

MEDICAL CONTESTED CASE HEARING NO. 12102
M6-12-39331-01

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 April 12, 2012, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to right carpal tunnel release and right ulnar nerve transposition for the compensable injury on (Date of Injury)?

PARTIES PRESENT

The petitioner/claimant appeared and was assisted by SR, ombudsman. The carrier/respondent appeared and was represented by RL, attorney.

BACKGROUND INFORMATION

The claimant has had several carpal tunnel and ulnar nerve procedures since the compensable injury in (Date of Injury). The most recent carpal tunnel and ulnar nerve release was in December, 2010. The claimant received substantial pain relief following that surgery. However, in or about July, 2011, the claimant began to have increased pain in her right upper extremity, including her right hand. The claimant was being seen during this time by PW, FNP-C on behalf of the claimant's treating doctor, Dr. W, M.D. During the time the claimant's right upper extremity pain was increasing Dr. W was attributing the claimant's diagnosis of chronic pain to CRPS. The claimant received stellate ganglion block injections in August and October, 2011, in connection with the CRPS diagnosis, from Dr. V, M.D. Each provided over 50% relief but only for a couple of weeks each time.

In November, 2011, Dr. S, M.D., who performed the December, 2010 carpal tunnel and ulnar nerve releases, was of the opinion that the right hand symptomology portion of the claimant's right upper extremity complaints were not due to CRPS. He ordered an EMG. Based on the EMG results from December 14, 2011, Dr. S maintained that the claimant required a revision of the 2010 carpal tunnel and ulnar nerve releases. In addition to the EMG, Dr. S noted a positive Tinel's sign at the claimant's cubital tunnel, a positive Tinel's sign at her carpal tunnel, a positive

carpal tunnel compression test, and a substantial amount of dense ulnar numbness with elbow flexion.

Dr. S's request for a carpal tunnel release and ulnar nerve transposition was denied by the carrier's initial utilization reviewer, an orthopedic surgeon, on December 28, 2011. The reviewer denied the ulnar nerve transposition on the basis that it is not recommended by the Official Disability Guide (ODG), and that simple decompressions have equivalent outcomes with fewer complications. The reviewer found no indications in the record that the specific indicators for ulnar transposition existed in the claimant's case. Additionally, the reviewer did not find sufficient documentation of the specific extent of conservative treatment rendered following the December, 2010 carpal and ulnar tunnel releases. The reviewer also found no clear explanation in the record as to why Dr. S anticipated that revision surgery would result in sustainable relief of symptoms when it had not done so following the most recent surgeries.

The utilization review doctor who reviewed the request on reconsideration, also an orthopedic surgeon, minimized the impact of the December, 2011 EMG results since there was no comparison in the record with any EMGs prior to the claimant's original surgeries. This reviewer also believed that more investigation into the etiology of the claimant's right upper extremity complaints. That is, whether they were related to the carpal tunnel and ulnar nerve or the diagnosis of CRPS. And like the original reviewer, reviewer on reconsideration failed to find any discussion in the record as to why it should be anticipated that the claimant would see any meaningful improvement with "yet another procedure" when the claimant had apparently failed so many prior surgeries.

In a January 6, 2012 causation letter, Dr. S addressed, albeit briefly, some of the concerns raised by the appellate review doctors. Dr. S noted that the claimant had engaged in conservative care in that she had "done a great deal of stretching exercises, done a great deal of scar massage, and has used antiinflammatory medications and avoided activity which she knows bothers it." (It is not completely clear what "it" is.) There was no mention, however, of the possible CRPS co-morbidity, or basis for believing that the revision surgery would resolve the claimant's chronic pain when the prior surgery had not.

An IRO reviewer, identified as a general surgeon with a specialization in hand surgery, reviewed the carrier's denial of the requested right carpal tunnel release and right ulnar nerve transposition in February, 2012. He noted that while the EMG did reveal indications of carpal and cubital tunnel syndromes, it was not clear whether the findings were new or post-surgical residuals. He also commented on the lack of a "comprehensive history of conservative treatment completed following surgical intervention after recurrence of symptoms." He stated that it was unclear if the claimant had had a trial of therapy/home exercise program, splinting, anti-inflammatories, or corticosteroid injection to the wrist or elbow. Some of those issues were addressed in Dr. S's

letter, but not all. Finally, the IRO reviewer opined that the pain generator had not been definitively located, since sympathetic pain had not been excluded as a potential pain generator.

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 (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."

