DOCKET NO. 453-03-1936.M2

_____,	**§**	**BEFORE THE**
PETITIONER	**§**	
	§	
VS.	**§**	**STATE OFFICE OF**
	§	
ST. PAUL FIRE & MARINE	**§**	
INSURANCE C0., RESPONDENT	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case involves the appeal by an injured worker (Claimant) from the decision of an Independent Review Organization (IRO) that affirmed the denial by St. Paul Fire & Marine Insurance Company (Carrier) of preauthorization for bilateral brachial plexus decompression.[1] The decision reverses the IRO, finding the Claimant met the burden of proving the surgery is medically necessary and should be preauthorized.

PROCEDURAL HISTORY

Apparently, this preauthorization case was filed with the Texas Workers' Compensation Commission (Commission) in May 2002, and at some point in time the Independent Review Organization (IRO) lost the record. After a telephone call from the Claimant's State Representative in mid March 2003, the IRO quickly rendered its decision. The preauthorization process was also delayed by Carrier's dispute as to whether the Claimant's compensable injury extended to her bilateral brachial plexopathy. A Commission hearing officer found the injury was related to her work-related accident in an opinion dated May 8, 2001. That decision was affirmed by the Commission's Appeals Panel on July 9, 2001.

On April 28, 2003, Barbara C. Marquardt, Administrative Law Judge (ALJ), convened the hearing on the 4th floor of the William P. Clements Building, 300 West Fifteenth Street, Austin, Texas. The Claimant appeared and was represented by Luz Losa, Ombudsman. Steve Tipton, attorney, appeared and represented the Carrier. The record closed on the same day.

LEGAL STANDARDS

A. Entitlement to Medical Benefits

[1] The "brachial plexus" is a complex network of nerves that is formed chiefly by the lower four cervical nerves and the first thoracic nerve and supplies nerves to the chest, shoulder, and arm. MERRIAM WEBSTER'S MEDICAL DICTIONARY (1995). In layperson's terms, this is the location where the nerves from the arm join at the neck.

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. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the injury; (2) promotes recovery; or (3) enhances the ability to return to or retain employment.[2] "Health care" includes "all reasonable and necessary medical . . . services."[3]

B. Preauthorization

Certain categories of health care identified by the Commission require preauthorization, which is dependent upon a prospective showing of medical necessity. The requested procedure involves outpatient surgical services, which require preauthorization.[4]

ISSUE

Apparently, brachial plexopathy is a very general term, and due to the location of the Claimant's symptoms, the more specific term for her injury is thoracic outlet syndrome.[5] The issue is whether the Claimant's diagnosis of brachial plexus syndrome, also known as brachial plexopathy, is correct. The brachial plexus, which is one of the largest and most complex structures in the peripheral nervous system, is composed primarily of five nerve roots at C5-T1 that innervate the entire upper extremity and hand. Brachial plexopathies are lesions along the brachial plexus causing neurological signs and symptoms depending on the site of the injury.

EVIDENCE & ARGUMENTS

A. Basic Facts

The Claimant, who was in her late 40s at the time of the accident, had worked as an eighteen-wheeler truck driver with her husband for ten years. She is right-hand dominant. Her husband was driving in a treacherous area in the rain on_____, while the Claimant slept in the sleeper part of the truck. The truck veered off the road, slid down into a ditch, and leaned up against a tree. The accident tossed the Claimant out of the bed to the floor, injuring her knee, neck, and lower back.

The Claimant reported neck and back pain, which were initially diagnosed as cervical and lumbar spine strain, and x-rays taken in the emergency room showed no evidence of a fracture. She continued to work for two months, but her pain increased, and she also began to experience pain in her right leg and numbness within her right arm. The Claimant has complained of pain and had muscle spasms in the neck and trapezius and rhomboid muscles since her first medical treatment following the accident. The pain in her lower back has improved significantly with physical therapy and use of a TENS unit, but her neck and upper extremity problems have worsened over time. Her main symptoms now are "exquisite" pain in the neck and right arm, and she has some difficulty in

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[2]Tex. Lab. Code Ann. '408.021.

