MEDICAL CONTESTED CASE HEARING NO. 18020

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. For the reasons discussed herein, the Administrative Law Judge (ALJ) determines that:

Claimant is not entitled to in-office left sacroiliac joint injection under fluoroscopy with monitored sedation.

ISSUES

A contested case hearing was held on August 14, 2018 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to in-office left sacroiliac (SI) joint injection under fluoroscopy with monitored sedation?

PARTIES PRESENT

Petitioner/Claimant (Claimant) was present, and assisted by KP, ombudsman.
Respondent/Carrier (Carrier) appeared and was represented by JL, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant.

For Carrier: None.

The following exhibits were admitted into evidence:

> Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.
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> Claimant's Exhibits C-1 through C-5. C-6 was not admitted.
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> Carrier's Exhibits CR-A through CR-C.

BACKGROUND INFORMATION

Claimant sustained a compensable injury on (Date of Injury). A prior Decision and Order was admitted into evidence, which explains Claimant's mechanism of injury. The parties stipulated that Claimant's compensable injury extends to and includes a lumbar sprain/strain and aggravation of the sacroiliac (SI) joint. Claimant credibly testified that over the last six years she has received approximately 12 SI joint injections, which provided long lasting pain relief. Claimant further testified that she is now on an anti-inflammatory medication, prescribed by her physician. Finally, Claimant explained that she continues to be prescribed the same dosage and amount of Norco, to be used as needed, such as when she is unable to receive SI joint injections.

Claimant's pain management doctor requested pre-authorization for a left SI joint injection, under sedation, with fluoroscopy. On January 16, 2018, a Utilization Review resulted in an adverse determination. It was determined that the Official Disability Guidelines (ODG) do not support SI joint injections for non-inflammatory SI pathology, and Claimant's medical records do not diagnose inflammatory SI disease. Additionally, there was no documentation of a decreased use of pain medication after the multiple SI joint injections as required by the ODGs to support a repeat injection.

On April 30, 2018, a subsequent Utilization Review resulted in an adverse determination. It was determined again that the ODGs do not support SI joint injections for non-inflammatory SI pathology, and Claimant's medical records do not diagnose inflammatory SI disease. Additionally, there was no documentation of a decreased use of pain medication after the multiple SI joint injections as required by the ODGs to support a repeat injection. This determination was upheld on May 4, 2018.

On June 4, 2018, an Independent Review Organization determination was issued, in which the prior adverse determinations were upheld.

Carrier argued the IRO determination was supported by the medical evidence.

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. 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(s), "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."

The ODG Hip and Pelvis (Acute and Chronic) Chapter provides as follows in the entry related to sacroiliac injection - therapeudic –

> Not recommended (neither therapeutic sacroiliac intra-articular nor periarticular injections) for non-inflammatory sacroiliac pathology, based on insufficient evidence. Recommended on a case-by-case basis as injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Current research is minimal in terms of trials of any sort that support the use of therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory pathology. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with injections for inflammatory spondyloarthropathy, although most rheumatologists now utilize biologic treatments (anti-TNF and/or disease modifying antirheumatic drugs) for treatment.

Current research and reviews available:

Chou et al., 2009: This is a systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center that states that there is insufficient evidence to evaluate validity or utility of therapeutic sacroiliac joint blocks. (*Chou, 2009*)

Vanelderen et al., 2010: These authors indicate that SI joint intra-articular injections may provide good pain relief for periods of up to 1 year, but give no reference to support this. They indicate periarticular sources of pain should be considered for treatment in addition to intra-articular injections. They describe in detail the Luukkainen et al. randomized trial of 24 patients who received periarticular injections with one month follow up (see below). (*Luukkainen, 2002*) They also cite Maugars et al.; a double-blind study evaluating SI joint injections for patients with spondyloarthropathy. The authors recommend intra-articular injections of local corticosteroid. (*Vanelderen, 2010*) (*Luukkainen, 2002*) (*Maugars, 1996*)

Hansen et al., 2012: Evidence was considered limited (or poor) for short-term and long-term relief from intra-articular steroid injections or periarticular injections. (*Hansen, 2012*)

Manchikanti et al., 2013: Evidence was considered limited for SI joint and periarticular injections. (*Manchikanti, 2013*)

Cohen et al., 2013: Cohen, et al. indicated that evidence for intra-articular injections was weak. They indicated there was moderate evidence supporting intra-articular injections for spondyloarthropathy and anecdotal evidence for beneficial effect in non-spondyloarthropathy pain. The authors listed a prospective study by Fischer et al., that found a mean duration of benefit of 12 months for *juvenile* patients with spondyloarthropathy who failed to respond to NSAIDs (a German language study). They also listed a study by Hanley et al., that examined 13 patients with inflammatory spondyloarthropathy and MRI evidence of sacroiliitis (the authors of this study indicated the injections were ineffective). The Maugars study was also cited. (*Cohen, 2013*) (*Fischer, 2003*) (*Hanley, 2000*) (*Maugars, 1996*)

Itz et al, 2015: This is the Dutch Multidisciplinary Guideline for Invasive Treatment for Pain Syndromes of the Lumbosacral Spine. This group recommended intra-articular SI joint injections as “only study related” (because no literature is available, or case reports are insufficient to indicate effectiveness or safety to give a clear recommendation for practice). The two studies cited for

support are those by Luukkainen, et al. and Maugars, et al. (*Itz, 2015*) (*Luukkainen, 2002*) (*Maugars, 1996*)

