MEDICAL CONTESTED CASE HEARING NO. 09068
M6-08-13368-01

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 benefit contested case hearing was held on September 15, 2008, 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 left wrist neuroplasty, decompression of the median nerve/carpal tunnel for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was represented by RB, attorney. Carrier appeared and was represented by attorney, JP.

BACKGROUND INFORMATION

Claimant sustained injuries to his lower back and bilateral upper extremities while working as a lathe operator for a vacuum cleaner manufacturer. He initially reported back pain and numbness in his arms from the elbow to fingertips.

A September 5, 2006 EMG/NCV report revealed evidence of severe median entrapment neuropathy (carpal tunnel syndrome) in both wrists. On December 12, 2006, a neurologist diagnosed Claimant with bilateral carpal tunnel syndrome without axonal loss and recommended that he be referred for consideration of a release procedure.

On April 18, 2007, Claimant's treating doctor, Dr. M, requested left wrist neuroplasty/decompression median nerve/carpal tunnel. On October 3, 2007, he requested the same procedure for the right wrist. The right wrist procedure was processed through medical review and ultimately denied by the Carrier review doctors as not reasonably necessary. An IRO upheld the denial of the right wrist surgery.

On December 20, 2007, the designated doctor, Dr. D, opined that the *ODG* (*Official Disability Guidelines*) standard of care had not been met in the Claimant's case as he needed carpal tunnel surgery and had been denied that treatment.

On February 6, 2008, Claimant saw Dr. C, a carrier-selected RME doctor, who opined that while Claimant might have bilateral carpal tunnel syndrome based on EMG testing, his clinical evaluation on that date did not reveal carpal tunnel syndrome. He opined, based on the lack of symptoms, that Claimant's carpal tunnel syndrome was mild or moderate rather than severe. He further opined that Claimant did not require surgical intervention based on the *ODG* because he did not have the

necessary objective findings to make a diagnosis of severe carpal tunnel syndrome.

On March 5, 2008, Dr. M requested left wrist neuroplasty and decompression of the median nerve/carpal tunnel a second time.

On March 10, 2008, the Carrier approved right wrist neuroplasty with decompression of the median nerve. That approval was upheld by the Carrier's physician reviewer who opined that based on the clinical information submitted, and using evidence-based peer-reviewed guidelines, the right wrist request was medically necessary.

On April 7, 2008, Dr. C opined that because Claimant did not meet the surgical criteria set out in the *ODG*, based on his examination, surgery was not necessary.

On May 2, 2008, a medical contested case hearing was held regarding the medical necessity of the requested right wrist procedure, and the hearing officer held that the preponderance of the medical evidence was contrary to the IRO's decision and right wrist neuroplasty with decompression of the median nerve was healthcare reasonably required for treatment of the _____ compensable injury.

With regard to the second request for the left wrist procedure, the first utilization review doctor, Dr. S, a general surgeon, cited the *ODG*. Dr. S noted that the designated doctor had recommended the surgery, but also noted inconsistencies in the report of the RME doctor, Dr. C, who found no clinical evidence of significant carpal tunnel syndrome and noted that a functional capacity evaluation performed in connection with his evaluation revealed consistently submaximal effort. Dr. S opined that given the clinical data he reviewed, surgical intervention was not warranted.

The utilization review doctor who reviewed the request on reconsideration, Dr. G, a board certified orthopedic surgeon, also denied the requested treatment. He also cited the *ODG* for the proposition that the requested left wrist neuroplasty, decompression median nerve/carpal tunnel was not medically necessary. He stated that the requesting doctor failed to demonstrate the presence of left carpal tunnel syndrome and the Claimant was not noted to have atrophy of the upper extremity. According to Dr. G, based on the clinical information submitted and using evidence-based, peer reviewed guidelines (*ODG*), the request was not certified.

An IRO reviewer and board certified orthopedic surgeon reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO denied the requested left wrist neuroplasty, decompression median nerve/carpal tunnel based on inconsistent and inconclusive medical documentation. He cited the differences in the examinations of Dr. D (the designated doctor) and Dr. C (the RME doctor), and Claimant's excessive subjective complaints. The IRO reviewer cited the *ODG* treatment guidelines in upholding the denial of the requested service.

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not

available, generally accepted standards of medical practice recognized in the medical community." "Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 in making decisions about the care of individual patients.

The Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG)*, and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. The utilization review and IRO doctors in the instant case have all cited the *ODG* in denying the requested left wrist neuroplasty, decompression median nerve/carpal tunnel. The treating doctor and designated doctor also cited the *ODG* in support of the request for surgery.

