MEDICAL CONTESTED CASE HEARING NO. 09207
M6-09-19601-01

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 July 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 injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic) for the compensable injury of _____.

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by LJ, ombudsman.
Respondent/Carrier appeared and was represented by JM, adjuster.

BACKGROUND INFORMATION

Claimant testified her doctors are proposing a cervical epidural steroid injection to relieve the swelling between the discs. They told her there is no other treatment that will help until the swelling is reduced. Carrier's utilization review doctors disagreed with the treating doctors over the medical necessity for the treatment, based upon the Official Disability Guidelines. The IRO doctor agreed with the denial of the proposed injection.

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.

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, 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 Official Disability Guidelines.

Under the Official Disability Guidelines in reference to injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic), the following recommendation is made:

> 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.

Criteria for the use of Epidural steroid injections, diagnostic:

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

Pursuant to the Official Disability Guidelines recommendations, cervical epidural steroid injections are indicated if there is documented radiculopathy and when the patient is initially unresponsive to conservative treatment such as physical therapy. In this case, the requesting physician documented left-sided numbness and weakness supported by a positive EMG showing mild radiculopathy at the left C5/6 nerve root. Additionally, Claimant tried physical therapy for 13-15 visits with some success until the treatments were completed. However, the Claimant offered no opinion or report from a qualified doctor to rebut the determination of the IRO or explain how the Claimant meets the criteria in the Official Disability Guidelines for a cervical epidural steroid injection. Based on the evidence presented, the Claimant failed to offer evidence based medicine sufficient to contradict the determination of the IRO. The preponderance of the evidence is not contrary to the decision 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 a volunteer fire fighter for (County).

C. On _____, Claimant sustained a compensable injury.

D. The Independent Review Organization determined Claimant should not have an injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic).

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. An injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic) 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 an injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic) is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to an injection spine C/T epidurography anesth N block/injection prone and flouroguide (cervical epidural steroid injection, therapeutic) for the compensable injury of _____.

ORDER

Carrier is/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 **(SELF-INSURED)** and the name and address of its registered agent for service of process is

KN, EXECUTIVE DIRECTOR
(SELF-INSURED)
(ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 22nd day of July, 2009.

KEN WROBEL
Hearing Officer