

MEDICAL CONTESTED CASE HEARING NO. 14036

**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.

**ISSUE**

A contested case hearing was held on December 10, 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 L2-3 translaminar epidural steroid injection for his compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Claimant appeared and was assisted by BO, ombudsman.

Respondent/Carrier appeared and was represented by JB, adjustor.

Petitioner did not attend the hearing.

**BACKGROUND INFORMATION**

Claimant sustained a compensable vertebral fracture, and underwent surgery and post-surgical physical therapy to address that injury. When his symptoms persisted, Claimant was treated with injections on two occasions, but indicated that only the initial injection eased his pain. Claimant's doctor has now recommended an additional injection, and Claimant deferred to the doctor's recommendation.

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 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(s), "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."

With regard to the proposed epidural steroid injection, the ODG reads as follows:

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition. In fact, according to SPORT, ESIs are associated with less improvement in spinal stenosis. (Radcliff, 2013)

*Short-term symptoms:* The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005) A recent RCT of 29 patients divided into three groups addressed the use of ESIs for treatment of spinal stenosis. A control group with no treatment was compared to a group

receiving passive physical therapy for two weeks and another receiving an interlaminar ESI at the stenotic level. At two weeks the group that received the ESI had significantly better pain relief than the other two groups. When the three groups were compared there was no statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. The authors stated that improvement only appeared to be in the early phase of treatment. (Koc, 2009)

*Use for chronic pain:* Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

*Transforaminal approach:* Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005) Two recent RCTs of caudal injections had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. (Manchikanti, 2011) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. (Iversen, 2011)

*Fluoroscopic guidance:* Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

*Factors that decrease success:* Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and

contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti , 2003) (CMS, 2004) (Delport, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) (Buenaventura, 2009) Also see Epidural steroid injections, “series of three” and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

*With discectomy:* Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

*Patient selection:* ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%). This success rate may be no more than that of a placebo effect, and surgery may be a more appropriate consideration. (Ghahreman, 2011)

*MRIs:* According to this RCT, the use of MRI before ESIs does not improve patient outcomes and has a minimal effect on decision making, but the use of MRI might have reduced the total number of injections required and may have improved outcomes in a subset of patients. Given these potential benefits as well as concerns related to missing important rare contraindications to epidural steroid injection, plus the small benefits of ESIs themselves, ODG continues to recommend that radiculopathy be corroborated by imaging studies and/or electrodiagnostic testing. (Cohen, 2012)

*Fracture risk:* Lumbar ESIs are associated with an increased risk for spinal fracture. Each single additional ESI increased the risk for fracture by 21%, with an increasing number of ESIs associated with an increasing likelihood of fracture.

Use of ESIs seems to promote deterioration of skeletal quality. This definable fracture risk should be balanced with the best available evidence regarding the long-term efficacy of ESIs, which is limited. Clinicians should consider these findings before prescribing ESIs for elderly patients. (Mandel, 2013)

*Recent research:* An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009) In this RCT there were no statistically significant differences between any of the three groups at any time points. This study had some limitations: only one type of steroid in one dose was tested; the approach used was caudal and transforaminal injections might provide superior results. (Weiner, 2012) Effects are short-term and minimal. At follow-up of up to 3 months, epidural steroids were associated with statistically significant reductions in mean leg pain and mean disability score, but neither of these short-term improvements reached the threshold for clinical significance. There were no significant differences in either leg pain or disability at 12 months follow-up. (Pinto, 2012)

### **Criteria for the use of Epidural steroid injections:**

*Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.*

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will

- be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless:
- (a) there is a question of the pain generator;
  - (b) there was possibility of inaccurate placement; or
  - (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
  - (6) No more than one interlaminar level should be injected at one session.
  - (7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
  - (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
  - (9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
  - (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
  - (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

In order to prevail, Claimant must show one of three things: that his proposed 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. The Hearing Officer’s comparison of the ODG criteria with Claimant’s medical records indicates that the proposed treatment does, indeed, comport with the requirements of the ODG, in that Claimant’s records document radiculopathy evident on an imaging study, an initial lack of response to conservative

treatment, and a significant relief of pain following Claimant's diagnostic injection. In addition, the role of Claimant's myocardial infarction in the interruption of his treatment has been adequately explained. Consequently, a decision in favor of Petitioner will be entered as to the sole issue presented for resolution herein.

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. On (Date of Injury), Claimant was the employee of the (Employer), Employer.
2. On (Date of Injury), Employer subscribed to workers' compensation insurance coverage through the New Hampshire Insurance Company, Carrier.
3. On (Date of Injury), Claimant's residence was located within seventy-five miles of the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
4. 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.
5. An L2-3 translaminar epidural steroid injection is 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 contrary to the decision of the IRO that an L2-3 translaminar epidural steroid injection is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

### **DECISION**

Claimant is entitled to an L2-3 translaminar epidural steroid injection for his 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 §408.021.

The true corporate name of the carrier is **NEW HAMPSHIRE 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 78701-3218**

Signed this 17<sup>th</sup> day of December, 2013.

Ellen Vannah  
Hearing Officer