MEDICAL CONTESTED CASE HEARING NO. 13060

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 medical contested case hearing was held on January 31, 2013, with the record closing on February 4, 2013,[1] to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (hereinafter "IRO") that Claimant is not entitled to lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner appeared without representation. Claimant appeared and was assisted by AF, ombudsman. Respondent appeared and was represented by BJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For Petitioner: Petitioner.

For Claimant: None.

For Respondent: NT, M.D.

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 through HO-3.

Claimant's Exhibits C-1 through C-7.

Respondent's Exhibits R-1 through R-11.

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[1] The record was left open so that Respondent could submit an audio copy of the testimony of NT, M.D., as there was a problem with the recording software. All the parties were notified of the submission of the audio copy and no objections were presented. Such audio copy was received on February 4, 2013 and was marked and admitted into evidence as Hearing Officer Exhibit HO-3.

BACKGROUND INFORMATION

Claimant was a worker for the employer, (Employer). On (Date of Injury), while on the floor welding, his right foot was run over by a company tractor. Claimant has seen several health care providers throughout the course of medical treatment for his injury. The compensable injury of (Date of Injury) is a crush injury to the right foot, bone contusions of the right 2nd, 3rd, 4th and 5th metatarsals, right ankle sprain, reflex sympathetic dystrophy (RSD) of the right foot, and complex regional pain syndrome (CRPS) of the right foot. There was no dispute that this was a compensable injury. Claimant received medical treatment for his injuries and had a spinal cord stimulator trial which did not alleviate his pain. Petitioner, who is board certified in anesthesiology and pain medicine, has treated Claimant and requested a lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510). Such requested treatment underwent utilization review and was denied on May 4, 2012 by MM, M.D. Reconsideration was requested and such reconsideration was denied on June 19, 2012 by SV, M.D. Petitioner then appealed the denials to an IRO and the IRO reviewer upheld the previous adverse determinations. Consequently, Petitioner appealed the IRO decision and this is the reason for the present discussion and decision.

DISCUSSION

Medical Necessity

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. TEX. LAB. CODE § 408.021. "Health care reasonably required" is defined 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. TEX. LAB. CODE § 401.011 (22a). Health care under the Texas Workers' Compensation system must be consistent with evidence-based medicine if that evidence is available. "Evidence-based medicine" means 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. TEX. LAB. CODE § 401.011 (18a). 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. TEX. LAB. CODE § 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with the Texas Labor Code. TEX. LAB. CODE § 413.017(1).

In accordance with the above statutory guidance, the Division has adopted treatment guidelines by rule. 28 Tex. Admin. Code § 137.100 (Division Rule 137.100). This Rule directs health care

providers to provide treatment in accordance with the current edition of the *Official Disability Guidelines* (hereinafter "ODG") and that 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.

The pertinent provisions of the ODG applicable to this case are as follows, to wit:

> CRPS, treatment:
>
> Recommended hierarchy of options as indicated below. The goal is to improve function. Multiple pathophysiological mechanisms are responsible including neuropathic (sympathetic and independently-maintained pain), and immunologic (regional inflammation and altered human leukocyte antigens). Both peripheral sensitization and central sensitization have been proposed. (Ribbers, 2003) (Stanton-Hicks, 2006) There are no evidence-based treatment guidelines but several groups have begun to organize treatment algorithms. Recommendations:
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> (1) Rehabilitation:
> (a) *Early stages:* Build a therapeutic alliance. Analgesia, encouragement and education are key. Physical modalities include desensitization, isometric exercises, resisted range of motion, and stress loading. If not applied appropriately, PT can actually be detrimental.
> (b) *Next steps:* Increase flexibility with introduction of gentle active ROM and stretching (to treat accompanying myofascial pain syndrome). Other modalities may include muscle relaxants, trigger point injections and electrical stimulation (based on anecdotal evidence). Edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present).
> (c) *Continued steps:* Continue active ROM; stress loading; scrubbing techniques; isotonic strengthening; general aerobic conditioning; and postural normalization.
> (d) *Final steps:* Normalization of use; assessment of ergonomics, posture and modifications at home and work. In some cases increased requirements of analgesic medications, psychotherapy, invasive anesthetic techniques and SCS may be required. See CRPS, spinal cord stimulators.
> (2) Psychological treatment: Focused on improved quality of life, development of pain coping skills, cognitive-behavioral therapy, and improving facilitation of other modalities.
> (a) *Early stages:* education.