[3]Tex. Lab. Code Ann. '401.011(19).

[4]Tex. Lab. Code Ann. '413.014; 28 Tex. Admin. Code '134.600(a)(4).

[5]Because the parties and doctors used the terms interchangeably in the evidence, the ALJ will do likewise in discussing the case.

her lower extremities.

The Claimant's treating physician, Joseph Crumbliss, M.D., has cared for the Claimant for the most part since her accident. He described her current most troubling symptoms as chronic pain in the right neck, arm and upper chest over the brachial plexus C pain that has worsened over time in her arm and requires medication. From the record, it appears that the only treatment that has given any relief from the symptoms related to her upper extremities has been prescriptions for Celebrex (an anti-inflammatory for her arthritis), Lortab (for pain), Zanaflex (a muscle relaxant) and Ambien (for sleep). Dr. Crumbliss stated that due to her pain and other symptoms, the Claimant is unable to function in any meaningful way.

Dr. Crumbliss has referred the Claimant to neurologists and a number of doctors who specialize in brachial plexus surgery. He described the two specialists who recommended the requested surgery, Drs. Orenstein and Oishi, as well-qualified to make the diagnosis. Dr. Orenstein is the physician with the most experience in brachial plexus surgery in the Fort Worth area, according to Dr. Crumbliss, and he also described Dr. Oishi as having similar expertise. Dr. Crumbliss made it very clear in a letter dated July 31, 2000, that this is not a case of symptom-magnification. In his many examinations of the Claimant over the years he has found that her pain and symptoms are real and severe.

By November 1999, the Claimant's symptoms included neck stiffness, low back pain, right leg pain, and right hand numbness. In December 1999, an MRI of the cervical spine revealed a broad-based posterior osteophyte[6] and a disc bulge at C4-C5. On December 28, 1999, Dr. Dickerson did a nerve conduction study with normal results, and on January 18, 2000, Dr. Paul Harris did an electromyographic study of the right upper extremity that found it normal. The Claimant continued to have problems B neck pain, inability to use her right hand for driving, inability to lift objects and perform the work of a truck driver, and numbness and tingling in the hand.

Dr. Gary Heath, a pain consultant, saw the Claimant in spring of 2000, at which time the majority of her symptoms were in the neck. He performed two epidural steroid injections at C4-C5: (1) on April 12, 2000, which gave her a 30 - 40% improvement with neck and arm pain for about one week; and (2) on May 1, which did not provide any relief. Then, on June 15, Dr. Heath performed a selective C5 nerve root block, which caused increased pain. During that time, the Claimant also had several weeks of physical therapy with no improvement in her symptoms.

On May 15, 2000, the Claimant was given a Functional Capacity Evaluation (FCE), which found her pain symptoms valid and stated that she could sit and drive a truck, but that she would have limited cervical active motion with turning her head. The FCE concluded that any lifting, pushing, pulling, or carrying of loads would be very difficult for her to perform.

On May 16, 2000, Roberta Kalafut, D.O., gave the Claimant a 9% whole body impairment rating, and Paul J. Foxcroft, M.D., acting as the designated doctor, concurred with that rating on July

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[6] An Aosteophyte@ is a pathological bony outgrowth. MERRIAM WEBSTER=S MEDICAL DICTIONARY (1995).

6, 2000. On July 16, 2001, the Claimant was examined for an impairment rating due to her neck, shoulder, and arm problems, by Paul J. Foxcroft, M.D., who is a specialist in orthopaedics.

