MEDICAL CONTESTED CASE HEARING NO. 11116
M6-11-31523-01

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 March 10, 2011 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that the Claimant is not entitled to a lumbar epidural steroid injection at L4-L5 for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by JO, ombudsman. Petitioner/Provider Dr. B appeared as a witness in this matter. Respondent/Carrier appeared and was represented by RM, adjuster.

BACKGROUND INFORMATION

Claimant's right foot got caught in a rug on _____. Claimant tripped over the rug and twisted her right knee and injured her lumbar spine. Claimant was diagnosed with a right knee medial meniscus tear and disc bulges at L4-L5 and L5-S1. Dr. B also diagnosed Claimant with right-sided L4-L5 radiculitis. As it relates to her lumbar spine, Claimant received physical therapy and oral anti-inflammatory medications which provided temporary relief. However, due to continuing symptoms, Dr. B recommended a lumbar epidural steroid injection (ESI) in conjunction with physical therapy. Dr. B's request was denied twice by the Carrier's utilization review agents (URAs), Dr. B (2) and Dr. A.

Dr. B (2), a physical medical and rehabilitation specialist, performed a preauthorization review for the medical necessity of the ESI on November 11, 2010. Dr. B (2) denied Dr. B's request for the lumbar ESI because there was no documented evidence of radiculopathy. Dr. B (2) specifically stated that "there is no documentation of a compressive lesion upon any of the neural elements in the lumbar spine that would be responsible for the presence of a lumbar radiculopathy."

Dr. B submitted a request for reconsideration to the Carrier. The request for reconsideration was reviewed by Dr. A, an orthopedic surgeon, on November 22, 2010. Dr. A also denied the request for an ESI injection because there was no documented evidence of radiculopathy. Dr. A provided three specific reasons for his denial of the ESI injection: (1) "The MRI report describes an annular disc bulge but does not describe significant neural foraminal stenosis that would be the etiology of her reported leg pain." (2) "Reportedly she complains of diffuse numbness and weakness throughout the entire leg which would not fit a typical dermatomal pattern." (3) "Her examination fails to demonstrate true objective signs of radiculopathy."

Dr. B requested an Independent Review Organization (IRO) to review Carrier's non-certification of the requested treatment. The IRO upheld the Carrier's denial and provided a rationale similar to the Carrier's URAs for its decision. Dr. B appealed the IRO decision to a Medical Contested Case Hearing.

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 in making decisions about the care of individual patients. 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 (t), "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."

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.

The IRO provided a summary of the information contained in the medical records and the following analysis and explanation of its decision:

> "I agree with the previous reviewers that the patient does not have established lumbar radiculopathy in order to warrant consideration for epidural injection. The lumbar spine MRI from May 7, 2010 does not reveal frank neural compression. Examinations have repeatedly revealed the patient to be neurologically intact. Right lower extremity weakness has been attributed to the patient's right knee condition and subsequent postsurgical status. Without an indication of lumbar radiculopathy, proceeding with a lumbar epidural steroid injection is not indicated. Further, the patient was declared to be at maximum medical improvement as of October 30, 2010. Therefore, my determination is to uphold the previous non-certifications for a lumbar epidural steroid injection."

Dr. B testified that the Claimant met all of the criteria found in the ODG to establish the medical necessity of the lumbar epidural steroid injection. Dr. B testified that his physical examination correlated with the findings on the MRI dated May 7, 2010. The MRI revealed disc bulges at L4-L5 and L5-S1 without herniation or neural compression. However, Dr. B testified that he personally reviewed the films and the MRI shows encroachment, atrophy, and a disc bulge at L4-L5. Dr. B stated that Claimant has evidence of nerve compression based on the MRI findings. Dr. B also stated that Claimant's physical examinations revealed a positive straight leg raise and a dermatomal distribution of weakness from the L4-L5 disc bulge. According to Dr. B, Claimant has also complained of diminished sensation, numbness, and tingling in her right lower extremity. A review of his medical reports dated October 26, 2010 and November 23, 2010 indicate that Claimant presented to Dr. B with complaints related to her right lower extremity. However, in both reports Dr. B attributes these symptoms to the right knee medial meniscus tear for which Claimant underwent surgery on November 17, 2010.

Dr. B also relied on an EMG that was performed on January 15, 2011 by Dr. P to support his testimony concerning medical evidence of radiculopathy. The EMG results indicated that Claimant has a right L4 nerve root irritation. Dr. B testified that the EMG confirms that Claimant has radiculopathy. Although the EMG indicates that there is evidence of radiculopathy, at the time of the IRO decision the EMG had not yet been performed. In accordance with Appeals Panel Decision 100379 and MCCH Decision M6-08-10212-01, in order to determine the medical necessity of the proposed treatment, the Hearing Officer cannot consider medical evidence that did not exist at the time of the IRO review. However, Dr. B could resubmit the request for the ESI injection with the results of the EMG.

When all of the evidence was reviewed, the IRO's decision was supported by a preponderance of evidence-based medical evidence. The Claimant and Petitioner failed to present evidence consistent with the requirement of Section 401.011(22-a) to establish that the preponderance of the evidence is contrary to the decision of the IRO dated December 20, 2010. Therefore, the decision of the IRO is upheld.

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 Claimant should not have a lumbar epidural steroid injection.

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. A lumbar epidural steroid injection at L4-L5 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that a lumbar epidural steroid injection at L4-L5 is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to a lumbar epidural steroid injection at L4-L5 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 §408.021.

The true corporate name of the insurance carrier is **HARTFORD INSURANCE COMPANY OF THE MIDWEST** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET #620
AUSTIN, TX 78701

Signed this 14th day of March, 2011.

Jacquelyn Coleman
Hearing Officer