The *ODG* Treatment Guidelines for carpal tunnel syndrome discuss surgical intervention as follows:

> 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 (sic) 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 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)

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

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

Both of the utilization review doctors and the IRO doctor denied the requested procedure citing the relevant provisions of the *ODG*, specifically the fact that there were discrepancies in the clinical examinations of the designated doctor and carrier-selected RME doctor, which called into question the diagnosis of left carpal tunnel syndrome. Claimant also relied on the *ODG* in disputing the IRO opinion and those of the utilization review doctors.

Dr. M, Claimant's treating doctor and the requesting doctor herein, stated that the condition in both the right and left wrists are identical. The issue in this case involves the medical necessity of surgery for the left wrist. Dr. M went through the *ODG* indications for surgery for a patient with mild to moderate carpal tunnel syndrome and explained in detail that Claimant has continuously had symptoms of pain and numbness as well as nocturnal symptoms and flick signs. He further stated that Claimant had positive Tinel's and Phalen's signs upon testing by a number of doctors on several occasions. Dr. M noted that both he and Dr. D noted decreased 2-point discrimination at 6mm. He further noted that pregnancy was not a concern and Claimant had been released to modified duty and had been wearing splints for some time. Dr. M stated that Claimant has been provided both over-the-counter and prescription analgesics, as well as both active and passive physical therapy, which had not alleviated his symptoms. Dr. M noted that Claimant had been prescribed a home exercise program and had positive electrodiagnostic studies revealing bilateral carpal tunnel syndrome. Dr. M opined that Claimant clearly qualified for carpal tunnel release surgery under the *ODG*.
Dr. G, also an orthopedic surgeon, was the physician advisor who approved the right wrist surgery on March 21, 2008, citing the *ODG* surgical criteria. Dr. G also denied the left wrist surgery on reconsideration on April 10, 2008, citing the same criteria. Dr. G testified at the hearing. He testified that he reviewed the IRO opinion and agreed with the denial of the requested left wrist surgery. Dr. G relied heavily upon the opinion of Dr. C, the carrier's RME doctor and what he viewed as inconsistencies and a lack of documentation in the medical records.

In the instant case, both parties relied on the *ODG* in support of their position for or against the requested treatment. The IRO cited the *ODG* as well, and opined essentially that because of the conflicting clinical evidence obtained as the result of the examinations performed by Drs. D and C, the requested procedure could not be approved. The IRO did not cite what *ODG* criteria was lacking, inconclusive or inconsistent.

The *ODG* provides two separate situations in which carpal tunnel release surgery may be indicated: severe CTS and mild/moderate CTS. Dr. M has set out, in detail, each of the five criteria under the mild/moderate category listed in the *ODG* and has explained how Claimant qualifies for surgery based on his demonstration of those criteria on clinical evaluation. The designated doctor, Dr. D, agreed. The opinions of Drs. M and D are supported by the clinical records of Dr. M.

The treating doctor's proposed treatment is in accord with the *ODG*. The vague references to inconsistencies in the clinical evidence do not amount to evidence-based medicine. Mere citation to the *ODG* does not carry the day. When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. In the instant case, Dr. M's report is specific and sets out exactly how Claimant's clinical presentation comports with the *ODG* indications for carpal tunnel surgery of the left wrist. Under the Act, treatment provided pursuant to the *ODG* is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**. The opinions of the IRO and Dr. G are general and based on oblique references to inconsistencies which are not apparent from a full review of the medical evidence presented. The preponderance of the medical evidence is contrary to the IRO decision. Claimant has met the *ODG* criteria for left carpal tunnel release surgery.

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 _____ Claimant was the employee of (Employer), when he sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant's treating orthopedic surgeon recommended left wrist neuroplasty, decompression median nerve/carpal tunnel for treatment of the _____ compensable injury.

4. The *ODG* indicates carpal tunnel surgery under certain circumstances and sets out a detailed list of required indications for surgery.

5. The IRO decision upheld the Carrier's denial of the requested left wrist neuroplasty, decompression median nerve/carpal tunnel.

6. Dr. M provided a narrative report setting out the *ODG* requirements for carpal tunnel release surgery and explaining how Claimant has met the requisite number of those requirements.

7. The requested service is consistent with the *ODG*.

8. The requested left wrist neuroplasty, decompression median nerve/carpal tunnel is health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

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

2. Venue was proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that left wrist neuroplasty, decompression median nerve/carpal tunnel is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to left wrist neuroplasty, decompression median nerve/carpal tunnel for the compensable injury of _____.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act and the Commissioner's Rules.

The true corporate name of the insurance carrier is **ACE AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

ROBIN MOUNTAIN
ESIS, INC.
6600 CAMPUS CIRCLE DRIVE EAST, SUITE 300
IRVING, TEXAS 75063

Signed this 30th day of December, 2008.

Erika Copeland
Hearing Officer