MEDICAL CONTESTED CASE HEARING NO. 13003
M6-12-39933-01

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 August 20, 2012 to decide the following disputed issue:

> Is the preponderance of the evidence-based medical evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, single level (L4-5), for the compensable (Date of Injury) injury?

PARTIES PRESENT

Petitioner/Provider, Dr. KB, appeared by telephone. Claimant appeared and was assisted by PB, ombudsman. Carrier/Respondent appeared and was represented by RJ, attorney.

BACKGROUND INFORMATION

It was undisputed that the Claimant sustained a compensable lumbosacral spine injury on (Date of Injury) while working as a utility line locator for (Employer). The evidence showed that her injury occurred as she pulled on a manhole cover to open it, which caused her to feel a pop in her back. She continued to work until her low back pain became unbearable. The record reflects that the Claimant has experienced pain in her legs, with no numbness or tingling. The record also reflects, however, that the Claimant sustained two other injuries close in time relative to the injury herein – one occurred a week before the injury herein, and the other occurred approximately three weeks after the injury herein. One of those injuries was to her ankles, and the other injury apparently affected her knees, and she has had surgery upon her knees. It thus is not clear that the leg pain that the Claimant has experienced is due to the (Date of Injury) low back injury. This is pivotal, because the disputed procedure is not indicated if the patient has radiculopathy.

Dr. KB, who is a board certified orthopedic surgeon, first saw the Claimant on January 23, 2012. The Claimant had been referred to Dr. B by Dr. GW after having had physical therapy and other conservative treatment. Dr. B's physical examination reflected primarily axial mechanical back

pain, and her motor strength and sensation were intact. He was provided an EMG report that Dr. Wali had ordered and was performed on December 9, 2010, which showed findings most consistent with chronic bilateral S1 root irritation, consistent with radiculopathy. Dr. B's diagnosis for the Claimant is lumbar facet syndrome, left L4 and left L5, and he recommended that Clamant undergo a medial branch block at her left L4 and L5 levels. Dr. B's request was denied twice by the Carrier's utilization review agents. Their denials were upheld by the IRO, who is a board certified anesthesiologist. The IRO denied Dr. B's request because the Claimant's records reflected that prior to 2012, she had findings consistent with radiculopathy. The IRO also noted that since the injury was two and a half years old, and if the injury had a legitimate facet aspect to her pain, then a prior facet injection may have been attempted. Dr. B appealed the IRO's 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 is 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 facet joint medial branch blocks (therapeutic injections), the ODG provides as follows:

> Not recommended except as a diagnostic tool. Minimal evidence for treatment.
>
> *Pain Physician 2005: In 2005 Pain Physician* published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2½ year study period (8.4 ± 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids that those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to *Pain Physician.*] The average relief per procedure was 11.9 ± 3.7 weeks.
>
> **Pain Physician 2007:** This review included an additional randomized controlled trial. (Manchikanti2, 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (Boswell2, 2007) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection

> performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). See also Facet joint intra-articular injections (therapeutic blocks).

For facet joint diagnostic blocks, which Dr. B testified is his purpose for wanting to perform the procedure on the Claimant, the ODG provides as follows:

> 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)
>
> ***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)

(11) 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 points of conflict between the IRO's opinion and Dr. B's opinion are whether the Claimant has radiculopathy, and whether she has previously undergone a facet joint block for this injury. According to Dr. B's testimony, which was persuasive, the answer to both questions is "no". Dr. B testified that the Claimant meets all the criteria for a facet joint diagnostic block, and that she has not previously had one. He also testified that an S1 root irritation, as reflected in the Claimant's December 9, 2010 EMG, does not necessarily equate to a radiculopathy. Moreover, the EMG and other testing that arguably reflect radiculopathy were prior to 2012, according to Dr. B's testimony. Dr. B testified that since he began treating the Claimant in early 2012, her sensory examinations have been intact and straight leg testing only produces back pain. After a careful review of the entire record, it is determined that

Dr. B's testimony supports the medical necessity of the disputed procedure for diagnostic purposes at a single level (L4-5). Dr. B has shown by a preponderance of evidence-based medical evidence that the requested procedure for diagnostic purposes is health care reasonably required for the compensable injury. It is, therefore, determined that the preponderance of the evidence-based medical evidence is contrary to the IRO decision.

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 present 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 had workers' compensation insurance coverage with Liberty Insurance Corp., Carrier.

D. On (Date of Injury), the Claimant sustained a compensable lumbosacral spine injury while in the course and scope of her employment with U.S. Infrastructure Corp.

2. Carrier delivered to Claimant and Petitioner 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 1.

3. Diagnostic injection(s), paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, single level (L4-5), is 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-based medical evidence is contrary to the decision of the IRO that diagnostic injection(s), paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, single level (L4-5), is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to diagnostic injection(s), paravertebral facet (zygapophysial) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral, single level (L4-5) for the compensable injury of (Date of Injury).

ORDER

Respondent/Carrier is **ORDERED** to pay medical benefits in accordance with this decision, the Act and the implementing Rules.

The true corporate name of the insurance carrier is **LIBERTY INSURANCE CORPORATION,** and the name and address of its registered agent for service of process is:

CORPORATION SERVICES COMPANY
211 E. 7TH STREET, STE. 620
AUSTIN, TX 78701

Signed this 17th day of September, 2012.

Patrice Fleming-Squirewell
Hearing Officer