MEDICAL CONTESTED CASE HEARING NO. 18008

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Administrative Law Judge determined that Claimant/Petitioner is not entitled to sympathetic nerve block T2, T3 of the right side for the compensable injury of (Date of Injury). The Administrative Law Judge also determined that Claimant/Petitioner did not timely appeal the IRO decision in this case.

STATEMENT OF THE CASE

On March 7, 2018, Teresa Boone, a Division Administrative Law Judge, held a contested case hearing to decide the following disputed issues:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to sympathetic nerve block T2, T3 of the right side?

2. Did the Claimant/Petitioner timely appeal the IRO decision?

After the hearing, the Administrative Law Judge entered into evidence the Division of Workers' Compensation record of Claimant's dispute of the IRO decision and informed the parties that Judicial Notice would be taken of the June, July, and August 2017, calendar. The record of Claimant's date of dispute and email correspondence was entered into evidence as Administrative Law Judge's Exhibit 3. The record closed on March 14, 2018.

PARTIES PRESENT

Claimant/Petitioner appeared and was assisted by BW, ombudsman. Carrier/Respondent appeared and was represented by CL, attorney.

The following witnesses testified:

For Claimant: JP, M.D.
For Carrier: None.

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 through ALJ-3.
Claimant's Exhibits C-1 through C-8.
Carrier's Exhibits CR-A through CR-D.

OFFICIAL NOTICE

Official notice was taken of the calendar for June, July, and August of 2017.

DISCUSSION

Timeliness of Appeal

Rule 133.308(s)(1)(A) states,

> The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section **or** 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division. Requests that are timely submitted to a Division location other than the Division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

A close reading reveals that the Rule actually provides for two separate deadlines for the filing of an appeal of the IRO decision with the later in time applying.

The parties in this case agreed that the IRO decision sent to the parties on June 28, 2017. Regarding the timeline of requesting the appeal, Claimant's treating doctor, JP, M.D., stated that that he did receive the IRO decision and attempted to address the reason(s) for the denial of treatment. However, Dr. P did not file an appeal to the IRO decision until August 14, 2017.

The applicable deadline for the filing of the appeal of the IRO decision in this case was 20 days from the date the IRO decision was sent to the parties, which was July 17, 2017. There are no other applicable provisions and/or Division Rules providing for extensions of and/or good cause exceptions to the 20-day deadline for appealing the IRO decisions. Because the Claimant/Petitioner did not comply with the 20-day deadline contained in the applicable Division Rules, the appeal of the IRO decision was untimely.

Medical Necessity

Evidence Based Medicine (EBM)

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."

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to sympathetic nerve block T2, T3 of the right side:

Recommendations (based on consensus guidelines) for use of sympathetic blocks (diagnostic block recommendations are included here, as well as in CRPS, diagnostic tests):

(1) There should be evidence that all other diagnoses have been ruled out before consideration of use.
(2) There should be evidence that the Budapest (Harden) criteria have been evaluated for and fulfilled.
(3) If a sympathetic block is utilized for diagnosis, there should be evidence that this block fulfills criteria for success including that skin temperature after the block shows sustained increase (≥ 1.5° C and/or an increase in temperature to > 34° C) without evidence of thermal or tactile sensory block. Documentation of motor and/or sensory block should occur. This is particularly important in the diagnostic phase to avoid overestimation of the sympathetic component of pain. A Horner's sign should be documented for upper extremity blocks. [Successful stellate block would be noted by Horner's syndrome, characterized by miosis (a constricted pupil), ptosis (a weak, droopy eyelid), or anhidrosis (decreased sweating).] The use of sedation with the block can

influence results, and this should be documented if utilized. (*Krumova, 2011*) (*Schurmann, 2001*)

(4) Therapeutic use of sympathetic blocks is only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled (See #1-3). These blocks are only recommended if there is evidence of lack of response to conservative treatment including pharmacologic therapy and physical rehabilitation.