Dr. Foxcroft noted the Claimant had some symptoms on the left, but that they were much less severe than those on the right side. On the right, she suffered pain in her neck that radiated to her right shoulder. It also radiated up to her head, and she had frequent headaches. She was very tender to touch anywhere over the front and back of her right shoulder. Her hands went to sleep, especially at night, which woke her up. If she handled a heavy skillet, her pain worsened, and then her right hand became numb. The numbness included her thumb and all of her fingers, excluding her small finger. Her right shoulder also became numb, causing her to lose sensation over the back of the shoulder. At the time of Dr. Foxcroft's examination she was taking Celebrex, 5 mg of Lortab (sometimes three times daily), and Ambien at night. Dr. Foxcroft's other findings included the following:

$ no gross evidence of muscle weakness;
$ full sensation below the shoulders, but decreased light touch and pinprick sensation over both sides of the right shoulder;
$ marked tenderness of the shoulder, and a positive Tinel's test (tapping along a nerve, looking for strange sensations and paresthesias) over the right supraclavicular fossa B much more positive over the clavicle than over the soft tissues of the brachial plexus; and
$ tender shoulder regions on both sides, but much less tender on the left than on the right.

Dr. Foxcroft gave the Claimant a 14% whole person impairment rating just for her pain and sensory deficits related to her shoulders and upper extremities.

B. The IRO Decision

The IRO decision was written by a board certified neurosurgeon. The denial was based on several factors. First, the doctor opined that it is extremely unusual for brachial plexus pathology to be bilateral, when it is secondary to trauma. Next, the fact that the ESIs were beneficial would suggest the pain was not related to the brachial plexus. Additionally, the Claimant has had normal physical and electrodiagnostic test results, which the doctor felt would be rather unusual when there is significant brachial plexus pathology.

C. Claimant's Evidence

On June 28, 2000, the Claimant was examined by Dr. Harry Orenstein, a specialist in upper extremity surgery and plastic surgery. He diagnosed bilateral brachial plexus compressions and recommended bilateral thoracic outlet decompression, as well as trapezius tenomyotomy, and selective denervation of trigger points along the superior aspect of the trapezius. In Dr. Orenstein's opinion, the Claimant's accident and injury pattern during the accident totally support his diagnosis. His physical examination revealed the following symptoms:

$ classic brachial plexus entrapment problems at the scalene muscle triangle region, with development of trapezius myofascial pain syndrome as a sequalae of this entrapment;

$ a positive intra scalene compression test;
$ positive Tinel's sign;
$ positive, painful dysesthesias;[7]
$ pulling and tugging in the brachial plexus region with contra lateral ear to shoulder motion;
$ a positive Adson's sign,[8] and a positive Wright's test[9];
$ trapezius myofascial pain syndrome manifest by diffuse muscle tenderness;
$ a positive trigger point test with distinct trigger points; and
$ irritability in the ulnar median and radial nerve distribution of hand and forearm.

Dr. Orenstein concluded that she needed decompression of the nerve at the scalene muscle triangle region. He would do that surgery on the right, followed by similar surgery on the left about two weeks later. Sometime in Fall 2000 the Carrier filed an "extent of injury" dispute, claiming that the brachial plexopathy was not related to the Claimant's compensable injury.

On March 20, 2001 (while the extent of injury case was pending), Scott N. Oishi, M.D., a Diplomate of the American Society of Plastic Surgery with specialties in reconstructive microsurgery and surgery of the hand, examined the Claimant. At that time, she complained of bilateral occipital headaches along with nocturnal awakening with numbness in the hands (greater in the right than in the left). She held her shoulders in anterior elevated position B placement of the shoulders in anatomic position caused severe pain overlying the supraclavicular brachial plexus, bilaterally, and worse on the right. He also noted these symptoms:

$ a sharp Tinel's over the supraclavicular brachial plexus with the right worse than the left;a positive scalene[10] compression test;
$ abduction external rotation positive on both sides for reproduction of symptoms;
$ a mild Tinel's over both radial tunnels and carpal tunnels;
$ normal intrinsic hand function; and
$ both hands warm without dystrophic findings.

Dr. Oishi "wholeheartedly" concluded the Claimant had bilateral neurogenic thoracic outlet syndrome. He felt she could be helped by the bilateral brachial plexus releases, the trapezius myotomy, and denervation of trigger points.

