NOTICE OF INTENT

Workforce Commission
Office of Workers' Compensation

Medical Treatment Guidelines
(LAC 40: I.2007, 2021, 2113)

The Louisiana Workforce Commission does hereby give notice of its intent to amend certain portions of the Louisiana Administrative Code, Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapter 20 and Chapter 21 regarding medical treatment guidelines. The purpose of this amendment is to update the medical treatment guidelines in accordance to a reoccurring maintenance schedule and add consistency throughout the guidelines. This Rule is promulgated by the authority vested in the assistant secretary of the Office of Workers' Compensation found in La. R.S. 23:1291 and La. R.S. 23:1310.7.

Title 40
LABOR AND EMPLOYMENT
Part I. Workers' Compensation Administration
Subpart 2. Medical Guidelines

Chapter 20. Spine Medical Treatment Guidelines
Subchapter A. Cervical Spine Injury
Editor's Note: Form LWC-WC 1009. Disputed Claim for Medical Treatment has been moved to §2328 of this Part.

§2007. Follow-Up Diagnostic Imaging and Testing Procedures

A. - C.2.c.iii. …

d. Provocation Discography

i. Description. Discography is not recommended for use in the cervical spine. ~~an accepted, but rarely indicated, invasive diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. Discograms have a significant false positive rate. It is essential that all indications, preconditions, special considerations, procedures, reporting requirements, and results, are carefully and specifically followed. Results should be interpreted judiciously. Fewer studies have been published on cervical and thoracic discography than on lumbar discography.~~

~~ii. Indications. Discography may be indicated when a patient has a history of functionally limiting, unremitting cervical pain of greater than four months duration, with or without arm pain, which has been unresponsive to all conservative interventions. A patient who does not desire operative therapeutic intervention is not a candidate for an invasive non-therapeutic intervention, such as provocation discography.~~

~~iii. Discography may prove useful for the evaluation of the pre-surgical spine, discogenic pain at levels above or below a prior spinal fusion, annular tear, or internal disc disruption.~~

~~iv. Discography may show disc degeneration and annular disruption in the absence of cervical pain. Discography may also elicit concordant pain in patients with mild and functionally inconsequential neck pain. Because patients with mild neck pain should not be considered for invasive treatment, discography should not be performed on these patients. The presence of an annular tear does not necessarily identify the tear as a pain generator.~~

~~v. Discography is not useful in previously operated discs. Discography may prove useful in evaluating the number of cervical spine levels that might require fusion. CT Discography provides further detailed information about morphological abnormalities of the disc and possible lateral disc herniations.~~

~~vi. Preconditions for provocation discography include all of the following:~~

~~(a). A patient with functionally limiting, unremitting neck and/or arm pain of greater than four months duration in whom conservative treatment has been unsuccessful and in whom the specific diagnosis of the pain generator has not been made apparent on the basis of other noninvasive imaging studies (e.g., MRI, CT, plain films, etc.). It is recommended that discography be reserved for use in patients with equivocal MRI findings, especially at levels adjacent to clearly pathological levels. Discography may be more sensitive than MRI or CT in detecting radial annular tears. However, radial tears must always be correlated with clinical presentation.~~

(b). Psychosocial evaluation has been completed. There is some evidence that false positives and complaints of long-term pain arising from the procedure itself occur more frequently in patients with somatoform disorders. Therefore, discograms should not be performed on patients with non-anatomic symptoms consistent with somatoform disorders.

(c). Patients who are considered surgical candidates (e.g., symptoms are of sufficient magnitude and the patient has been informed of the possible surgical options that may be available based upon the results of discography). Discography should never be the sole indication for surgery.

(d). Informed consent regarding the risks and potential diagnostic benefits of discography has been obtained.

vii. Complications include, but are not limited to, discitis, nerve damage, retropharyngeal abscess, chemical meningitis, pain exacerbation, and anaphylaxis. Therefore, prior to consideration of discography, the patient should undergo other diagnostic modalities in an effort to define the etiology of the patient's complaint including psychological evaluation, myelography, CT and MRI.

viii. Contraindications include:

(a). active infection of any type or continuing antibiotic treatment for infection; and/or

(b). bleeding diathesis or pharmaceutical anticoagulation with warfarin, etc.; and/or

(c). significant spinal stenosis at the level being studied as visualized by MRI, myelography or CT scan; and/or

(d). presence of clinical myelopathy; and/or

(e). effacement of the cord, thecal sac or circumferential absence of epidural fat; and

(f). known allergic reactions.

ix. Special Considerations

(a). Discography should not be performed by the physician expected to perform the therapeutic procedure. The procedure should be carried out by an experienced individual who has received specialized training in the technique of provocation discography.

