MEDICAL CONTESTED CASE HEARING NO. 14018

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 December 6, 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 a repeat nerve conduction study of the bilateral upper extremities for the compensable injury of (Date of Injury)?

The record remained open following the December 6, 2012, contested case hearing so that the hearing officer could send a 10 day letter to the Petitioner and an additional 10 day letter was forwarded to the Claimant. The record closed effective October 11, 2013.

PARTIES PRESENT

Petitioner/Claimant appeared failed to appear and did not respond to the Division's 10-day letter.
Respondent/Carrier appeared and was represented by DG, attorney.
Petitioner/Provider appeared and was represented by Dr. KR.

BACKGROUND INFORMATION

Although properly notified, the Claimant failed to appear for the medical contested case hearing scheduled for 8:30 a.m. on December 6, 2012. A letter advising that the hearing had convened and that the record would be held open for ten days to afford Claimant the opportunity to respond and request that the hearing be rescheduled to permit him to present evidence on the disputed issues was mailed to Claimant on December 7, 2012. Claimant failed to respond to the Division's 10-day letter.

The evidence presented in the hearing revealed that Claimant sustained a compensable injury on (Date of Injury), and underwent surgery to his left shoulder on May 11, 2011. Claimant underwent EMG/NCV testing on July 14, 2011, which was suggestive of C6-C7 radiculopathy. Subsequently, Claimant was involved in an automobile accident on September 23, 2011, and injured his left shoulder and hand, which required surgery. An EMG was conducted on February 20, 2012, which revealed findings consistent with left C7 radiculopathy and left C8-TR1 levels and/or brachial plexopathy. Provider requested a repeat NCS to differentiae the pain pathology.

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(s), "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 pertinent provisions of the ODG applicable to this case are as follows, to wit:

Nerve conduction studies (NCS):

Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the *Carpal Tunnel Syndrome* Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective.

Nerve conduction studies (NCS):

Recommended in patients with clinical signs of CTS who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal

tunnel syndrome must be proved by positive findings on clinical examination and should 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. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a physician. (Utah, 2006) See Electrodiagnostic studies; and Portable nerve conduction devices.

Electrodiagnostic studies (EDS):

Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. (Bienek, 2006) Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG). For more information, see the Carpal Tunnel Syndrome chapter. Among patients seeking treatment for hand and wrist disorders generally, workers' compensation patients underwent more procedures and more doctor visits than patients using standard health insurance. WC patients underwent surgery at a higher rate -- 44% compared to 35% -- and electrodiagnostic testing -- 26% compared to 15%. (Day, 2010)

Electrodiagnostic studies (EDS):

Recommended in patients with clinical signs of CTS who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. See also Nerve conduction studies (NCS) and Electromyography (EMG). In general, carpal tunnel syndrome should be proved by positive findings on clinical examination and should 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. Studies have not shown portable nerve conduction devices to be effective. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). In more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of carpal tunnel syndrome but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment. (Various references listed under “Detection of Neurologic Abnormalities”) (Smith, 2002) (Jablecki2, 2002) (AHRQ, 2003) (Podnar, 2005) (Lew, 2005) (Schrijver, 2005) (Sheu, 2006) Poor overlap between various screening procedures warns against the use of electrodiagnostic findings alone without also considering the symptom presentation. (Homan, 1999) A large cohort study showed that over one third of patients undergoing CTR may have had an inappropriate electrodiagnostic workup before the surgery. (Storm, 2005) Despite the fact that electrodiagnostic testing is considered by many to be the “gold standard” for the diagnosis of CTS, some studies have suggested that it not be a requirement. According to one systematic review, “in cases of clear-cut clinical CTS, electrodiagnosis is not warranted either as a diagnostic test, where clinical symptoms are well