The Claimant saw Dr. Orenstein again on June 20, 2001, and on January 16, 2002, while awaiting the outcome of the Commission's appeals process. Each time, Dr. Orenstein expressed

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[7] ADysesthesia@ means impairment of sensitivity, especially to touch. MERRIAM WEBSTER=S MEDICAL DICTIONARY (1995).

[8] AAdson=s sign@ is used to diagnose thoracic outlet syndrome. When the patient=s head is placed in a certain position, it causes a diminution or total loss of radial pulse on the affected side. STEDMAN=S MEDICAL DICTIONARY (27th ed. 2000).

[9] AWright=s syndrome@ is a neurovascular syndrome caused by hyperabduction of the arm, which may cause occlusion of the subclavian artery, producing sensory symptoms due to stretching of the brachial plexus. DORLAND=S ILLUSTRATED MEDICAL DICTIONARY (28th ed. 1994).

[10] AScalene@ or Ascalenus@ means any one of three deeply situated muscles on each side of the neck that extend from the transverse processes of two or more cervical vertebra to the first or second rib. *Id.*

concern that her condition was continuing to deteriorate bilaterally. Apparently, as time progresses with a condition like this, the prognosis worsens.

D. Carrier's Evidence

On December 22, 2000, Dr. Kalafut wrote a letter concluding it was unlikely the Claimant had a brachial plexus compressive neuropathy based on her normal MRI, neuroelectrical studies, normal reflexes, absence of sensory and motor loss, and the absence of associated severe injuries (such as fractures of cervical transverse processes or fractures of first ribs). Dr. Kalafut stated that upper plexus lesions (C5,C6 Roots/Upper Trunk) primarily affect muscles about the shoulder girdle with deficits noted in abduction and external rotation of the shoulder, and flexion and supination of the forearms. Severe upper level injuries result in the upper extremity hanging beside the trunk with the inability to lift the arm. Intermediate (C6, C7 Roots/Middle Trunk) lesions, which are very uncommon, result in impairment of the forearm, wrist, finger extension, pronation, radial hand flexion, and loss of the triceps reflex. Lower plexus lesions (C8,T1) impair ulnar mediated muscles and are seen mainly in the lower forearm and hand, median innervated hand muscles, and some radial nerve innervated muscles. These injuries can be profound and often result from severe traction type injuries and nerve root avulsions.[11]

According to Dr. Kalafut, brachial plexopathies involving severe lesions are most often caused by traction or stretch, but they can also be caused by the following: contusions or bruising, compression (from crutches, backpack straps, fractures of the clavicle), laceration, or ischemia[12] (mainly related to neurovascular injuries and radiation-induced lesions). Dr. Kalafut concluded it was unlikely the Claimant had a brachial plexus compressive neuropathy based on her normal MRI (in that it did not show fractures of the cervical transverse processes) and absence of a first rib fracture, neuroelectrical studies, normal reflexes, absence of lost muscle strength, absence of sensory and motor loss, and the absence of associated severe injuries (such as fractures of cervical transverse processes). In Dr. Kalafut's opinion, diagnosing brachial plexopathy based on tenderness over the brachial plexus would be subjective and would not stand up against valid objective documentation.

Dr. Kalafut then sought a second-opinion exam by a rehabilitation psychiatrist, Dr. Ferral Endsley, on January 12, 2001. Dr. Endsley found the Claimant's negative EMG and nerve conduction studies did not support a brachial plexus injury.

On September 17, the Claimant also saw Patty K. Young, M.D., for another opinion about her need for thoracic outlet decompression surgery. Dr. Young is trained in diagnosing brachial plexopathies and performs surgery, including thoracic outlet syndrome surgery, on them. At that time, the Claimant's complaints included the following:

$ numbness in both hands, with the right hand symptoms being worse;
$ numbness in the hands involving the thumb and all but the small finger, with tingling but no pain;

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[11] An Aavulsion@ is the tearing out of a body part. MERRIAM WEBSTER=S MEDICAL DICTIONARY (1995).