(b). Discography should be performed in a blinded format that avoids leading the patient with anticipated responses. The procedure should always include one or more disc levels thought to be normal or nonpainful in order to serve as an internal control. The patient should not know what level is being injected in order to avoidspurious results. Adjacent discs may be identified as pain generators in more than half of cases in which discogenic pain is identified at one level. Because surgery is likely to fail in multi-level discogenic pain, injection of as many levels as feasible can prevent many operative failures. Abnormal disc levels may be repeated to confirm concordance.

(c). Sterile technique must be utilized.

(d). Judicious use of light sedation during the procedure is acceptable, represents the most common practice nationally at the current time, and is recommended by most experts in the field. The patient must be awake and able to accurately report pain levels during the provocation portion of the procedure.

(e). CT or MRI should establish cervical spinal dimensions and ruled out spinal stenosis.

(f). Intradiscal injection of local anesthetic may be carried out after the provocation portion of the examination and the patient’s response.

(g). It is recommended that a post-discogram CT be considered as it frequently provides additional useful information about disc morphology or other pathology.

x. Reporting of Discography. In addition to a narrative report, the discography report should contain a standardized classification of disc morphology and the pain response. All results should be clearly separated in the report from the narrative portion. Asymptomatic annular tears are common and the concordant pain response is an essential finding for a positive discogram.

xi. When discography is performed to identify the source of a patient’s neck pain, both a concordant pain response and morphological abnormalities must be present at the pathological level prior to initiating any treatment directed at that level. The patient must be awake during the provocation phase of the procedure; therefore, sedative medication must be carefully titrated.

xii. Caution should be used when interpreting results from discography. One study using asymptomatic volunteers reported pain in the majority of discs injected, but no subjects reported pain exceeding 6/10 on a pain scale in a normal disc.

xiii. Reporting disc morphology as visualized by the post-injection CT scan (when available) should follow the Modified Dallas Discogram Scale where:

(a). Grade 0 = Normal Nucleus.

(b). Grade 1 = Annular tear confined to inner one-third of annulus fibrosis.

~~(c). Grade 2 = Annular tear extending to the middle third of the annulus fibrosis.~~
~~(d). Grade 3 = Annular tear extending to the outer one-third of the annulus fibrosis.~~
~~(e). Grade 4 = A grade 3 tear plus dissection within the outer annulus to involve more than 30 degrees of the disc circumference.~~
~~(f). Grade 5 = Full thickness tear with extra-annular leakage of contrast, either focal or diffuse.~~
~~xiv. Reporting of pain response should be consistent with the operational criteria of the International Spine Intervention Society Guidelines (ISIS). The report must include the level of concordance for neck and arm pain separately using a 10-point VAS, or similar quantitative assessment. It should be noted that the change in the VAS score before and after provocation is more important than the number reported.~~
~~xv. The diagnosis of discogenic pain is less likely when there are more discs with dissimilar pain and fewer with no pain. At least two discs with no pain on stimulation and one disc with concordant pain registering at least 7 on a 10-point VAS or equivalent should be present to qualify for a diagnosis of discogenic pain. The VAS score prior to the discogram should be taken into account when interpreting the VAS score reported by the patient during the discogram.~~
~~(a). Time parameters for provocation discography are as follows:~~
~~(i). frequency: one time only;~~
~~(ii). maximum: repeat discography is rarely indicated.~~
~~xvi. Thermography is an accepted and established procedure, but has no use as a diagnostic test for cervical pain. It may be used to diagnose regional pain disorders and in these cases, refer to the Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines.~~

3. – 3.e.i. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1634 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1121 (June 2014), LR 49:517 (March 2023).

Subchapter B. Low Back Pain
§2021. Therapeutic Procedures - Non-Operative

A. – H.3.d.ii. …

iii. Timing/Frequency/Duration

(a). Frequency and optimum duration: two to three injections per year. If the first injection does not provide a diagnostic response of temporary and sustained pain relief substantiated by accepted pain scales, (i.e.,50 percent pain reduction substantiated by tools such as VAS), and improvement in function, similar injections should not be repeated. At least six weeks of functional benefit should be obtained with each therapeutic injection. If there is a 50 percent reduction in pain that lasts less than six weeks, the injection can be considered as part of the series of two injections used for the purpose of confirming the sacroiliac pain generator prior to sacroiliac fusion.

