

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 September 28, 2009 to decide the following disputed issue:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to a right L2, L3 median nerve radiofrequency thermocoagulation (RFTC) for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by SG, ombudsman. Respondent/Carrier appeared and was represented by GS, attorney.

BACKGROUND INFORMATION

It was undisputed that the Claimant sustained a compensable injury to his lumbar spine on _____ when he jumped approximately 12 to 14 feet off of a roof after the ladder he was using was blown over due to heavy wind. Claimant underwent a lumbar laminectomy and fusion with hardware at L4-L5 in December 1998 by Dr. E. In December 1999, because of complaints of worsening pain, Dr. E performed surgery upon the Claimant again to remove the hardware. The Claimant has received treatment in the form of a pain pump, which was implanted in 2000, and he has received some lumbar injections. Dr. G is the Claimant's pain management doctor, who has seen the Claimant regularly for refills of the medications given through the pump. Medical records in evidence show that Dr. G has previously performed bilateral lumbar median nerve RFTC's upon the Claimant at L1, L2, L3, L4, L5 and S1. Dr. G requested to perform a right L2, L3 median nerve RFTC upon the Claimant in April 2009, which was denied twice by the Carrier. Dr. G requested review by an IRO, who determined that the recommended treatment was not medically necessary.

The IRO reviewer, a board certified anesthesiologist with a subspecialty in pain medicine, upheld the Carrier's adverse determination noting that the Claimant underwent a right L4 and L5 (and possibly an S1) medial branch radiofrequency ablation (RFA) on March 9, 2009, and a left L5 and S1 medial branch RFA on March 23, 2009, and that the records show that the Claimant received no therapeutic benefit from these given his complaints of significant pain shortly thereafter. The IRO reviewer also noted that as to the requested procedure at L2 and L3, there were no records provided showing any previous diagnostic medial branch blocks done in the area to diagnose the facet joint as the pain generator, nor was there documentation provided showing that the requested procedure has previously been performed in the area and provided significant relief to the Claimant, which should be documented to be greater than 50% of his pain for 12

weeks. The IRO reviewer cited the *Official Disability Guidelines* (ODG) as the basis for the determination.

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 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 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."

Pursuant to the ODG, the recommendations for facet joint radiofrequency neurotomy are as follows:

Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics). Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.

Current research: Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. ([Hooten, 2005](#)) ([van Kleef, 1999](#)) ([Boswell, 2005](#)) ([Leclaire, 2001](#)) ([Van Kleef, 1999](#)) ([Gallagher, 1994](#)) ([van Wijk, 2005](#)) A recent small RCT found that the percutaneous radiofrequency neurotomy treatment group showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacro-iliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment,

and it provided relief for only one component of the patients' pain. (Nath, 2008) *Observational Trials:* One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007)

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported “sparse evidence” to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiskal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)

Technique: There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.

Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery.

Factors associated with success: Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)

Duration of pain relief: One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)

Complications: Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti, 2003) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); Facet joint intra-articular injections (therapeutic blocks). Also see Neck Chapter and Pain Chapter.

Criteria for use of facet joint radiofrequency neurotomy:

- (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).
- (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at $\geq 50\%$ relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.
- (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
- (4) No more than two joint levels are to be performed at one time.
- (5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
- (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

The Claimant testified that he continues to suffer from significant pain and symptoms due to this injury which prevent him from doing most activities. He provided medical records that showed that he has received RFTC's previously performed by Dr. G, but the evidence does not show that he has had at least 50% reduction of pain for at least 12 weeks duration from these procedures. He did not present any information from Dr. G showing how he meets the criteria in the ODG, especially in the face of the IRO decision stating that he does not meet the criteria. On this basis, it is determined that the Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision regarding the requested procedure. Therefore, it is concluded that the Claimant has not met the requisite evidentiary standard required to overcome the IRO decision and that the preponderance of the evidence is not contrary to the IRO decision that the Claimant is not entitled to a right L2, L3 median nerve RFTC for his compensable _____ injury.

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 _____, the Claimant was the employee of (Employer).
 - C. On _____, Employer had workers' compensation insurance coverage with U.S. Fidelity & Guaranty Co., Carrier.
 - D. On _____, the Claimant sustained a compensable injury to his lumbar spine.

- E. The IRO report dated June 29, 2009 upheld the Carrier's adverse determination herein regarding a right L2, L3 median nerve RFTC for the Claimant's compensable _____ 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 1.
 3. The Claimant failed to prove that he meets the requirements in the ODG for a right L2, L3 median nerve RFTC and the requested procedure is not consistent with the recommendations in the ODG.
 4. The requested right L2, L3 median nerve RFTC 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 right L2, L3 median nerve RFTC is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to a right L2, L3 median nerve RFTC for the compensable injury of _____.

ORDER

The Carrier is not liable for the benefits at issue in this hearing. The Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is the **UNITED STATES FIDELITY AND GUARANTY COMPANY**, and the name and address of its registered agent for service of process is:

**CORPORATION SERVICE COMPANY
701 BRAZOS, STE. 1050
AUSTIN, TX 78701**

Signed this 13th day of October, 2009.

Patrice Fleming-Squirewell
Hearing Officer