On the date of this medical contested case hearing, the ODG provides the following with regard to Carpal tunnel release surgery (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") (Chung, 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 paresthesia; (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:

1. Muscle atrophy, severe weakness of thenar muscles
2. 2-point discrimination test > 6 mm

B. Positive electrodiagnostic testing

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II. *Not severe CTS*, requiring ALL of the following:

A. 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)

B. 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)

C. Comorbidities: no current pregnancy

D. Initial conservative treatment, requiring THREE of the following:

1. Activity modification \geq 1 month
2. Night wrist splint \geq 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.]

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

On the date of this medical contested case hearing, the ODG provides the following with regard to surgery for cubital tunnel syndrome (ulnar nerve entrapment):

III. Recommended as indicated below (simple decompression in most cases). Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow. Surgery for ulnar neuropathy at the elbow is effective at least two-thirds of the time. The outcomes of simple decompression (SD) and anterior subcutaneous transposition (AST) are equivalent, except for the complication rate, which is 31% in AST. Because the intervention is simpler and associated with fewer complications, SD is generally advised. (Bartels, 2005) (Asamoto, 2005) (Lund, 2006) (Nabhan, 2007) Although clinically equally effective, simple decompression was associated with lower cost than anterior subcutaneous transposition for the treatment of ulnar neuropathy at the elbow. The main difference was in the costs related to sick leave, which is significantly shorter for simple decompression. (Bartels2, 2005) (Nabhan, 2005) Simple decompression may offer excellent intermediate and long-term relief of symptoms. Less complete relief of symptoms following ulnar nerve decompression may be related to unrecognized carpal tunnel syndrome or weight gain. (Nathan, 2005) Medial epicondylectomy for persons with cubital tunnel syndrome was superior to anterior transposition in relieving pain and in improving global outcome scores. Patients whose cubital tunnel syndrome is caused by an acute trauma have better outcomes after surgical treatment than patients with cubital tunnel syndrome from other causes. (AHRQ, 2002) Partial medial epicondylectomy seems to be safe and reliable for treatment of cubital compression neuropathy at the elbow. (Efstathopoulos, 2006) One study reviewed the results of two surgical methods for treating cubital tunnel syndrome. From 1994 to 2001, minimal medial epicondylectomy was performed on 22 elbows, and anterior subcutaneous transposition of the ulnar nerve was done on 34 elbows. In the group treated by medial epicondylectomy, 9 of the results (41%) were excellent, 10 (45%) were good, 2 (9%) were fair, and 1 result (5%) was poor. In the group treated by anterior subcutaneous transposition of ulnar nerve, 14 of the results (41%) were excellent, 13 (38%) were good, 6 (18%) were fair, and 1 result (3%) was poor. No significant difference was found between the 2 groups ($P < .05$). (Baek, 2005) (Greenwald, 2006) Age at surgery, duration of cubital tunnel syndrome, preoperative severity, and clinical symptom score and motor nerve conduction velocity in the early postoperative stage (one month after surgery) were found to be important prognostic factors of the syndrome. (Yamamoto, 2006)

Simple decompression vs anterior transposition: Transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. Otherwise simple decompression is recommended. (Heithoff, 1999) (Posner, 1998) (Bartels, 2005) (Elhassan, 2007) Irrespective of the surgical method, roughly 90% of patients are satisfied with surgical treatment of the ulnar nerve entrapment. However, one specific group of patients (people with habitual ulnar luxation or subluxation of the ulnar nerve) experienced a distinctly better result when treated by anterior transposition than by simple decompression, so simple decompression of the ulnar nerve can be recommended in all patients without cubital (sub)luxation of the nerve, whereas people with a tendency of cubital (sub)luxation of the ulnar nerve should be treated by submuscular anterior transposition. (Bimmler, 1996) In this study, both simple decompression and anterior transposition resulted in improvement in over 80% of cases, but a higher percentage of full recovery was seen in the cases treated by simple decompression. (Chan, 1980) The results of simple decompression of the ulnar nerve are similar to transposition, so the former simpler method is recommended as the standard procedure. (Lugnegård, 1982) The advantages of simple decompression make it the procedure of choice for most cases of ulnar neuropathy. (Nathan, 1992) The simpler procedure of neurolysis in situ is the treatment of choice, but submuscular transposition remains appropriate in certain circumstances. (Biggs, 2006)

ODG Indications for Surgery -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:

- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees
- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.
- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.
- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

Based on a careful review of the evidence presented in the hearing, the claimant failed to meet her burden of overcoming the IRO decision by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for right carpal tunnel release and right ulnar nerve transposition prescribed in the ODG. The preponderance of the evidence-based medicine is not

contrary to the decision of the IRO and, consequently, the claimant is not entitled to the proposed right carpal tunnel release and right ulnar nerve transposition.

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 Workers' Compensation Division of the Texas Department of Insurance.
 - B. On (Date of Injury), the claimant was the employee of (Employer), Employer.
 - C. On (Date of Injury), the claimant sustained a compensable injury of right carpal tunnel syndrome and to her right ulnar nerve.
 - D. The IRO determined that the claimant is not entitled to right carpal tunnel release and right ulnar nerve transposition.
2. The carrier delivered to the claimant a single document stating the true corporate name of the carrier, and the name and street address of the carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. Right carpal tunnel release and right ulnar nerve transposition is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance 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 right carpal tunnel release and right ulnar nerve transposition is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

The claimant is not entitled to right carpal tunnel release and right ulnar nerve transposition for the compensable injury on (Date of Injury).

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 **ARROWWOOD INDEMNITY COMPANY, AS SUCCESSOR IN INTEREST TO SECURITY INSURANCE COMPANY OF HARTFORD, AS SUCCESSOR IN INTEREST TO THE CONNECTICUT INDEMNITY COMPANY**, and the name and address of its registered agent for service of process is:

**CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TX 78701-3232**

Signed this 20th day of April, 2012.

William M. Routon II
Hearing Officer