(b). …

e. - i.i. …

j. Basivertebral Nerve Ablation (BVN). This procedure is approved for a subgroup of chronic low back pain patients who have vertebrogenic-related symptomology.

i. Procedure is indicated if all of the following are met:

(a). Main symptom is low back pain, has had chronic low back pain for a minimum of 6 months, and patient is mature skeletally;

(b). Despite attempts at nonsurgical management, the patient has failed to satisfactorily improve; and

(c). Type 1 (hypointensity) or Type 2 (hyperintensity) Modic changes are reported at the endplates that are the suspected pain generators by the reading radiologist and/or treating physician. If MRI is contra-indicated in the patient, a CT/SPET merge with increased uptake at the suspected endplate is acceptable.

ii. Procedure is not indicated if any of the following occurs:

(a). Patients has implantable pulse generators (pacemakers, defibrillators) or other electronic implants unless specific precautions are taken to maintain safety;

(b). Active systemic infection or spine infection;

(c). Severe cardiac or pulmonary compromise;

(d). Lumbar radiculopathy or radicular pain due to neurocompression (for example, HNP, stenosis), neurogenic claudication, as primary symptoms;

(e). Metabolic bone disease (for example, osteoporosis), trauma/compression fracture or spinal cancer, treatment of spine fragility fracture; or

(f). Evidence on imaging implies another cause for the patient's low back pain symptoms, including but not limited to degenerative scoliosis or facet arthropathy or effusion with clinically suspected facet joint pain, disc herniation, segmental instability, lumbar stenosis.

(g). Prior basivertebral denervation at the suspected level.

4. - 14.a. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1664 (June 2011), amended by the Louisiana Workforce Commission, Office of Workers Compensation, LR 40:1140 (June 2014), LR 46:1452 (September 2020), LR 49:520 (March 2023). amended LR 50:

Chapter 21. Pain Medical Treatment Guidelines

Subchapter A. Chronic Pain Disorder Medical Treatment Guidelines

Editor's Note: Form LWC-WC 1009. Disputed Claim for Medical Treatment has been moved to §2328 of this Part.

§2113. Therapeutic Procedures - Operative

A. - A.7. …

8. Peripheral Nerve Stimulation—~~There are no randomized controlled studies for this treatment.~~ This modality should only be employed with a clear nerve injury or when the majority of pain is clearly in a nerve distribution in patients who have completed six months of other appropriate therapy including the same pre-trial psychosocial evaluation and treatment as are recommended for spinal cord stimulation. A screening trial should take place over three to seven days and is considered successful if the patient meets both of the following criteria: (a) experiences a 50 percent decrease in pain, which may be confirmed by Visual Analogue Scale (VAS) or Numerical Rating Scale (NRS) and (b) demonstrates objective functional gains or decreased utilization of pain medications. ~~Objective, measurable, functional gains must be evaluated by an independent occupational therapist and/or physical therapist and the primary treating physician prior to and before discontinuation of the trial. The primary treating doctor is not the doctor who placed the nerve stimulator.~~ It may be used for proven occipital, ulnar, median, and other isolated nerve injuries.

9. - 9.f. …

~~10. Neuroablation with Rhizotomy as the Exception~~

~~a. Neuroablation or neuro-destructive procedures are not commonly used in the management of non-malignant pain. These techniques require specific expertise to perform, have erratic results, and high rates of complication. Therefore, the OWCA does not recommend the use of neuroablative procedures, except medial branch nerve rhizotomy, for injured workers with chronic pain.~~

~~11.~~10. Dorsal Nerve Root Resection: This procedure is not recommended. There exists the possibility of complications including unintended extensive nerve damage causing significant motor or sensibility changes from larger than anticipated lesioning of the ganglia at the dorsal ganglia level. For radio-frequency ablation refer to Radio Frequency Ablation - Dorsal Nerve Root Ganglion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.1.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers Compensation Administration, LR 37:1711 (June 2011), amended LR 46:246 (February 2020), repromulgated LR 46:397 (March 2020). amended LR 50:

Family Impact Statement

This amendment to Title 40 should have no impact on families.

Poverty Impact Statement

This amendment to Title 40 should have no impact on poverty or family income.

Provider Impact Statement

1. This Rule should have no impact on the staffing level of the Office of Workers' Compensation as adequate staff already exists to handle the procedural changes.

2. This Rule should create no additional cost to providers or payers.

3. This Rule should have no impact on ability of the provider to provide the same level of service that it currently provides.

Small Business Statement

This amendment to Title 40 should have no direct impact on small or local businesses.

Public Comments

All interested persons are invited to submit written comments or hearing request on the proposed Rule. Such comments or request should be sent to Tavares Walker, OWC-Administration, 1001 North 23rd Street, Baton Rouge, LA 70802. Such comments should be received by 5:00 pm on March 10, 2024.

Susana Schowen
Secretary