

MEDICAL CONTESTED CASE HEARING NO. 13103

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 June 10, 2013, to decide the following disputed issue:

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

At Carrier's request, without objection, the following issue was added:

2. Does the Division have jurisdiction to hear an appeal of the IRO decision?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by CM, ombudsman. Respondent/Carrier appeared and was represented by WS, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable low back injury on (Date of Injury). He initially treated with a chiropractor, but in early 2006 he began seeing MK, MD of (Healthcare Provider). Dr. K recommended decompressive lumbar laminectomy that was performed on July 17, 2006. After the surgery, Claimant continued to complain of pain that was attributed to facet arthropathy. Dr. K referred Claimant to Dr. L, MD, another member of his practice group, for a consultation in August of 2008. Dr. L diagnosed severe mechanical back pain with intractable spasm and recommended palliative treatment and a flexion/extension MRI once Claimant's pain was under control. On November 17, 2009, Dr. L saw Claimant and recommended a decompression from L4 to S1 with instrumented fusion at the same levels. On October 18, 2010, Claimant underwent wide laminectomies from L4 through S1 and posterior lumbar interbody arthrodesis at L4-5 and L5-S1 with spinal instrumentation and insertion of a biomechanical interbody fusion device.

Claimant continued to have low back complaints. On September 4, 2012, Dr. L wrote that he believed that Claimant's pain was related to chronic nerve damage due to delayed surgery, chronic muscle deconditioning, and bilateral sacroiliac joint irritation as a result of the 2010

fusion and “subsequent fixed segment” from L4 through S1. He wrote that he would refer Claimant to Dr. AO “who is very adept at injecting the sacroiliac joints both diagnostically and therapeutically” in combination with a physical therapy program.

Dr. O saw Claimant on September 25, 2012. In his chart note of that date, Dr. O wrote:

At this time, we are going to offer him bilateral sacroiliac joint injections x1 with 2-week followup (sic). It is possible that (sic) radicular component of his pain may be from a sciatic nerve closely exiting next to have (sic) an inflamed SI joint.

On October 3, 2012, Dr. O requested pre-authorization for bilateral sacroiliac joint injections with fluoroscopy. Carrier, through Corvel, denied the pre-authorization on October 9, 2012. The utilization review agent (URA), SV, MD of (City), Texas, determined that the requested injections were not reasonably necessary because there was insufficient detail in the submitted medical records to show that Claimant had tried and failed at least 4 to 6 weeks of “aggressive or conservative” therapy and the medical records failed to show positive exam test findings to indicate SI joint dysfunction. A review of Dr. V’s opinion was requested. The request was submitted to YM, MD. Dr. M recommended that the requested injections be denied because the clinical documentation presented failed to show that Claimant had exhausted recent conservative therapy. Dr. V and Dr. M both cited the Official Disability Guidelines (ODG) in making their decisions.

Claimant appealed Carrier’s denial of treatment to an Independent Review Organization (IRO). The Texas Department of Insurance (the Department) appointed Parker Healthcare Management Organization, Inc. as the IRO. On January 9, 2013, the IRO sent notice of its decision upholding Carrier’s denial of pre-authorization to the Department, Dr. O, Carrier, Corvel, and Claimant. In upholding Carrier’s denial, the IRO’s physician reviewer noted that there was no documentation submitted showing aggressive conservative therapy and that Claimant has evidence of chronic radicular pain syndrome. The physician reviewer noted that the ODG recommends sacroiliac injections as an option only if the patient has failed at least 4-6 weeks of aggressive conservative therapy and that the injections are not recommended for treatment of any radicular pain syndrome.

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 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 for the treatment of a particular patient. 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. 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 (s).) The written appeal must be filed with the Division's Chief Clerk of Proceedings no later than 20 days after the date the IRO decision is sent to the appealing party. (Division Rule 133.308(s)(1)(A).)