(5) In the initial therapeutic phase, maximum sustained relief is generally obtained after 3 to 6 blocks. These blocks are generally given in fairly quick succession in the first two weeks of treatment with tapering to once a week. Continuing treatment longer than 2 to 3 weeks is unusual.

(6) In the therapeutic phase repeat blocks should only be undertaken if there is evidence of increased range of motion, pain and medication use reduction, and increased tolerance of activity and touch (decreased allodynia) is documented to permit participation in physical therapy/ occupational therapy. Sympathetic blocks are not a stand-alone treatment.

(7) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.

(8) In acute exacerbations of patients who have documented evidence of sympathetically medicated pain (see #1-3), 1 to 3 blocks may be required for treatment.

(9) A formal test of the therapeutic blocks should be documented (preferably using skin temperature).

(*Burton, 2006*) (*Stanton-Hicks, 2004*) (*Stanton-Hicks, 2006*) (*International Research Foundation for RSD/CRPS, 2003*) (*Colorado, 2006*) (*Washington, 2002*) (*Rho, 2002*) (*Perez, 2010*) (*van Eijs, 2011*)

Local anesthetic sympathetic blocks:

Recommended for limited, select cases, primarily for diagnosis of sympathetically mediated pain and therapeutically as an adjunct to facilitate physical therapy/ *functional restoration*. When used for therapeutic purposes the procedure is not considered a stand-alone treatment. The role of sympathetic blocks for treatment of CRPS is largely empirical (with a general lack of evidence-based research for support) but can be clinically important in individual cases in which the procedure ameliorates pain and improves function, allowing for a less painful “window of opportunity” for rehabilitation techniques. (*Harden, 2013*) Use of sympathetic blocks should be balanced against the side effect ratio and evidence of limited response to treatment. See *CRPS, diagnostic tests*.

IV regional anesthesia: Not recommended due to lack of evidence for use. This procedure is a technique that allows placement of medications directly in the effected extremity but current literature indicates efficacy is poor. (*Harden, 2013*) There is no role for IV diagnostic blocks with phentolamine or IVRA with guanethidine. Other procedures include IV regional blocks with lidocaine, lidocaine-methyl-prednisolone, droperidol, ketanserin, atropine, bretylium

clonidine, and reserpine. If used, there must be evidence that current CRPS criteria have been met and all other diagnoses have been ruled out. Evidence of sympathetically mediated pain should be provided (see the recommendations below). The reason for the necessity of this procedure over-and-above a standard sympathetic block should also be provided. (*Perez, 2010*) (*Harden, 2013*) (*Tran, 2010*) See also *CRPS, treatment*.

General information on sympathetic procedures

Current literature: A recent study indicated that there was low-quality literature to support this procedure (some evidence of effect, but conclusions were limited by study design, divergent CRPS diagnostic criteria, differing injection techniques and lack of consistent criteria for positive response). Results were inconsistent and/or extrapolation of questionable reliability with inconclusive evidence to recommend for or against the intervention. (*Dworkin, 2013*) Other studies have found evidence non-conclusive for this procedure or that low-quality evidence showed this procedure was not effective. (*O'Connell, 2013*) (*Tran, 2010*) The blocks are thought to be most beneficial when used early in the disease as an adjunct to rehabilitation with physical or occupational therapy. No controlled trials have shown any significant benefit from sympathetic blockade. (*Dworkin 2013*) (*O'Connell, 2013*) (*Tran, 2010*) (*van Eijs, 2012*) (*Perez, 2010*) (*van Eijs, 2011*) (*Nelson, 2006*) (*Varrassi, 2006*) (*Cepeda, 2005*) (*Hartrick, 2004*) (*Grabow, 2005*) (*Cepeda, 2002*) (*Forouzanfar, 2002*) (*Sharma, 2006*)

Historical basis for use: The use of sympathetic blocks for diagnostic and therapeutic purposes in the management of CRPS is based on a previous hypothesis concerning the involvement of the sympathetic nervous system in the pathophysiological mechanism of the disease. (*van Eijs, 2012*) It has been determined that a sympathetic mechanism is only present in a small subset of patients, and less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. See *Sympathetically maintained pain* (SMP).

