MEDICAL CONTESTED CASE HEARING NO. 09204
M6-09-17069-01

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 June 22, 2009 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a cervical epidural steroid injection at C5 and C6 for the compensable injury of ___________?

PARTIES PRESENT

Claimant appeared and was assisted by SF-G, ombudsman. Petitioner/Provider Dr. KB appeared as a witness in this matter. Respondent/Carrier appeared and was represented by HW, adjuster.

BACKGROUND INFORMATION

Claimant was employed as a bus driver for the claim employer. Claimant sustained compensable injuries to her left shoulder, cervical spine, and lumbar spine when she slipped and fell while coming down the steps of the school bus. Claimant underwent a left shoulder rotator cuff repair on December 13, 2007 and subsequent to the surgery the doctor continued to note pain in the shoulder, weakness, neck pain, and arm pain. The claimant's orthopedic surgeon, Dr. KB, ordered an MRI of the cervical spine and diagnosed the claimant with a C5-C6 disc protrusion. The medical records indicate that the claimant underwent conservative care for her cervical spine and continued to complain of symptoms related to her neck. Dr. B ordered an epidural steroid injection to help alleviate the claimant's pain complaints.

After Dr. B requested pre-authorization for the cervical epidural steroid injection at C5-C6, two utilization reviews were conducted. Both URAs denied the request because the medical documentation did not show consistent evidence of radiculopathy. Dr. B appealed the carrier's decision to an IRO. The IRO upheld the carrier's denial and provided the same reason, no consistent evidence of radiculopathy.

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 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. The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the ODG.

With regard to epidural steroid injections, the ODG provides as follows:

> 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) 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.

Claimant's requesting doctor, KB, M.D., a board certified orthopedic surgeon, testified that the claimant meets the criteria outlined in the ODG regarding radiculopathy and meets the criteria for a therapeutic epidural steroid injection. Dr. B testified that the claimant's MRI that was done on August 15, 2008 revealed a C5-C6 disc protrusion and that the claimant's physical examination revealed radiculopathy based on the dermatomal distribution. Dr. B provided testimony and documentary evidence concerning the definition of radiculopathy that is found in the ODG which is the definition found in the Fifth edition of the AMA Guides. Dr. B stated that the claimant had shoulder pain and arm pain that followed the C5-C6 nerve root. He testified and the medical records indicated that she had parasthesia and sensory changes. He also noted that the claimant had a positive Spurling sign. Dr. B testified and the medical records indicate that she has undergone physical therapy and received conservative treatment including medications. Claimant testified that she continues to be symptomatic and she hopes that the injection will alleviate some of her pain. The medical evidence and testimony presented supports consistent evidence of radiculopathy. Dr. B's testimony supports the medical necessity of the epidural steroid injection and constitutes evidence based medicine which outweighs the findings of the IRO.

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).

   C. Claimant sustained a compensable injury on ___________.

   D. The Independent Review Organization (IRO) determined that the claimant should not have a cervical epidural steroid injection at C5 and C6.

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 medical evidence presented supports consistent evidence of radiculopathy.

3. A cervical epidural steroid injection at C5 and C6 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 decision of the IRO that a cervical epidural steroid injection at C5 and C6 is not health care reasonably required for the compensable injury of ___________.

DECISION

Claimant is entitled to a cervical epidural steroid injection for the compensable injury of ___________.

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 insurance carrier is **TASB RISK MANAGEMENT FUND** and the name and address of its registered agent for service of process is:

TASB RISK MANAGEMENT FUND
JAMES B. CROW, SECRETARY
12007 RESEARCH BLVD.
AUSTIN, TX 78759

Signed this 6th day of July, 2009.

Jacquelyn Coleman
Hearing Officer