Claimant's appeal of the IRO decision was received by the Division on February 15, 2013. Since the IRO decision was sent to the parties on January 9, 2013, Claimant was required by Rule 133.308(s)(1)(A) to file his appeal of that decision on or before January 29, 2013. January 29, 2013, fell on a Tuesday. It was not a holiday. Claimant asserts that he did not receive a copy of the IRO decision until February 11, 2013. There is, however, no good cause exception to the failure to timely file an appeal of an IRO decision and the time limits for the filing of the appeal are determined by the date the IRO sends the parties its decision, not the date of receipt. Because Claimant failed to timely appeal the IRO decision, the Division does not have jurisdiction to hear the appeal.

The ODG low back chapter states that sacroiliac joint injections are recommended as an option if the injured employee has failed at least 4-5 weeks of aggressive conservative therapy and directs the reader to the hip and pelvis chapter for more information, references, and criteria for the use of sacroiliac blocks. The hip and pelvis chapter refers the reader to sacroiliac joint blocks, where it states:

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 (sic) 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 a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

Dr. O did not provide the IRO physician reviewer with any documentation to support his opinion that bilateral sacroiliac joint injections is health care reasonably necessary for the compensable injury. Dr. L, in a letter April 3, 2013, stated that he believes that sacroiliac joint injections are indicated because Claimant now has a fixed, immobile segment in his lumbar spine “which necessarily transmits the forces directly into the SI-joints bilaterally.” Dr. L then goes on to write that if the injections provide any relief, even transient relief, he would consider “definitive SI-joint fixation.” Dr. L did not address the concerns of the URA doctors or the IRO physician reviewer. One can infer from his referral of Claimant to Dr. O and the lack of discussion in his letter that Dr. L has no firm evidence upon which to base his support of the requested bilateral sacroiliac joint injections.

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 coverage with Church Mutual Insurance Company, Carrier.
 - D. Claimant sustained a compensable injury on (Date of Injury).
 - E. Claimant’s doctor, DO, MD, requested pre-authorization for bilateral sacroiliac joint injections with fluoroscopy.
 - F. The request for bilateral sacroiliac joint injections with fluoroscopy was denied by Carrier.
 - G. Carrier’s denial of pre-authorization for the requested bilateral sacroiliac joint injections with fluoroscopy was appealed to an Independent Review Organization.
 - H. The Department appointed Parker Healthcare Management Organization, Inc., as the Independent Review Organization.

- I. The Independent Review Organization upheld Carrier's denial of bilateral sacroiliac joint injections with fluoroscopy.
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. The Independent Review Organization sent its decision to the parties, including Claimant, on January 9, 2013.
4. Tuesday, January 29, 2013, was the 20th day after the Independent Review Organization sent its decision to the parties.
5. Claimant filed his appeal of the Independent Review Organization's decision with the Division on February 15, 2013.
6. The preponderance of the evidence based medicine is not contrary to the Independent Review Organization's determination that bilateral sacroiliac joint injections are not recommended by the ODG in light of the medical records provided to the Independent Review Organization.
7. The expert medical evidence failed to establish evidence-based medical evidence that would tend to show that bilateral sacroiliac joint injection is a recommended health care treatment for chronic radicular pain.
8. The evidence failed to establish that Claimant has at least 3 positive exam findings as listed in the relevant portion of the ODG, that a diagnostic evaluation has addressed any other possible pain generators, and that Claimant has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management.
9. Bilateral sacroiliac joint injection 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 a bilateral sacroiliac joint injection is not health care reasonably required for the compensable injury of (Date of Injury).

4. Claimant failed to timely appeal the IRO decision and the Division does not have jurisdiction to hear the appeal of the IRO decision.

DECISION

Claimant failed to timely appeal the IRO decision and the Division does not have jurisdiction to hear the appeal of the IRO decision. Claimant is not entitled to a bilateral 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 **CHURCH MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TX 75201**

Signed this 13th day of June, 2013.

KENNETH A. HUCHTON
Hearing Officer