MEDICAL CONTESTED CASE HEARING NO. 12097
M6-12-37678-01

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.

ISSUE

A contested case hearing was held on March 28, 2012 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to a carpal tunnel release (CTR), median nerve at the forearm, for her compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by BO, ombudsman. Respondent/Carrier was represented by RJ, attorney.

BACKGROUND INFORMATION

It was undisputed that the Claimant sustained a compensable right wrist injury on (Date of Injury) while working for (Employer). She underwent a right CTR and flexor tenolysis surgery on March 16, 2009 performed by Dr. J. Initially, the Claimant reported improvement in her symptoms after the surgery, but eventually her condition began to deteriorate. She came under the care of Dr. U, D.C., who diagnosed "post status [CTR]" and "reflex sympathetic complex regional pain syndrome". *See Claimant's Exhibit C-11.* Dr. U referred the Claimant to Dr. K for a second opinion, and on December 6, 2010, Dr. K conducted his examination. Dr. K opined that the Claimant's diagnoses are reflex sympathetic dystrophy (RSD)/complex regional pain syndrome (CRPS), status-post right CTR, and right cubital tunnel syndrome. He recommended that the Claimant receive a stellate ganglion nerve block in her right wrist, pain management and physical therapy pursuant to the diagnoses of RSD/CRPS. Pre-authorization for the block and the therapy was requested in or about February 2011, but approval for this treatment was denied on February 24, 2011 because it was determined that the information provided did not establish that the Claimant had RSD/CRPS in her right upper extremity. The Claimant thereafter came under the care of Dr. G, whom she first saw on July 8, 2011. Dr. G determined that the Claimant had right wrist carpal tunnel syndrome (CTS) and pronator syndrome based on his clinical findings. An EMG performed on August 22, 2011 showed evidence of residual right median neuropathy at the

wrist, consistent with a residual mild to moderate right CTS, but it showed no electrodiagnostic evidence of pronator syndrome.

Dr. G requested the treatment disputed herein, namely, a repeat right wrist CTR, median nerve at the forearm. Both of the Carrier's utilization review agent (URA) doctors denied pre-authorization for the requested treatment, which is noted in their correspondence to be neuroplasty and/or transposition, ulnar nerve at elbow. Both of the Carrier's URA doctors relied upon the *Official Disability Guidelines* (ODG), and stated that the ODG does not address repeat CTR surgery. In analyzing the treatment under the ODG for an initial (as opposed to repeat) CTR, the URA doctors opined that there was no information provided showing that conservative treatment had been attempted (since the March 16, 2009 surgery) prior to requesting the surgery at issue herein. The IRO upheld the adverse determination, relying upon medical judgment/clinical experience and the *Official Disability Guidelines* (ODG).

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 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."

The ODG provides the following for CTR:

> Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. See Severity definitions. Carpal tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. (Unfortunately, many CTR surgeries are performed on patients without a correct diagnosis of CTS, and these surgeries do not have successful outcomes.) Outcomes in workers' comp cases may not be as good as outcomes overall, but studies still support the benefits from surgery. Carpal tunnel syndrome may be treated initially with education, activity modification, medications and night splints before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits), but outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Surgical decompression of the median nerve usually has a high rate of long-term success in relieving symptoms, with many studies showing success in over 90% of patients where the diagnosis of CTS has been confirmed by electrodiagnostic testing. (Patients with the mildest symptoms display the poorest post-surgery results, but in patients with moderate or severe CTS, the outcomes from surgery are better than splinting.) Carpal tunnel syndrome should be confirmed by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Any contributions to symptoms by cervical radiculopathy (double crush syndrome) will not be relieved by the surgery. (Various references listed under “Surgical Considerations”) (ChU, 1998) (Verdugo, 2002) (Shin, 2000) (AHRQ, 2003) (Lyall, 2002) (Gerritsen-JAMA, 2002) (Verdugo-Cochrane, 2003) (Hui, 2004) (Hui, 2005) (Bilic, 2006) (Atroshi, 2006) (Ucan, 2006) Being depressed and a workers' compensation claimant predicts being out of work after carpal tunnel release surgery. This highlights the importance of psychosocial management of musculoskeletal disorders. (Amick, 2004) (Karjalainen-Cochrane, 2002) (Crossman, 2001) (Denniston, 2001) (Feuerstein, 1999) Older age should

