MEDICAL CONTESTED CASE HEARING NO. 11082
M6-10-29844-01

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 contested case hearing was held on December 14, 2010, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to neuroplasty and/or transposition of the ulnar nerve at the elbow for the compensable injury of _____?

PARTIES PRESENT

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

BACKGROUND INFORMATION

Claimant apparently injured his lower back, neck, left shoulder and left arm unloading merchandise from a truck on _____. Claimant's past medical treatment for this injury is not well documented. The medical records indicate that Claimant had left shoulder surgery to repair a rotator cuff tear on January 9, 2009. Following that surgery, Claimant had a left elbow neuroplasty on April 17, 2009 by Dr. T.

Dr. T's records indicate that the left elbow neuroplasty was not totally successful. As of October 2009, Claimant continues to have decreased sensation in the ulnar aspects of the left forearm and hand. Dr. T notes that Claimant is not in severe pain and has active use of the left hand. Dr. T believes further decompression surgery will not help Claimant as he has permanent damage to the ulnar nerve that occurred prior to the decompression surgery of April 17, 2009.

Claimant's treating doctor, a chiropractor, referred Claimant for a second opinion as to both left arm pain and left shoulder pain. Claimant was evaluated by Dr. C on April 14, 2010. Dr. C did not believe that further surgery to the left shoulder was warranted. As far as revision ulnar nerve surgery, Dr. C noted that Claimant did not get any relief from the prior surgery and that nerve studies suggest the nerve is still problematic. Under these conditions, Dr. C noted that revision surgery would be potentially helpful, but given Claimant's complex neck and shoulder problems there was no guarantee.

Dr. C's recommendation is the basis of this medical necessity dispute. The Carrier has denied Dr. C's request for ulnar nerve revision surgery. Claimant requested review by an independent review organization (IRO). The IRO has upheld the Carrier's denial of ulnar nerve surgery and Claimant has requested this Contested Case Hearing.

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 Official Disability Guidelines (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.

Both parties contend that their position is supported by the Surgery for Cubital Tunnel Syndrome provisions of the Official Disability Guidelines (ODG). These provisions are quoted below:

> Recommended as indicated below (simple decompression). Surgical transposition of the ulnar nerve is not recommended. Surgery for ulnar neuropathy at the elbow is effective two-thirds of the time. The outcomes of simple decompression (SD) and anterior subcutaneous transposition (AST) are equivalent, except for the complication rate, which is 31% in AST. Because the intervention is simpler and associated with fewer complications, SD is advised, even in the presence of (sub)luxation. (Bartels, 2005) (Asamoto, 2005) (Lund, 2006) (Nabhan, 2007) Although clinically equally effective, simple decompression was associated with lower cost than anterior subcutaneous transposition for the treatment of ulnar neuropathy at the elbow. The main difference was in the costs related to sick leave, which is significantly shorter for simple decompression. (Bartels2, 2005) (Nabhan, 2005) Simple decompression may offer excellent intermediate and long-term relief of symptoms. Less complete relief of symptoms following ulnar nerve decompression may be related to unrecognized carpal tunnel syndrome or weight gain. (Nathan, 2005) Medial epicondylectomy for persons with cubital

tunnel syndrome was superior to anterior transposition in relieving pain and in improving global outcome scores. Patients whose cubital tunnel syndrome is caused by an acute trauma have better outcomes after surgical treatment than patients with cubital tunnel syndrome from other causes. (AHRQ, 2002) Partial medial epicondylectomy seems to be safe and reliable for treatment of cubital compression neuropathy at the elbow. (Efstathopoulos, 2006) One study reviewed the results of two surgical methods for treating cubital tunnel syndrome. From 1994 to 2001, minimal medial epicondylectomy was performed on 22 elbows, and anterior subcutaneous transposition of the ulnar nerve was done on 34 elbows. In the group treated by medial epicondylectomy, 9 of the results (41%) were excellent, 10 (45%) were good, 2 (9%) were fair, and 1 result (5%) was poor. In the group treated by anterior subcutaneous transposition of ulnar nerve, 14 of the results (41%) were excellent, 13 (38%) were good, 6 (18%) were fair, and 1 result (3%) was poor. No significant difference was found between the 2 groups ($P < .05$). (Baek, 2005) (Greenwald, 2006) Age at surgery, duration of cubital tunnel syndrome, preoperative severity, and clinical symptom score and motor nerve conduction velocity in the early postoperative stage (one month after surgery) were found to be important prognostic factors of the syndrome. (Yamamoto, 2006)
ODG Indications for Surgery -- Simple Decompression (SD) for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following:
- Exercise: Strengthening the elbow flexors/extensors isometrically and isotonically within 0-45 degrees
- Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma.
- Medications: Nonsteroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve.
- Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence.

Claimant contends that the preponderance of the medical evidence is contrary to the IRO decision. First, Claimant argues that the IRO decision is incorrect. Second, Claimant argues that he meets the criteria set out in the ODG.

In regard to the Claimant's first argument, I find that Claimant is correct. The IRO decision states that Claimant does not have repeat electrodiagnostic testing showing pathology at the ulnar nerve and therefore the transposition of the ulnar nerve is not medically indicated. Claimant does have repeat electrodiagnostic testing showing pathology at the ulnar nerve. This was admitted into evidence as Claimant's exhibit 8. In addition, Claimant points out that repeat electrodiagnostic testing is not required by the ODG. The IRO decision makes no specific reference to any evidence based medicine requiring repeat electrodiagnostic testing.
In regard to the second argument, Claimant contends that he did, in fact, comply with the ODG. He notes that the ODG provides four indications for surgery. Claimant must have failed conservative treatment to the elbow that consisted of exercise, activity modification, medications

and a pad/splint for a three month trial period. Claimant testified at the MCCH that he had complied with all four requirements for cubital tunnel surgery as set out in the ODG.

Claimant's testimony is insufficient to establish that he has complied with the ODG requirements for cubital tunnel surgery. He needs expert medical evidence to establish that he has failed the conservative treatment outlined in the ODG. For example, the first requirement is exercise by strengthening the elbow flexors/extensions isometrically and isotomically within 0-45 degrees. Exercise in general does not meet this requirement. Claimant testified that he had physical therapy and he offered records to support his claim. A review of the physical therapy records show it was aimed at the lumbar spine, cervical spine and left shoulder. Left elbow pain was recorded, but no exercise for the left elbow was documented.

Claimant failed to establish that he met the requirements of the ODG for cubital tunnel syndrome. Although the IRO decision was mistaken in its reference to evidence based medicine, the Claimant can overturn the IRO decision only by a showing of evidence based medicine contrary to the IRO decision. Claimant failed to establish that he is entitled to neuroplasty and/or transposition of the ulnar nerve at the elbow for the compensable injury of _____.

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).

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 decision upheld the Carrier's denial of Claimant's request for a neuroplasty and/or transposition of the ulnar nerve at the elbow for the compensable injury of _____.

4. Claimant failed to present expert medical evidence to establish that he met the ODG requirements for a neuroplasty and/or transposition of the ulnar nerve at the elbow.

5. Neuroplasty and/or transposition of the ulnar nerve at the elbow 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 neuroplasty and/or transposition of the ulnar nerve at the elbow is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to neuroplasty and/or transposition of the ulnar nerve at the elbow 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 SERVICES COMPANY
211 E. 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701

Signed this 3rd day of January, 2011.

Donald E. Woods
Hearing Officer