(b) *Next steps:* clinical psychological assessment (after 6 to 8 weeks): identification of stressors; identification of comorbid Axis I psychiatric disorders (depression, anxiety, panic and post-traumatic stress).

(3) Pain management:

(a) *Pharmacological:* antidepressants (particularly amitriptyline); anticonvulsants (particularly gabapentin); steroids; NSAIDS; opioids; calcitonin; bisphosphonates; α1 adrenoceptor antagonists (terazosin or phenoxybenzamine). The latter class of drugs has been helpful in SMP. Clonidine has been given transdermally and epidurally. (See CRPS, medications.) Bisphosphonates have some literature support in the presence of osteopenia. (Rho, 2002)

(b) *Minimally invasive:* depends on degree of SMP, stage of rehabilitation (passive or active movement), and response to blocks. (See CRPS, sympathetic blocks.) Responders to sympathetic blocks (3 to 6 blocks with concomitant PT) may be all that is required. For non-responders somatic block or epidural infusion may be required to optimize analgesia for PT.

(c) *More invasive:* After failure of progression or partial relief, consider tunneled epidural catheters for prolonged sympathetic or somatic blocks or neurostimulation with SCS in CRPS-I and II. See CRPS, spinal cord stimulators. Also consider peripheral nerve stimulation in CRPS-II and intrathecal drug delivery in patients with dystonia, failed neurostimulation, long-standing disease, multi-limb involvement and requirement of palliative care.

(d) *Surgical:* Sympathectomy is not generally recommended, but has been considered in patients that respond to sympathetic blocks. Pre-procedure the patient should have outcomes assessed with radiofrequency and neurolytic procedures. (See CRPS, sympathectomy.) Motor Cortex Stimulation has been considered.

Outcome measures for all treatments of CRPS: Objective measures such as the the Beck Depression Inventory, the State Trait Anxiety Inventory, McGill Pain Questionnaire-Short Form, the Pain Disability Index, & the Treatment Outcomes in Pain Survey (the last three may not meet the APA standards for standardized test in clinical use). See Psychological evaluations. See also CRPS, diagnostic criteria; CRPS, medications; CRPS, prevention; CRPS, sympathetic blocks; & Sympathetically maintained pain (SMP). See also Spinal cord stimulators (SCS).

CRPS, diagnostic criteria:

Recommend using a combination of criteria as indicated below. There are no objective gold-standard diagnostic criteria for CRPS I or II. A comparison

between three sets of diagnostic criteria for CRPS I concluded that there was a substantial lack of agreement between different diagnostic sets. (Perez, 2007)

A. CRPS-I (RSD):

The IASP (International Association for the Study of Pain) has defined this diagnosis as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. (Stanton-Hicks, 1995) Diagnostic criteria defined by IASP in 1995 were the following:

(1) The presence of an initiating noxious event or cause of immobilization that leads to development of the syndrome;
(2) Continuing pain, allodynia, or hyperalgesia which is disproportionate to the inciting event and/or spontaneous pain in the absence of external stimuli;
(3) Evidence *at some time* of edema, changes in skin blood flow, or abnormal sudomotor activity in the pain region; &
(4) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain or dysfunction. Criteria 2-4 must be satisfied to make the diagnosis.

These criteria were found to be able to pick up a true positive with few false negatives (sensitivity 99% to 100%), but their use resulted in a large number of false positives (specificity range of 36% to 55%). (Bruehl, 1999) (Galer, 1998) Up to 37% of patients with painful diabetic neuropathy may meet the clinical criteria for CRPS using the original diagnostic criteria. (Quisel, 2005) To improve specificity the IASP suggested the following criteria:

(1) Continuing pain disproportionate to the inciting event;
(2) A report of one *symptom* from each of the following four categories and one *physical finding* from two of the following four categories:
    (a) Sensory: hyperesthesia,
    (b) Vasomotor: temperature asymmetry or skin color changes or asymmetry,
    (c) Sudomotor/edema: edema or sweating changes or sweating asymmetry, or
    (d) Motor/trophic: reports of decreased range of motion or motor dysfunction (weakness/tremor or dystonia) or trophic changes: hair, nail, skin.