[12] AIschemia@ means localized tissue anemia due to obstruction of the inflow of arterial blood. *Id.*

$ tingling and numbness awakening her at night;
$ shooting neck pain that causes increased numbness in both hands;
$ no change in hand symptoms with elevation of arms over the head;
$ no symptoms (pain, aches, numbness) in the arms;
$ in the shoulders and upper back, constant soreness within the supraclavicular fossa region, trapezius region, entire clavicular area, and along the superior aspect of the scapula B symptoms worse on the right than the left, but no numbness in that entire region;
$ raising the arms above horizontal causing increased pain throughout, including shooting pain into the neck, the paraspinous area, and the base of her skull;
$ numbness in the interscapular area of her back, associated with lightheadedness and nausea, which began in Spring 2001;
$ activities (combing hair, elevating arms) increasing numbness in the interscapular midthoracic area of the back, but not changing symptoms within her bilateral upper extremities;
$ inability to turn neck side-to-side because of intense pain in the paraspinal areas of the neck;
$ inability to flex the neck forward secondary to pain;
$ with standing, mid to lower back pain, but no pain with sitting or lying down; and
$ increased numbness in the interscapular area and pain in the neck in the bilateral paraspinal areas (with the right always worse than the left) B being the only symptoms made worse by arm elevation over the head.

Dr. Young diagnosed chronic cervical strain with profound diffuse muscle tenderness and pain throughout the thoracic outlet areas, shoulders, and bilateral upper extremities. Additionally, the Claimant has multiple diffuse sites of nerve irritability, with marked pain and tenderness throughout the musculature of her bilateral upper extremities. Dr. Young stated that thoracic outlet compression is most frequently associated with normal neuroelectrical and electromyographic studies, and it is a very difficult diagnosis to make. There are no objective measurements to use to support physical examination findings; most frequently, it is diagnosed by symptomatology, history, and physical exam findings. Dr. Young doubted the presence of thoracic outlet compression bilaterally, because the Claimant does not have the most classic findings B positive provocative findings and maneuvers of arm abduction and external rotation, with worsening symptoms over time. She also stated that many of the diffuse positive findings are not consistent with thoracic outlet compression. Dr. Young concluded that surgical decompression would not be appropriate. But she made it clear that if some of the Claimant's symptoms quieted down, and she was found to have isolated, positive provocative findings, surgical decompression might be helpful in the future.

There is a half-page note in the file from Gary N. Pamplin, M.D., who is board certified in orthopaedic and hand surgery, dated April 23, 2002. There is no evidence on whether or not Dr. Pamplin is trained in, and does, brachial plexus release surgery. He stated that none of Dr. Orenstein's findings verifying the diagnosis are supported in standard, peer-reviewed medical journals. Referring to the MRI of the cervical spine done in December 1999, he opined the Claimant's problems are much more likely from the condition of her cervical spine.

E. Analysis & Conclusion

The only matter that is absolutely clear from this record is that the Claimant suffers from severe pain and incapacity related to her ____ work-related injury. She has been unable to work since two months after the injury and is unable to function in any meaningful way. Of the many doctors consulted in the case, only three were proven to have expertise in clinically diagnosing and operating on thoracic outlet syndrome: Drs. Orenstein, Oishi, and Young.

The ALJ finds the Claimant refuted the assertion by Dr. Kalafut that the absence of severe injuries in the accident made it unlikely she has brachial plexis pathology, as well as the statement in the IRO decision that it is extremely unusual for brachial plexus pathology to be bilateral. First, the experts on this subject, Drs. Orenstein and Oishi, found the Claimant's accident and injury pattern during the accident totally support the diagnosis. Second, Dr. Kalafut herself stated that this type of injury can be caused by contusions or bruising, which apparently was the source in the Claimant's case. None of the doctors consulted expressed doubts about the likelihood of brachial plexopathy to be bilateral.