defined, or as a predictive indicator of surgical outcome, but it may still be useful in cases where the clinical diagnosis is not clear." (Jordan, 2002) Regarding preplacement nerve testing for CTS, not hiring workers with abnormal post-offer preplacement median nerve tests to reduce costs of work-related CTS is not a cost-effective strategy for employers. (Franzblau, 2004) NC-stat technology cannot be recommended for screening or diagnosis of CTS in an industrial population. (Katz, 2006) For more information see NC-stat nerve conduction studies. There is concordance between the results of EDS and the initial diagnostic hypothesis only 40% of the time, confirming the usefulness of EDS. (Cocito, 2006) In using demographic and clinical data to identify the clinical pattern that predicts the diagnosis of CTS, the best pattern associated with the diagnosis was the presence of parenthesis or pain in at least 2 of the first 4 digits in association with one of the following: female gender, symptoms worsening at night or on awakening, a BMI >/=30, thenar atrophy, or other sign (Tinel's, Phalen's, or Reversed Phalen's signs). However, the clinical picture alone in the workers' compensation case, without neurophysiologic studies, may not be sufficient to correctly predict the diagnosis of CTS. (Gomes, 2006) This study used the CTS-6 assessment tool along with a comprehensive history and physical examination in diagnosing CTS, and concluded that in unambiguous cases of CTS, electrodiagnostic testing would not be warranted if its sole purpose is to confirm the diagnosis of CTS. As such, its value in this situation is not only to confirm a physician's suspicion of CTS, but also to quantify and stratify the severity of the condition. (Graham, 2008) See also multiple extremity testing. Note: ODG recommends that NCS should be done to support the diagnosis of CTS prior to surgery in workers' compensation cases. If an individual has appropriate responses to treatment (i.e. injections, modification of activities, meds) but still has symptoms with normal NCS, surgery may be appropriate on a case-by-case basis and reasonable documentation by the treating physician.

Protocols for electrodiagnostic studies: The American Association of Electrodiagnostic Medicine, American Academy of Neurology, and the American Academy of Physical Medicine and Rehabilitation have jointly published their practice parameter for electrodiagnostic studies in carpal tunnel syndrome. In patients with suspected CTS, the following EDX studies are recommended:
(1) Perform a median sensory NCS across the wrist with a conduction distance of 13 to 14 cm. If the result is abnormal, compare the result of the median sensory NCS to the result of a sensory NCS of one other adjacent sensory nerve in the symptomatic limb.

Dr. KR, a board certified chiropractor, testified on behalf of the medical provider/petitioner. Dr. R opined the EMG conducted on February 20, 2012, was due to cervical radiculopathy or brachial plexopathy or shoulder-region related. Dr. R was emphatic that the third test was needed to differentiate the two potential pathology: the shoulder or the neck. More specifically, the test was needed to inform the treating doctor of the specific pathology in an effort to develop a treatment plan.

The URA reviewer, a Texas state-licensed Doctor of Chiropractic reviewed the case and upheld the denial of the repeat NCS of the bilateral upper extremities. The basis of the denial was the request was not supported by the submitted documentation and evidence. More specifically, the submitted documentation failed to establish the presence of significant clinical neurological deterioration since the prior diagnostic studies. In addition, there was no evidence that the Claimant was currently a surgical candidate. Lastly, there was no documentation or discussion of specifically how the electrodiagnostic information on repeat NCS will affect the Claimant's care and clinical outcomes.

A peer reviewer, DG, M.D., P.A., Preventive Medicine/Occupational Medicine, reviewed the documents and based on the information found the specific medical service was not medically necessary and/or appropriate. The reviewer utilized:

1) standardized clinical review criteria and treatment standards, developed by physicians utilizing current clinical research and standards of practice recommended by reputable healthcare professionals and institutional organizations and by the federal government, and
2) any treatment guidelines mandated by jurisdictional law and regulations.

The medical documentation and testimony was insufficient to establish that the medical treatment requested was medically necessary. Therefore, the Petitioner has failed to meet its burden that the decision of the IRO should be reversed that Claimant is not entitled to repeat NCS of the bilateral upper extremities.

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. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

2. On (Date of Injury), Claimant was the employee of (Employer), Employer.

3. Claimant sustained a compensable injury on (Date of Injury).

4. The Division sent a single document stating the true corporate name of the Carrier and the name and street address of Carrier's registered agent for service with the 10-day letter to the Claimant at the Claimant's address of record and the Petitioner/Provider at Petitioner/Provider's address of record. That document was admitted into evidence as Hearing Officer Exhibit Number 2.

5. Claimant failed to appear for the December 6, 2012, medical contested case hearing.

6. The Claimant did not have good cause for failing to appear at the medical contested case hearing scheduled for December 6, 2012.

7. The IRO determined that a repeat nerve conduction study of the bilateral upper extremities were not health care reasonably required for treatment of the compensable injury of (Date of Injury).

8. A repeat nerve conduction study of the bilateral upper extremities 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 a repeat nerve conduction study of the bilateral upper extremities is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a repeat nerve conduction study of the bilateral upper extremities 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 **HARTFORD CASUALTY INSURANCE 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 14th day of October, 2013.

Jacqueline Harrison
Hearing Officer