MEDICAL CONTESTED CASE HEARING NO. 09047
M6-08-14448-01

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 September 16, 2008, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the IRO decision that Claimant is not entitled to thoracic facet joint nerve rhizotomies at T9 - T11 left for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by MV, Ombudsman.

Carrier appeared and was represented by RJ, Attorney.

BACKGROUND INFORMATION

Claimant injured his lumbar spine in a lifting incident on _____. He had lumbar surgery in 2001, followed by a second surgery in 2003. The second surgery resulted in a fusion with instrumentation. Claimant did not have a good result and was diagnosed with a failed back syndrome. His present treating doctor is Dr. D, a pain management specialist.

Claimant was evaluated by Dr. D on February 16, 2008. The medical record from that visit noted that the plan was to request pre-certification of thoracic facet joint nerve block, T9, T10, T11, bilaterally.

On April 14, 2008, the Carrier, through Coventry Workers' Comp Services, pre-certified Dr. D's request to perform thoracic facet joint nerve rhizotomies. The pre-certification was for the right side only. This report notes the request for the necessity of the left side procedure should be reviewed after the effect of the right side is documented. If the right side is successful, then the left side would be approved. This report relies on the ODG and notes that conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Overall, despite the less than clear literature support for thoracic rhizotomies (due to the infrequent presentation of these joints versus cervical/lumbar), the clinical presentation meets the criteria of symptoms, exam, and diagnostic confirmation. The point being the Carrier properly noted all of the cautions and concerns outlined in the ODG and pre-certified the procedure with one caveat: Do the right side first and if it is successful in relieving pain, then the Carrier would approve the left side.

On April 25, 2008, Dr. D performed the procedure of thoracic facet joint rhizotomies of the right side at T9, T10 and T11 as pre-certified by the Carrier. Claimant was seen in a follow-up exam on May 9, 2008 and was found to have a 50% reduction in back pain. Based on this

positive finding, Dr. D requested approval to proceed with the same procedure on the left side, as per the instruction from the Carrier's utilization review decision.

The Carrier denied the present request for thoracic facet joint nerve rhizotomies on the left at T9, T10 and T11 without reference to their earlier decision to approve this procedure on the left side if the right side was successful in reducing back pain. Instead, the Carrier returned to the same cautions and concerns raised by the ODG which had already been dealt with in the April utilization review. Claimant appealed the Carrier's denial and the medical dispute was referred to an IRO for decision. The IRO, in a fairly brief opinion, upheld the Carrier's denial. Dr. D has requested a Medical Contested Case Hearing (MCCH) to review the IRO decision.

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.

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 Official Disability Guidelines (ODG).

The ODG discusses the procedure requested in this case under the heading of "Facet Joint Radiofrequency Neurotomy":

> "Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.
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> *Current research:* Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (van Kleef, 1999) (Boswell, 2005) (Leclaire, 2001) (Van Kleef, 1999) (Gallagher, 1994) (van Wijk, 2005) A recent small RCT found that the percutaneous

radiofrequency neurotomy treatment group showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacro-iliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment, and it provided relief for only one component of the patients' pain. (Nath, 2008) *Observational Trials:* One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007)

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-*Cochrane*, 2003) (Niemesto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported "sparse evidence" to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiskal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)

Technique: There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.

Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain, and history of back surgery.

Factors associated with success: Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)

Duration of pain relief: One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly

secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)

Complications: Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti , 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter."

Although the ODG lists this procedure as being under study, it does provide for approval on a case-by-case basis when the following criteria has been met:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at $\geq$ 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement of VAS score, and documented improvement in function.

(4) No more than two joint levels are to be performed at one time.

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

The IRO decision upheld the Carrier's denial of the requested procedure based on its finding that Claimant did not meet criteria number one. Specifically, the IRO correctly states that the ODG requires that the diagnosis be confirmed by medial branch blocks. The IRO decision states that Claimant has undergone comparative facet joint injections - not medial branch blocks. As Dr. D points out, the problem with the IRO finding is that comparative facet joint injections are the same procedure as medial branch blocks. Dr. D's position that a medial branch blocks and a facet joint injections are the same procedure is supported by the ODG. The procedures are cross-referenced in the ODG. The IRO finding that Claimant did not meet the first listed criteria is incorrect. Facet joint nerve injections and medial branch blocks are the same procedure. It is noted that the Carrier's initial utilization review that approved thoracic facet joint nerve rhizotomies on the right side on April 14, 2008 found that Claimant had two sets of diagnostic facet joint injections with positive pain relief results. Clearly, that decision considered the facet joint injections to be the same as medial branch blocks and that Claimant did meet the first criteria set out in the ODG.

Claimant's burden in this case is to show that the preponderance of the evidence is contrary to the IRO decision. The IRO decision is factually incorrect. Claimant did meet the criteria for this procedure set out in the ODG. The diagnosis of facet joint pain was confirmed by the use of medial branch blocks in November 2007 and again in January 2008.

The Carrier raised, for the first time, at the Contested Case Hearing (CCH) that the Claimant failed to meet criteria number 4 to wit: (4) No more than two joint levels are to be performed at one time. The Carrier points out that Claimant's request is for three levels on the left side. There are several problems with Carrier's argument. First, the IRO decision does not mention or rely on criteria number 4. None of the medical reports in this case use this criteria as a reason for denial. To the contrary, the Carrier utilization review report on April 14, 2008 specifically approved a 3-level procedure on the right. Second, I do not believe this is a legal argument that can be raised by the Carrier at the Contested Case Hearing (CCH). This calls for a medical doctor's interpretation of a medical guideline. For example, are the two levels referred to in criteria number 4 to be bilaterally at two levels or one side at two levels. Are two levels bilaterally the same as three levels on one side? It takes expert medical evidence to raise this problem as to the proper interpretation of the ODG. No doctor, that I can find, has raised failure to meet criteria number 4 as a grounds for disapproval of the procedure. Certainly, the IRO decision did not rely on this criteria. Lastly, as pointed out above, the Carrier has already approved 3-level facet joint rhizotomies on the right with the caveat that if the right side is successful, it would approve the 3-level facet joint rhizotomies on the left side. The caveat seems to have gotten lost in the Carrier's review process.

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 _____, Claimant was the employee of (Employer).

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 IRO decision found that the diagnosis of facet joint pain had not been confirmed by a medial branch block as required by the ODG.

4. Claimant's diagnosis of facet joint pain was confirmed by thoracic facet joint nerve injections, the same procedure as a medial branch block.

5. Thoracic facet joint nerve rhizotomies at T9 - T11 on the left side is health care reasonably required for the compensable injury of _____.

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 IRO decision that Claimant is not entitled to thoracic facet joint nerve rhizotomies at T9 - T11, left for the compensable injury of _____.

DECISION

Claimant is entitled to thoracic facet joint nerve rhizotomies at T9 - T11, left for the compensable injury of _____.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

The true corporate name of the insurance carrier is **TPCIGA FOR RELIANCE NATIONAL**, and the name and address of its registered agent for service of process is:

MARVIN KELLY, EXECUTIVE DIRECTOR
9120 BURNET ROAD
AUSTIN, TEXAS 78758

Signed this 24th day of September, 2008.

Donald E. Woods
Hearing Officer