MEDICAL CONTESTED CASE HEARING NO. 14061

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the preponderance of the evidence is not contrary to the decision of the Independent Review Organization that a thoracic epidural steroid injection is not health care reasonably required for the compensable injury of (Date of Injury).

ISSUE

On April 24, 2014, William M. Routon II, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to a thoracic epidural steroid injection for the compensable injury on (Date of Injury)?

PARTIES PRESENT

The petitioner/claimant appeared and was assisted by PA, ombudsman. The carrier/respondent appeared and was represented by BJ, attorney.

BACKGROUND INFORMATION

The mechanism of the compensable injury resulted in rib fractures, and cervical and thoracic spine fractures. The claimant's treating doctor referred the claimant to a pain management doctor, R L, M. D., who requested authorization for a thoracic epidural steroid injection (ESI). The first utilization review doctor, an anesthesiologist, denied Dr. L's authorization request for a thoracic epidural steroid injection. He pointed out that since ESIs are recommended as a possible short-term treatment for radicular pain, one of requirements set out by the Official Disability Guides (ODG) for ESIs is that radiculopathy must be documented. He noted that the thoracic MRI showed no indication of any nerve root impingement. Based on an absence of clinical documentation of radiculopathy by examination, and on the MRI that showed only mild spinal canal stenosis, the reviewer asserted that the ODG requirements for an ESI for the claimant's thoracic spine could not be and were not met.

The utilization review doctor who reviewed the request on reconsideration, a board certified anesthesiologist, fellowship trained in pain medicine, denied the ESI request for essentially the

same reasons as the initial reviewer. He stated that "physical examination does not reveal any significant radicular symptoms or neurological deficits with regard to the thoracic spine." He added that he also found no indication of a failure to respond to previous conservative treatment.

An IRO reviewer, identified as an anesthesiologist and pain management doctor, upheld the carrier's denial of a thoracic ESI for the same reasons as the utilization doctors—that thoracic radiculopathy was not documented. He specifically stated that the submitted documents "did not provide any information regarding the absence of sensory, motor, or reflex deficits or any other associated findings indicative of thoracic radiculopathy," that the MRI "did not reveal any significant thoracic disk herniation, nerve root compression, and/or spinal stenosis," and that the documentation "did not indicate any failure of conservative treatment."

DISCUSSION

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 (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."

On the date of this medical contested case hearing, the Neck and Upper Back Chapter of the ODG provides the following with regard to epidural steroid injections:

> Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-*Cochrane*, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) Epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) Intramuscular injection of lidocaine for chronic mechanical neck disorders (MND) and intravenous injection of methylprednisolone for acute whiplash were effective treatments. There was limited evidence of effectiveness of epidural injection of

methyl prednisolone and lidocaine for chronic MND with radicular findings. (Peloso-*Cochrane*, 2006) See the Low Back Chapter for more information and references.

Criteria for the use of Epidural steroid injections, therapeutic:

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

(1) Radiculopathy must be documented by physical examination and 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) for guidance
(4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
(8) Repeat injections should be based on continued objective documented pain and function response.
(9) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or 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.

Criteria for the use of Epidural steroid injections, diagnostic:

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

The claimant presented no evidence from Dr. L or any other doctor to attempt to establish that a thoracic ESI in this case was supported by the ODG or was an exception to the ODG requirements. The carrier presented the testimony of BS, M. D. who, consistent with the opinions of the reviewing doctors, noted that there was no physical, radiographic, or neurological evidence presented to objectively establish any thoracic radiculopathy in this case. And Dr. S asserted, as did the reviewing doctors, that the establishment of radiculopathy was a necessary requirement to support the reasonableness and necessity of a thoracic ESI.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet his burden of overcoming the IRO decision by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for a thoracic epidural steroid injection prescribed in the ODG. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to the thoracic epidural steroid injection.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Workers' Compensation Division of the Texas Department of Insurance.

   B. On (Date of Injury), the claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), the claimant sustained a compensable injury of multiple left rib fractures, spinal contusion, T1-T3 compression fractures, and cervical fractures.

   D. On (Date of Injury), the employer provided workers' compensation insurance with Texas Mutual Insurance Company, Carrier.

E. The IRO determined that the claimant is not entitled to a thoracic epidural steroid injection.

2. The carrier delivered to the claimant a single document stating the true corporate name of the carrier, and the name and street address of the carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. A thoracic epidural steroid injection is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance 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 thoracic epidural steroid injection is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

The claimant is not entitled to a thoracic epidural steroid injection for the compensable injury on (Date of Injury).

ORDER

The carrier is not liable for the benefits at issue in this hearing. The 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
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 29th day of April, 2014.

William M. Routon II
Hearing Officer