not be a contraindication to CTR. (Weber, 2005) (Hobby2, 2005) In a sample of patients aged 70 years and older, patient satisfaction was 93 percent after surgical treatment versus 54 percent after nonsurgical treatment. (Ettema, 2006) Mini palm technique may be as good or better than endoscopic or open release. (Melhorn, 1994) (Cellocco, 2005) Steroid injections and wrist splinting may be effective for relief of CTS symptoms but the benefit decreases over time. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of an improved response to conservative treatment. Selected patients presenting with mild to moderate carpal tunnel syndrome (i.e., with no thenar wasting or obvious underlying cause) may receive either a steroid injection or wear a wrist night splint for 3 weeks. This will allow identification of the patients who respond well to conservative therapy and do not need surgery. (Graham, 2004) (Ly-Pen, 2005) See Injections. While diabetes is a risk factor for CTS, patients with diabetes have the same probability of positive surgical outcome as patients with idiopathic CTS. (Mondelli, 2004) Statistical evaluation identified five factors which were important in predicting lack of response to conservative treatment versus surgery: (1) age over 50 years; (2) duration over ten months; (3) constant paranesthesia; (4) stenosing flexor tenosynovitis; & (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were improved by medical therapy, 40% were improved with one factor, 17% were improved with two factors, and 7% were improved with three factors, and no patient with four or five factors present was cured by medical management. (Kaplan, 1990) Operative treatment was undertaken for 31% of new presentations of carpal tunnel syndrome in 2000. (Latinovic, 2006) In the treatment of carpal tunnel syndrome, decompression surgery produces a better long-term outcome than local corticosteroid injections, according to data presented at the American College of Rheumatology meeting. At 1 year, the results showed that local corticosteroid injection was as effective as decompression surgery; however, at 7 years, the estimated accumulated incidence of therapeutic failure in the corticosteroid group was 41.8% compared with 11.6% in the surgery group, because the effects of corticosteroid injections fade with time. (Ly-Pen, 2007) This RCT concluded that patients with CTS who do not have satisfactory improvement with nonsurgical treatment should be offered surgery. Symptoms in both groups improved, but surgical treatment led to better outcome than did non-surgical treatment. However, the clinical relevance of this difference was modest. (Jarvik, 2009) This systematic review found that the recent literature demonstrates a trend toward recommending early surgery for CTS cases with or without median nerve denervation. (Bernardino, 2011) Despite the fact that symptoms are impaired in diabetic patients with CTS compared with non-diabetic patients with CTS, diabetic patients experience similar symptomatic

and functional benefits from carpal tunnel release as do non-diabetic patients. (Thomsen, 2010)

Adjunctive procedures: The 2008 AAOS CTS clinical treatment guidelines concluded that surgeons not routinely use the following procedures when performing carpal tunnel release: Skin nerve preservation; & Epineurotomy. The following procedures had no recommendation for or against their use: Flexor retinaculum lengthening; Internal neurolysis; Tenosynovectomy; & Ulnar bursa preservation. (Keith, 2010)

ODG Indications for Surgery™ **-- Carpal Tunnel Release:**

I. **Severe CTS,** requiring ALL of the following**:**
   A. Symptoms/findings of severe CTS, requiring ALL of the following:
   B. Muscle atrophy, severe weakness of thenar muscles
      1. 2-point discrimination test > 6 mm
   C. Positive electrodiagnostic testing

OR

II. **Not severe CTS**, requiring ALL of the following:
   D. Symptoms (pain/numbness/paresthesia/impaired dexterity), requiring TWO of the following:
      1. Abnormal Katz hand diagram scores
      2. Nocturnal symptoms
      3. Flick sign (shaking hand)
   E. Findings by physical exam, requiring TWO of the following:
      1. Compression test
      2. Semmes-Weinstein monofilament test
      3. Phalen sign
      4. Tinel's sign
      5. Decreased 2-point discrimination
      6. Mild thenar weakness (thumb abduction)
   F. Comorbidities: no current pregnancy
   G. Initial conservative treatment, requiring THREE of the following:
      1. Activity modification >= 1 month
      2. Night wrist splint >= 1 month
      3. Nonprescription analgesia (i.e., acetaminophen)

4. Home exercise training (provided by physician, healthcare provider or therapist)
5. Successful initial outcome from corticosteroid injection trial (optional). See Injections. [Initial relief of symptoms can assist in confirmation of diagnosis and can be a good indicator for success of surgery if electrodiagnostic testing is not readily available.]

H. Positive electrodiagnostic testing [note that successful outcomes from injection trial or conservative treatment may affect test results] (Hagebeuk, 2004)

The IRO decision states that the denial is based on a lack of documentation showing that appropriate conservative treatment had been completed prior to requesting the repeat surgery. The IRO also notes that while Dr. G has diagnosed pronator syndrome in this case, there is no electrodiagnostic evidence of the condition. The Claimant's closing argument asserts that her testimony demonstrates that she meets the criteria for "Not Severe CTS" under Section II of the relevant portion of the ODG, as quoted above, but the medical evidence in the record does not establish that she meets all the criteria. While the Claimant's testimony was credible and the medical evidence does establish that she has right CTS, the record does not establish that the preponderance of the evidence-based medical evidence is contrary to the IRO's decision in this case. For this reason, it is determined that the Claimant is not entitled to a right CTR, median nerve at forearm, for her compensable (Date of Injury) 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 (Date of Injury), the Claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), Employer had workers' compensation insurance coverage with Liberty Insurance Corp., carrier.

   D. On (Date of Injury), the Claimant sustained a compensable right wrist injury while in the course and scope of her employment with (Employer).

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. A right CTR, median nerve at forearm, is 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 Claimant is not entitled to a right CTR, median nerve at forearm, for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a right CTR, median nerve at forearm, 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 **LIBERTY INSURANCE CORPORATION,** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 E. 7TH STREET, STE. 620
AUSTIN, TX 78701

Signed this 5th day of April, 2012.

Patrice Fleming-Squirewell
Hearing Officer