it is noted that this initial requirement is a positive finding in three out of fifteen listed tests, and Claimant exhibited positive findings in only two of those tests. Although Claimant's medical records do reflect a positive result for axial left low back pain with straight leg raising, this test is not one of the fifteen set forth in the ODG, and therefore will not assist Claimant in meeting his burden of proof to show that his recommended treatment does, indeed, satisfy the ODG.

Since Claimant has not shown that his recommended treatment is consistent with the ODG, that evidence-based medicine exists that is more persuasive than the ODG, or that the requested treatment is not addressed by the ODG, he may not prevail in his attempt to obtain approval for the procedure in question.

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.

2. Carrier delivered to Claimant/Petitioner 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. An outpatient left sacroiliac joint injection is 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that an outpatient left sacroiliac joint injection is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to an outpatient left sacroiliac joint injection 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:

RICHARD J. GERGASKO
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 6th day of June, 2013.

Ellen Vannah
Hearing Officer