Dr. Young, whose evidence generally favored the Carrier's position, stated that thoracic outlet compression is most frequently associated with normal neuroelectrical and electromyographic studies, and it is a very difficult diagnosis to make. According to Dr. Young, there are no objective measurements to use to support physical examination findings; most frequently, it is diagnosed by symptomatology, history, and physical exam findings. Given this fact, the ALJ finds the evidence favoring the Carrier's position from the following physicians (none of whom were shown to have experience in thoracic outlet syndrome) carries no weight in the case: Roberta Kalafut, D.O. (whose letterhead describes her as a specialist in *non*-surgical care), who relied on the normal MRI and neuroelectrical studies; Dr. Ferral Endsley, the psychiatrist who relied on the negative EMG and nerve conduction studies; and Dr. Gary Pamplin, who opined that Dr. Orenstein's findings supporting the diagnosis would not stand up compared to medical peer review literature, but neglected to cite any such literature.

In fact, some of the evidence meets the criteria Dr. Young focused on for diagnosing thoracic outlet syndrome. First, the Claimant's symptoms have worsened over time. Second, Dr. Orenstein found a positive Wright's test, apparently meaning Claimant has sensory symptoms related to hyperabduction of the arm that stretched the brachial plexus. Third, Dr. Oishi found abduction external rotation was positive on both sides for reproducing symptoms. Fourth, Dr. Young actually stated that at some time in the future, surgical decompression might be helpful to the Claimant.

The IRO decision is not at all convincing. It focuses on the Claimant's normal physical and electrodiagnostic test results. Since it is known that the Claimant has significant cervical problems in addition to the thoracic outlet syndrome, the fact that the ESIs she received reduced her pain for a time may relate to her cervical problems and does not refute her thoracic outlet syndrome symptoms at all.

Briefly, in addition to the matters referenced above, Drs. Orenstein and Oishi identified all of the following symptoms as bases for the diagnosis of thoracic outlet syndrome:

$ classic brachial plexus entrapment problems at the scalene muscle triangle region;
$ a positive intra scalene compression test;
$ positive Tinel's sign;
$ positive, painful dysesthesias;
$ pulling and tugging in the brachial plexus region with contra lateral ear to shoulder motion;
$ a positive Adson's sign;
$ trapezius myofascial pain syndrome manifested by diffuse muscle tenderness;
$ a positive trigger point test with distinct trigger points;
$ irritability in the ulnar median and radial nerve distribution of hand and forearm;
$ severe bilateral pain overlying the supraclavicular brachial plexus caused by placement of the shoulders in anatomic position;
$ a sharp Tinel's sign over the supraclavicular brachial plexus with the right worse than the left;
$ a positive scalene compression test; and
$ a mild Tinel's sign over both radial tunnels and carpal tunnels.

Given the evidence, the ALJ finds the Claimant proved her case. The bilateral thoracic outlet decompression is likely to offer her some permanent relief that could reduce her use of medication and increase her capacity for carrying out functions of daily living.

FINDINGS OF FACT

1. The Claimant (____) worked as an eighteen-wheeler truck driver with her husband. She is right-hand dominant.

    a. On_____, while the Claimant slept in the sleeper part of the truck and her husband drove, the truck veered off the road, slid down into a ditch, and leaned up against a tree.

    b. The accident tossed the Claimant out of the bed to the floor, injuring her knee, neck, and lower back.

2. The Claimant reported neck and back pain, which were initially diagnosed as cervical and lumbar spine strain, and x-rays taken in the emergency room showed no evidence of a fracture. She has complained of pain and had muscle spasms in the neck and trapezius and rhomboid muscles since her first medical treatment following the accident.

    a. The Claimant continued to work for two months, but her pain increased, and she also began to experience pain in her right leg and numbness within her right arm.

    b. The pain in her lower back has improved significantly with physical therapy and use of a TENS unit, but her neck and upper extremity problems have worsened over time.

    c. Her main symptoms now are "exquisite" pain in the neck and right arm and upper

chest over the brachial plexus, with similar, but less severe, symptoms on the left. She also has numbness and tingling in her hands. Due to these symptoms, she is unable to function in any meaningful way and has not worked since two months after the accident. She is unable to use her right hand for driving, to lift objects, and to perform the work of a truck driver.

