MEDICAL CONTESTED CASE HEARING NO. 14032

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 November 12, 2013 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 epidural steroid injections at C2-C3, C3-C4, and C4-C5 (62318 and 77113), for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by SB, ombudsman.
Respondent/Carrier appeared and was represented by SS, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable injury to her cervical spine and lumbar spine on (Date of Injury) when her vehicle was rear-ended by another vehicle. Dr. SB performed a cervical fusion and discectomy on March 5, 1997. Claimant began treating with a pain management specialist, Dr. MR, on March 1, 1999 for pain complaints from head to toe after her surgery. Dr. R recommended cervical epidural steroid injections that were performed on April 20, 1999. Since that time, Claimant has continued to treat with Dr. R for pain management. Her current treatment consists of oral medications and a morphine pain pump. Dr. R recommended three epidural steroid injections at C2-C3, C3-C4, and C4-C5. Dr. F recommended the epidural steroid injections to reduce the claimant's pain complaints. Dr. R's request was denied twice by the carrier's utilization review agents and their denial was upheld by the Independent Review Organization (IRO).

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. 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 is considered a party 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.

Claimant testified concerning the medical treatment that she has received for her compensable injury. Claimant also testified about her current pain complaints and how her injury affects her activities of daily living. Claimant also presented the testimony of Dr. R to support the medical necessity of the cervical epidural steroid injections. Dr. R testified that the epidural steroid injections that were previously done did provide Claimant with approximately 25% to 50% pain relief. Dr. R testified that Claimant is currently on medications and using a pain pump which have helped, but the current treatment is not enough to bring down Claimant's pain level. Dr. R testified concerning how the epidural steroid injections are performed. He also explained that there was no objective evidence of radiculopathy on physical examination or on the diagnostic testing. Dr. R stated that it is his medical opinion that the epidural steroid injections are medically necessary for Claimant's cervical spine.

The testimony of the Claimant and Dr. R was considered. The medical records in evidence were also reviewed. However, based on the evidence presented, all of the ODG requirements for the requested cervical epidural steroid injections are not met in this case. There was also no evidence-based medical evidence presented to support departing from the guidelines. Since all of the ODG requirements for the requested procedure have not been met and since no other evidence-based medical evidence was put forth in support of the necessity of the proposed procedures, Petitioner/Claimant has failed to prove 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 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. Claimant sustained a compensable injury on (Date of Injury).

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. Cervical epidural steroid injections at C2-C3, C3-C4, and C4-C5 are not 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 is not contrary to the decision of the IRO that cervical epidural steroid injections at C2-C3, C3-C4, and C4-C5 are not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to cervical epidural steroid injections at C2-C3, C3-C4, and C4-C5 for the compensable injury of (Date of Injury).

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 **HIGHLANDS INSURANCE COMPANY** and the name and address of its registered agent for service of process is:

PRIME TEMPUS, INC., SPECIAL DEPUTY RECEIVER
CRAIG A. KOENIG
27310 RANCH ROAD 12
DRIPPING SPRINGS, TEXAS 78620

Signed this 21st day of November, 2013.

Jacquelyn Coleman
Hearing Officer