MEDICAL CONTESTED CASE HEARING NO. 11062
M6-10-28570-01

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.

ISSUES

A contested case hearing was held on November 17, 2010 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 an EMG/NCS to the left upper extremity for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by RR, ombudsman.
Respondent/Carrier was represented by RJ, attorney.

BACKGROUND INFORMATION

On _____, Claimant sustained a compensable injury to her left upper extremity as a result of performing her job duties. As a result of the compensable injury, Claimant has not had any surgery nor does it appear that surgery has been recommended. Claimant testified that she continues with symptoms though the symptoms have decreased and improved. Claimant is taking medication. Claimant's treating physician has requested an EMG/NCS study to determine the severity of her diagnosed carpal tunnel syndrome to her left upper extremity. The request for the EMG/NCS study has been denied by the Carrier and referred to an IRO who upheld the Carrier's denial.

The IRO reviewer, Board Certified in Orthopedic Surgery, concluded that per the Official Disability Guidelines (*ODG*) the requested treatment is not appropriate for the Claimant's compensable injury.

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."

Under the *ODG,* electromyography (EMG) for carpal tunnel syndrome states as follows:

> Recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). There are situations in which both electromyography and nerve conduction studies need to be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. Electromyographic examinations should be done by physicians. (Utah, 2006) Surface EMG is not recommended. See Electrodiagnostic studies.

The *ODG*, under the carpal tunnel section, specifically then refers to the electrodiagnostic studies and states as follows:

> 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 paresthesias 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.

Furthermore, the section of the *ODG* dealing with nerve conduction study (NCS) states:

> 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.

Claimant's treating physician testified and stated that he has recommended the EMG/NCS study as a diagnostic tool to determine the course of treatment necessary for Claimant's compensable injury and that requesting these diagnostic tests are part of his personal protocols and standard operating procedure for his practice. The treating physician testified that Claimant's diagnosis is tenosynovitis and possible carpal tunnel syndrome. The physician noted that Claimant began treating with him in May of 2010 and presented with radiating pain to her hands. Although the Claimant may have carpal tunnel syndrome, there was no indication or discussion that Claimant is a surgical candidate. In fact, the treating physician acknowledged that Claimant's condition is improving. The *ODG* specifically states that carpal tunnel syndrome must be proved by positive findings on clinical examination. The IRO reviewer noted that "[t]here is neither Tinel's sign or Phalen's sign, documentation of objective numbness, two-point discrimination, or any other signs of carpal tunnel syndrome. There is furthermore, no evidence based on physical examination of numbness affecting the ulnar distribution to lead the treating physician to a complementary diagnosis by EMG of lunar neuropathy." The reviewer went on to note that "even if the EMG/NCS on this individual was positive, given the total absence of objective physical findings and very murky subjective/objective symptoms, this patient would not meet the criteria as per the Official Disability Guidelines and Treatment Guidelines."

The treating physician failed to specifically discuss the *ODG* nor does he cite any studies showing that the requested studies are necessary for the compensable injury. Claimant's treating physician failed to offer evidence-based medical evidence to establish that the requested diagnostic testing meets the ODG guidelines for EMG and NCS studies to Claimant's left upper extremity. Based on the evidence presented, the Claimant did not meet her burden to present evidence based medical evidence contrary to the IRO's determination.

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).

C. On _____, Claimant sustained a compensable injury.

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

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

4. Claimant failed to present evidence based medicine contrary to the IRO decision.

5. EMG/NCS to the left upper extremity is not 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that an EMG/NCS to the left upper extremity is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to an EMG/NCS to the left upper extremity for the compensable injury of _____.

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 **LIBERTY INSURANCE CORPORATION,** and the name and address of its registered agent for service of process is

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

Signed this 22nd day of November, 2010.

Teresa G. Hartley
Hearing Officer