This decreased the number of false positives (specificity 94%) but also decreased the number of true positives (sensitivity of 70%). (Bruehl, 1999)

The Harden Criteria have updated these with the following four criteria:

(1) Continuing pain, which is disproportionate to any inciting event; &
(2) Must report at least one symptom in three of the four following categories:
    (a) Sensory: Reports of hyperesthesia and/or allodynia;
    (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry;
    (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry;
    (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); &
(3) Must display at least one sign at time of evaluation in two or more of the following categories:
    (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement);
    (b) Vasomotor: Evidence of temperature asymmetry (>1°C) and/or skin color changes and/or asymmetry;
    (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry;
    (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); &
(4) There is no other diagnosis that better explains the signs and symptoms (Harden, 2007)

The Washington State Department of Labor and Industries guidelines include the presence of four of the following physical findings:
(1) Vasomotor changes: temperature/color change;
(2) Edema;
(3) Trophic changes: skin, hair, and/or nail growth abnormalities;
(4) Impaired motor function (tremor, abnormal limb positioning and/or diffuse weakness that can't be explained by neuralgic loss or musculoskeletal dysfunction);
(5) Hyperpathia/allodynia; or
(6) Sudomotor changes: sweating.
Diagnostic tests (only needed if four physical findings were not present): 3-phase bone scan that is abnormal in pattern characteristics for CRPS. (Washington, 2002)

The State of Colorado Division of Workers' Compensation Medical Treatment Guidelines adopted the following diagnostic criteria in 2006:

(1) The patient complains of pain (usually diffuse burning or aching);
(2) Physical findings of at least vasomotor and/or sudomotor signs, allodynia and/or trophic findings add strength to the diagnosis;
(3) At least two diagnostic testing procedures are positive and these procedures include the following:
    (a) Diagnostic imaging: Plain film radiography/triple phase bone scan,
    (b) Injections: Diagnostic sympathetic blocks,
    (c) Thermography: Cold water stress test/warm water stress test, or
    (d) Autonomic Test Battery.

    The authors provide the following caveat: Even the most sensitive tests can have false negatives, and the patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate. (Colorado, 2006)

Other authors have questioned the usefulness of diagnostic testing over and above history and physical findings. (Quisel, 2005) (Yung, 2003) (Perez2, 2005) A negative diagnostic test should not question a clinically typical presentation of CRPS and should not delay treatment. (Birklein, 2005)

B. CRPS-II (causalgia):
Nerve damage can be detected by EMG but pain is not contained to that distribution. (Stanton-Hicks, 1995) CRPS I and II appear to be clinically similar. (Bruehl, 1999) CRPS-II is defined by the IASP as:
(1) The presence of continuing pain, allodynia, or hyperalgesia after a nerve injury, not necessarily limited to the distribution of the injured nerve;
(2) Evidence at some time of edema, changes in skin blood flow, and/or abnormal sudomotor activity in the region of pain; &
(3) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction.

The state of Colorado also uses the above criteria but adds that there must be documentation of peripheral nerve injury with pain initially in the distribution of the injured nerve. (Colorado, 2006)

C. Differential Diagnoses of CRPS
These need to include local pathology, peripheral neuropathies, infectious processes, inflammatory and vascular disorders. (Quisel, 2005) (Stanton-Hicks, 2006) Also include the following conditions: pain dysfunction syndrome; cumulative trauma syndrome; repetitive strain syndrome; overuse syndrome; tennis elbow; shoulder-hand syndrome; nonspecific thoracic outlet syndrome; fibromyalgia; posttraumatic vasoconstriction; undetected fracture; post-herpetic

neuralgia; diabetic neuropathy. (Stanton-Hicks, 2004) Others have suggested that likely differential diagnoses should include:

(1) Disuse;
(2) Somatoform disorder (symptoms related to psychological factors); &
(3) Factitious disorder (deliberately feigning symptoms).

(Barth, 2009) See also Treatment for CRPS; Sympathetically maintained pain (SMP); CRPS, medications; CRPS, prevention; CRPS, sympathetic and epidural blocks.