3. The Claimant's treating physician, Joseph Crumbliss, M.D., has cared for the Claimant for the most part since her accident.

   a. Dr. Crumbliss found physical therapy is not warranted in treating the symptoms referenced in Finding 2c.

   b. The only treatment Dr. Crumbliss has found to give any relief from the symptoms related to her upper extremities have been prescriptions for Celebrex (an anti-inflammatory for her arthritis), Lortab (for pain), Zanaflex (a muscle relaxant) and Ambien (for sleep).

4. By November 1999, the Claimant's symptoms included neck stiffness, low back pain, right leg pain, and right hand numbness.

   a. A cervical MRI revealed a posterior osteophyte and a disc bulge at C4-C5.

   b. Nerve conduction and electromyographic studies had normal results.

5. The following treatments have been given to the Claimant: two epidural steroid injections at C4-C5, the first of which gave her a 30 - 40% improvement with neck and arm pain for about one week, and the second of which did not provide any relief; a selective C5 nerve root block, which caused increased pain; and several weeks of physical therapy that caused no improvement in her upper extremity symptoms.

6. On May 16, 2000, Roberta Kalafut, D.O., gave the Claimant a 9% whole body impairment rating, and on July 16, 2001, Paul J. Foxcroft, M.D., gave her a 14% whole body impairment rating due to her neck, shoulder, and arm problems.

7. The Claimant's upper extremity symptoms are due to classic brachial plexus entrapment problems at the scalene muscle triangle region, with development of trapezius myofascial pain syndrome as a sequalae of this entrapment. This condition is also known as thoracic outlet syndrome. All of the following factors support this diagnosis:

   $ the Claimant's accident and injury pattern;
   $ a positive intra scalene compression test;
   $ positive, painful dysesthesias;
   $ pulling and tugging in the brachial plexus region with contra lateral ear to shoulder motion;
   $ a positive Adson's sign, and a positive Wright's test;

- $ trapezius myofascial pain syndrome manifested by diffused muscle tenderness;
- $ a positive trigger point test with distinct trigger points;
- $ irritability in the ulnar median and radial nerve distribution of hand and forearm.
- $ bilateral occipital headaches along with nocturnal awakening with numbness in the hands, right greater than in the left;
- $ severe bilateral pain overlying the supraclavicular brachial plexus caused by placement of the shoulders in anatomic position;
- $ a sharp Tinel's over the supraclavicular brachial plexus B right worse than the left;
- $ a positive scalene compression test;
- $ a positive reproduction of symptoms on both sides from abduction external rotation;
- $ a mild Tinel's over both radial tunnels and carpal tunnels; and
- $ worsening symptoms bilaterally over time.

8. Since June 28, 2000, Dr. Harry Orenstein and Dr. Crumbliss have continued to seek preauthorization for outpatient surgery to decompress the nerve at the scalene muscle triangle region B first on the right side, followed by similar surgery on the left about two weeks later. This procedure is likely to offer the Claimant some permanent relief that will reduce her use of medication and increase her capacity for carrying out functions of daily living.

9. The Claimant has filed timely appeals from the Carrier's denial of preauthorization and the IRO decision denying preauthorization.

CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (the Commission) has jurisdiction to decide the issue presented pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031(d) and TEX. GOV'T CODE ANN., ch. 2003. (Vernon 2003)

3. An employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN.. §408.021(a).

4. Outpatient surgery requires preauthorization. TEX. LAB. CODE ANN. §413.014; 28 TEX. ADMIN. CODE §134.600(a)(4).

5. Based on the findings, the requested surgery is medically necessary and should be preauthorized.

ORDER

IT IS, THEREFORE, ORDERED that the Petitioner, _____, is entitled to preauthorization for bilateral brachial plexus decompression.

SIGNED this 20th day of May 2003.

BARBARA C. MARQUARDT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS