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 benefit contested case hearing was held on March 4, 2009, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to selective nerve root block and MAC anesthesia for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by KF, ombudsman. Carrier appeared and was represented by attorney, DP.

BACKGROUND INFORMATION

Claimant sustained injuries to his lower back and left lower extremity, as well as his left ankle, when he fell while working as a painter.

Claimant has treated with various doctors. He began treating with Dr. H, a pain management doctor, in 2006. He received medication and injections and was told that he might need surgery. Claimant testified that he has undergone the requested selective nerve root block in the past and reported some success. Claimant testified that after the nerve root block, his pain and swelling were reduced; he rested more comfortably; and, he was able to perform his daily activities with less pain and less dependence on pain medication.

Claimant's medical records show that he has had at least two MRIs. One, performed on September 19, 2005, revealed a broad based and posterolateral disc protrusion at L4-5 with obliteration of the epidural fat and impingement on the thecal sac, as well as a central disc protrusion at L5-S1 without impingement on the thecal sac or nerve roots. The most recent MRI, performed on February 7, 2008, revealed normal discs from L1-2 through L4-5 and a broad 1mm disc bulge with borderline canal stenosis at L5-S1.

EMG studies performed in 2006 and 2007 revealed no evidence of radiculopathy.

Early medical records show that Claimant underwent various injections with little relief. The records of Dr. H, show that Claimant reported temporary relief (1-2 weeks) with epidural steroid injections administered by previous doctors. Dr. H diagnosed a herniated disc at L4-5 and a disk tear at L5-S1, possible reflex sympathetic dystrophy of the left ankle, clinical L5-S1 radiculopathy on the left and low back pain. Dr. H ordered a new MRI (the February 7, 2008 MRI) and revised his

diagnosis to disc protrusion at L5-S1, left ankle trauma, possible left ankle RSD and clinical L5-S1 radiculopathy with left low back pain. He ordered a lumbar ESI at L5-S1 and continued Claimant on his current medications without a change in dose.

In May of 2008, following a February 27, 2008 ESI, Dr. H noted that Claimant had 70% relief for three weeks. Dr. H continued Claimant's medications with no change in dose and a second ESI was performed on May 30, 2008. On August 19, 2008, Claimant reported 80% relief for almost three months following the last injection, with a return of pain on a scale of 8 out of 10 on that date. The doctor continued Claimant's medications without change, and recommended a selective nerve root block at L5 on the left. That procedure was performed on October 23, 2008. According to Dr. H's notes, Claimant had excellent relief six days after the procedure, but he called to report a return of 7/10 pain on November 17, 2008.

On January 22, 2009, Dr. H's nurse practitioner requested a repeat selective nerve root block at L5 on the left. She noted that Claimant reported significant improvement after the first nerve root block but was having worsening symptoms with radiation into the left lower extremity in the L5 distribution, including weakness in the left lower extremity, positive straight leg raise on the left, and, pain in his left hip.

An IRO reviewer, a board certified pain management/anesthesiology doctor, upheld the carrier's denial of the requested selective nerve root block and MAC anesthesia. The IRO reviewer stated that Claimant was not now, nor had he ever been, a candidate for lumbar epidural steroid injections. The reviewer noted that Claimant's February 7, 2008 MRI was essentially normal, and there was no corroborating evidence on physical examination or electrodiagnostic study of findings sufficient to justify a radiculopathy diagnosis. The reviewer cited the *ODG* and opined that lumbar epidural steroid injections are medically reasonable and necessary where there is radicular pain consistent with both MRI findings of focal disc herniation and either physical examination or electrodiagnostic study evidence of radiculopathy and those findings were missing the instant case. The reviewer concluded, per the *ODG*, that Claimant was not an appropriate candidate for any epidural steroid injections, including selective nerve root blocks.

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

"Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 about the care of individual patients.

The Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the

current edition of the *Official Disability Guidelines (ODG),* and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. As the IRO doctor in the instant case stated, the *ODG* allows for selective nerve root blocks for the treatment of low back injuries and sets out the circumstances under which such treatment is recommended as reasonable and necessary.

The *ODG* Treatment Guidelines for selective nerve root blocks for the treatment of the low back refer the reader to "epidural steroid injections, diagnostic," which the *ODG* discuss as follows:

> Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5% of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. When used for diagnostic purposes the following indications have been recommended:
>
> 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
> 2) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
> 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
> 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive;
> 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

The records of Dr. H show that he is not seeking to use the selective nerve root blocks for diagnostic purposes. Rather, he is seeking to use the nerve root blocks therapeutically.

The *ODG* discuss therapeutic epidural steroid injections 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.
> *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)

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)

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) 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)
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)

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, 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000)
(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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

The board-certified pain management/anesthesiology IRO reviewer denied the requested procedure citing the relevant provisions of the *ODG*, specifically the fact that there was no documented evidence of radicular pain, and the fact that Claimant had no significant improvement with previous injections. Claimant also relied on the *ODG* in disputing the IRO opinion and claimed that he had documented evidence of radiculopathy based on clinical examination and had improved with prior injections.

When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. Mere citation to the *ODG* does not carry the day. In the instant case, the IRO report is specific and sets out exactly how Claimant fails to meet the criteria set out in the *ODG*.

The *ODG* contemplate the use of selective nerve root blocks for diagnostic purposes. It is clear that Dr. H is not seeking to use them for that purpose. According to the *ODG*, repeat therapeutic injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Contrary to Claimant's testimony, Dr. H's clinical records do not show that Claimant has met the criteria set out in the *ODG* for repeat injections. The intended treatment is, therefore, not supported by the *ODG*. Further, as the IRO reviewer pointed out, in Claimant's case, with no objective evidence of radiculopathy, the therapeutic use of epidural steroid injections, including selective nerve root blocks, is not supported. Claimant has provided no evidence-based medical opinion to overcome the presumption afforded the *ODG*. As such, Claimant has not provided evidence-based medicine sufficient to overcome the IRO opinion in the instant case.

Under the Act, treatment provided pursuant to the *ODG* is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**. Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. The preponderance of the evidence is not contrary to the IRO decision and the requested selective nerve root block and MAC anesthesia does not meet the criteria set out in the *ODG*.

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), when he sustained a compensable injury.

C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

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

3. Claimant's pain management doctor recommended selective nerve root block and MAC anesthesia for treatment of Claimant's compensable low back injury.

4. For treatment of the low back, the *ODG* sets out the circumstances under which selective nerve root blocks are recommended.

5. Claimant's doctor is not seeking to use the selective nerve root blocks for diagnostic purposes.

6. Claimant does not have objective evidence of radiculopathy as evidenced by MRI and two EMG/NVC tests were normal.

7. The medical records do not show that Claimant had objective documented pain relief, decreased need for pain medications, and functional response following a previous selective nerve root block.

8. The IRO decision upheld the Carrier's denial of the requested selective nerve root block and MAC anesthesia because the requested service did not meet the criteria set out in the *ODG*.

9. The requested service is not consistent with the *ODG* criteria for selective nerve root block and MAC anesthesia.

10. The requested selective nerve root block and MAC anesthesia is not 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that selective nerve root block and MAC anesthesia is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to selective nerve root block and MAC anesthesia for the compensable injury of _____.

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 Section 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

RUSSELL OLIVER, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 9th day of March, 2009.

Erika Copeland
Hearing Officer