Predictors of response: Researchers have suggested the following are predictors of poor response to blocks: (1) Long duration of symptoms prior to intervention; (2) Elevated anxiety levels; (3) Poor coping skills; (4) Litigation; (5) Allodynia and hypoesthesia. At this time there are no symptoms or signs that predict treatment success. (*Hartrick, 2004*) (*Nelson, 2006*) (*van Eijs, 2012*)

Interpretation of block results: There is a lack of consensus in terms of defining a successful sympathetic block. Based on consensus, a current suggestion of successful block is one that demonstrates an adequate and sustained increase in skin temperature (≥ 1.5° C and/or an increase in temperature to > 34° C) without evidence of thermal or tactile sensory block. A Horner's sign is should be documented for upper extremity blocks.

Claimant's treating doctor, JP, M.D., testified at the hearing. He stated that he was not the doctor who requested the nerve blocks. The requesting doctor was not willing to assist Claimant with getting the approval through the Workers' Compensation process, so Dr. P decided to step in and see if he could assist Claimant with getting the procedure. He stated that he was not familiar with

the Official Disability Guidelines (ODG), so he could not address whether the requested treatment was within these Guidelines. Dr. P stated that it was his understanding that the requested nerve block was the proper treatment, as this treatment had been done as a matter of course over the years of his medical practice. In addition, Dr. P did not provide any basis for the requested treatment in evidence based medicine. Therefore, based upon a review of the evidence, the decision from the IRO became final as a matter of law because it was not timely disputed. In addition, because Claimant did not meet her burden to prove that the preponderance of the evidence was contrary to the decision of the IRO. Therefore, even if the IRO decision had been disputed timely, Claimant is not entitled to sympathetic nerve block T2, T3 of the right side.

The Administrative Law Judge considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. The Texas Department of Insurance, Division of Workers' Compensation has jurisdiction to hear this matter.

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

   C. On (Date of Injury), Claimant/Petitioner was the employee of (Employer), Employer.

   D. On (Date of Injury), Employer provided workers' compensation insurance with Travelers Causalty & Surety Company, Carrier/Respondent.

   E. On (Date of Injury), Claimant/Petitioner sustained a compensable injury.

   F. The compensable injury of (Date of Injury), extends to and includes at least carpal tunnel syndrome, bilateral upper limb and complex regional pain syndrome 1, of the right upper limb.

   G. The Independent Review Organization determined Claimant/Petitioner should not have the requested treatment of sympathetic nerve block T2, T3 of the right side.

2. Carrier/Respondent delivered to Claimant/Petitioner a single document stating the true corporate name of Carrie/Respondent, and the name and street address of Carrier/Respondent's registered agent, which document was admitted into evidence as Administrative Law Judge's Exhibit Number 2.

3. Claimant/Petitioner's appeal of the IRO decision was not filed within the 20-day deadline contained in Division Rule 133.308(s)(1)(A).

4. Sympathetic nerve block T2, T3 of the right side 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 the Claimant is not entitled to sympathetic nerve block T2, T3 of the right side.

4. Claimant/Petitioner did not timely appeal the IRO decision in this case.

DECISION

Claimant/Petitioner is not entitled to sympathetic nerve block T2, T3 of the right side for the compensable injury of (Date of Injury). Claimant/Petitioner did not timely appeal the IRO decision in this case.

ORDER

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

The true corporate name of the insurance carrier is **TRAVELERS CAUSALTY & SURETY COMPANY**, and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7th STREET, STE. 620
AUSTIN, TX 78701-3218

Signed this 14th day of March, 2018.

Teresa Boone
Administrative Law Judge