MEDICAL CONTESTED CASE HEARING NO. 15008

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 Independent Review Organization (IRO) decision that Claimant is not entitled to lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as outpatient.

STATEMENT OF THE CASE

On October 23, 2014, Britt Clark, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the Independent Review Organization (IRO) decision that Claimant is not entitled to lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as outpatient?

PARTIES PRESENT

Claimant appeared and was assisted by LP, ombudsman. Carrier appeared and was represented by WS, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

> For Claimant: Claimant, MP M.D., CM, RN, BS, CCM.
>
> For Carrier: None.

The following exhibits were admitted into evidence:

> Hearing Officer's Exhibits HO-1 and HO-2.
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> Claimant's Exhibits C-1 through C-7.
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> Carrier's Exhibits CR-A through CR-D.

DISCUSSION

Claimant contended that the preponderance of the evidence was contrary to the opinion of the Independent Review Organization (IRO) decision that he was not entitled to an outpatient

lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as outpatient and relied on the testimony of Dr. MP, his treating doctor, and CM, his nurse-case manager. Carrier argued that Dr. P's opinion offers no evidence-based medicine to overcome the IRO decision, which is based on the Official Disability Guidelines (ODG).

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."

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to facet joint diagnostic blocks:

> Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with

the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009)

Etiology of false positive blocks: Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (Cohen, 2014)

MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (Clemans, 2005) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumaticos, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient

evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. (Cohen, 2010) See also Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

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 last at least 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)

Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that

would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]

The IRO reviewer agreed with two utilization review doctors and opined that the requested treatment did not meet ODG criteria. The IRO reviewer indicated that the Claimant continued to present with radicular symptoms, and that there was no indication of any therapeutic intervention being recommended in conjunction with the facet joint injections. To rebut the IRO, Claimant relied on the opinion of Dr. P. Dr. P testified that Claimant had no radicular complaints going into his lower extremity, and that Claimant's pain was localized in his lower back upon his examinations, and his records support that assertion. Dr. P testified that the diagnostic injection was needed to see if Claimant's low back condition was mechanical in nature, and if proven successful, Claimant would need a radiofrequency rhizotomy. Dr. P indicated that they had "tried everything else", he noted that Claimant had physical therapy, massage therapy, and other conservative measures, and therefore believed that the treatment was necessary. Dr. P did not reference the ODG in his testimony and did not provide any evidence-based medicine to support his request for the disputed treatment. Dr. P's testimony expressed frustration with the IRO process and implicitly with the Carrier's denial; however, Claimant has the burden of proof on this case to show by the preponderance of evidence-based medical evidence that the disputed procedure is health care that is clinically appropriate and considered effective for his injury. Evidence-based medical evidence entails the opinion of a qualified expert that is supported by evidence-based medicine. Claimant also provided the testimony of his nurse-case manager, C M. While Ms. M's testimony bolstered Dr. P's analysis regarding the lack of radicular complaints and the clinical findings to show facet pain, her testimony did not constitute evidence-based medicine to support the need for the disputed procedure. Claimant should note that this case did not involve his credibility. He is a very credible individual, and the Hearing Officer found his description of pain and his recitation of his treatment history credible. However, lay testimony is not probative to the medical issue at the hearing. The Hearing Officer carefully considered the testimony of his doctor and his nurse-case manager, and carefully reviewed the documentary evidence prior to rendering this decision. The evidence presented at the hearing simply cannot be construed to constitute evidence-based medical evidence sufficient to overcome the decision of the Independent Review Organization (IRO) reviewer. As Claimant did not overcome the IRO decision by a preponderance of the evidence-based medical evidence, he has accordingly failed to meet his burden of proof.

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 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 insurance through Ace American Insurance Company, Carrier.

   D. On (Date of Injury), Claimant sustained a compensable injury.

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. Lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as 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 Independent Review Organization (IRO) decision that Claimant is not entitled to lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as outpatient.

DECISION

Claimant is not entitled to lumbar facet joint injection under fluoroscopy at left L3, L4, and L5 as outpatient.

ORDER

Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **ACE AMERICAN INSURANCE COMPANY**, and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
1999 BRYAN STREET, SUITE 900
DALLAS, TX 75201-3136

Signed this 29th day of October, 2014.

BRITT CLARK
Hearing Officer