Chou et al., 2015: This is a report from the Agency for Healthcare Research and Quality. The evidence was considered insufficient to evaluate sacroiliac joint corticosteroid injections. The one study cited was Luukainen et al. (*Chou, 2015*) (*Luukkainen, 2002*)

Kennedy et al., 2015: A review was undertaken as a contribution to a multi-society Appropriate Use Criteria Task Force project convened by the International Spine Intervention Society to assess effectiveness of intra-articular steroid injections in treating SI joint pain. Two randomized controlled trials were cited to support moderate strength recommendation for this treatment. The first was Maugars et al., 1996, and the second (Kim et al., 2010) was a study comparing intra-articular prolotherapy versus steroid injection. The authors of the Kim et al., study found that prolotherapy was a more successful therapy. Several observational studies were also cited. (*Maugars, 1996*) (*Kim, 2010*)

Other case series of intra-articular blocks for non-inflammatory pathology:

Lillang et al., 2009: This is a prospective case series of 39 patients who underwent dual diagnostic intra-articular blocks. Twenty-six (66.7%) experienced pain relief of greater than 50% for 5 weeks. Thirteen patients (33.3%) responded for a shorter-term period (mean 4.4 ± 1.8 weeks). Risk factors for shorter term response included history of lumbosacral spinal fusion. (*Lillang, 2009*)

Research on periarticular or combined periarticular/intra-articular injections:

Luukkainen et al., 2002: This study, which is double-blind and controlled, is commonly cited to support periarticular injections. Twenty-four patients were treated with periarticular injections (13 with steroid and local and 11 with saline and local). Follow up was at 1 month with improvement in the steroid group. (*Luukkainen, 2002*)

Borowsky et al., 2008: This was a retrospective review of 2 large case series. Patients receiving intra-articular injections alone had a positive response (defined as a 50% drop in VAS pain score or a report that activities of daily living had "greatly improved") at 3 months of 12.5% versus 31.25% for the combined injections. The authors suggested that significant extra-articular sources of sacroiliac region pain existed and that intra-articular diagnostic blocks underestimated the prevalence of sacroiliac region pain. (*Borowsky, 2008*)

Research on intra-articular injections for inflammatory spondyloarthropathy (in adults):

Hanly et al., 2000: This is a study of 19 patients with symptoms of inflammatory low back pain. Thirteen had radiographic evidence of sacroiliitis. All patients received bilateral SI joint injections with steroid. Transient improvement was most pronounced at 1-3 months after injection. This did not reach statistical significance by 6 months. The author's conclusion was that the injections were ineffective in the management of patients with inflammatory spondyloarthropathy. (*Hanly, 2000*)

Maugars, 1996: This is a double-blind study of 10 patients (13 injections) with painful sacroiliitis. In 5/6 joints injected in the treatment group the patients had relief of > 70% compared to 0/7 in the placebo group at one month. Re-injection with corticosteroid occurred at one month with inclusion of 6/7 of the placebo group. Results of this combined group showed 58% success at 6 months. (*Maugars, 1996*)

Bollow et al., 1996: Sixty-six patients with inflammatory back pain were treated with CT-guided corticosteroid injections. Statistically significant abatement of subjective complaints occurred in 92.5%. at 1.7 ± 1.1 weeks with improvement lasting for 10 ± 5 months. (*Bollow, 1996*)

The IRO doctor, a physician who practices in the area of pain management, determined that Claimant did not meet the recommended criteria of the ODG for an in-office left SI joint injection under fluoroscopy with monitored sedation. Specifically, in 2015 the ODG was updated with respect to SI injections, in that the pathophysiology of the sacroiliac dysfunction needed to be clearly stated. Additionally, the IRO doctor explained that the evidentiary basis for approval of SI injections was now the presence of an inflammatory or rheumatic mechanism.

Based on the evidence presented, Claimant did not meet her burden of proof to overcome the decision of the IRO by a preponderance of evidence-based medical evidence. As a preponderance of the evidence is found not to be contrary to the decision of the IRO that the requested in-office left sacroiliac (SI) joint injection under fluoroscopy with monitored sedation is not health care reasonably required for the compensable injury of (Date of Injury), Claimant is held not to be entitled to that procedure.

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. The Texas Department of Insurance, Division of Workers' Compensation has jurisdiction to hear this matter.

   B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   C. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   D. On (Date of Injury), Employer provided workers' compensation insurance as a self-insured, administered through TASB Risk Management Fund, Carrier.

   E. On (Date of Injury), Claimant sustained a compensable injury.

   F. The compensable injury of (Date of Injury), extends to and includes lumbar sprain/strain and aggravation of the sacroiliac joint.

   G. The Independent Review Organization (IRO) determined that Claimant should not have the requested treatment of in-office left sacroiliac (SI) joint injection under fluoroscopy with monitored sedation.

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 Administrative Law Judge's Exhibit Number 2.

3. The preponderance of the evidence is not contrary to the decision of the Independent Review Organization that Claimant is not entitled to in-office left sacroiliac joint injection under fluoroscopy with monitored sedation.

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. Claimant is not entitled to in-office left sacroiliac joint injection under fluoroscopy with monitored sedation.

DECISION

Claimant is not entitled to in-office left sacroiliac joint injection under fluoroscopy with monitored sedation.

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 **TEXAS ASSOCIATION OF SCHOOL BOARDS (TASB) RISK MANAGEMENT FUND** and the name and address of its registered agent for service of process is:

JAMES B. CROW
7703 N. LAMAR
AUSTIN, TEXAS 78752

Signed this 15th day of August, 2018.

Amber Morgan
Administrative Law Judge