CRPS, sympathetic and epidural blocks:

Recommended only as indicated below, for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. Detailed information about stellate ganglion blocks, thoracic sympathetic blocks, and lumbar sympathetic blocks is found in Regional sympathetic blocks. Recommendations for the use of sympathetic blocks are listed below. They are recommended for a limited role, primarily for diagnosis of sympathetically mediated pain and as an adjunct to facilitate physical therapy. It should be noted that sympathetic blocks are not specific for CRPS. See Sympathetically maintained pain (SMP). Repeated blocks are only recommended if continued improvement is observed. Systematic reviews reveal a paucity of published evidence supporting the use of local anesthetic sympathetic blocks for the treatment of CRPS and usefulness remains controversial. Less than 1/3 of patients with CRPS are likely to respond to sympathetic blockade. No controlled trials have shown any significant benefit from sympathetic blockade. (Varrassi, 2006) (Cepeda, 2005) (Hartrick, 2004) (Grabow, 2005) (Cepeda, 2002) (Forouzanfar, 2002) (Sharma, 2006) *Predictors of poor response:* Long duration of symptoms prior to intervention; Elevated anxiety levels; Poor coping skills; Litigation. (Hartrick, 2004) (Nelson, 2006) *Alternatives to regional sympathetic blocks:* may be necessary when there is evidence of coagulopathy, systemic infection, and/or post-surgical changes. These include peripheral nerve and plexus blocks and epidural administration of local anesthetics. *Mixed conduction blocks (central neural blocks):* suggested when analgesia is insufficient by pharmacologic means to support physical therapy: (1) Implanted catheters at the brachial or lumbosacral plexus: allows for 1 to 2 weeks of therapy. Side effects include technical failure and infection; & (2) Epidural tunneled catheters: allows for long-term therapy: Side effects: same as above. *Clonidine* has also been effective epidurally. (Stanton-Hicks, 2006) *Baclofen* has been demonstrated to be effective intrathecally to reduce dystonia. (van Hilten, 2000) *IV regional sympathetic blocks:* controversial due to varying success. Guanethadine was used, but is no longer available in the US. Bretylium and reserpine require daily blocks, and have potential side effects of transient syncope with apnea, orthostatic hypotension,

pain with administration, nausea and vomiting. Bretylium provided more than 30% pain relief for a mean of 20 days compared to placebo. (Hord, 1992) Due to modest benefits and the invasiveness of the therapies, epidural clonidine injection and intravenous regional sympathetic block with bretylium should be offered only after careful counseling, and they should be followed by intensive physical therapy. Intravenous regional sympathetic block (Bier's block) with guanethidine and lidocaine resulted in excellent pain relief and full restoration of both function and range of movement of the affected extremity in patients suffering from CRPS-I of the hand. (Paraskevas, 2005) Local or systemic parecoxib combined with lidocaine/clonidine IV regional analgesia is an effective treatment for CRPS-I in a dominant upper limb. (Frade, 2005) See also Sympathetically maintained pain (SMP); & Regional sympathetic blocks.

Recommendations (based on consensus guidelines) for use of sympathetic blocks:

(1) In the initial diagnostic phase if less than 50% improvement is noted for the duration of the local anesthetic, no further blocks are recommended.
(2) 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.
(3) 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) in physical therapy/occupational therapy.
(4) There should be evidence that physical or occupational therapy is incorporated with the duration of symptom relief of the block during the therapeutic phase.
(5) In acute exacerbations, 1 to 3 blocks may be required for treatment. (5) A formal test of the block should be documented (preferably using skin temperature).
(6) 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.

(Burton, 2006) (Stanton-Hicks, 2004) (Stanton-Hicks, 2006) (International Research Foundation for RSD/CRPS, 2003) (Colorado, 2006) (Washington, 2002) (Rho, 2002)

Lumbar sympathetic block:
Recommended as indicated below. Useful for diagnosis and treatment of pain of the pelvis and lower extremity secondary to CRPS-I and II. This block is

> commonly used for differential diagnosis and is the preferred treatment of sympathetic pain involving the lower extremity. For diagnostic testing, use three blocks over a 3-14 day period. For a positive response, pain relief should be 50% or greater for the duration of the local anesthetic and pain relief should be associated with functional improvement. Should be followed by intensive physical therapy. (Colorado, 2002)

In the instant case, the utilization review doctors denied the requested treatment and the IRO reviewer upheld the denial of the requested treatment. The IRO reviewer who is board certified in anesthesiology and pain management reviewed Petitioner's records and opined that the proposed procedure was not indicated as medically necessary based on the clinical data provided. Thereafter, the IRO reviewer cited medical judgment, clinical experience and expertise in accordance with accepted medical standards and the ODG in upholding the denials of the requested treatment.

When weighing expert testimony, the hearing officer must first determine whether the doctor rendering an expert opinion is qualified to offer such. In addition, the hearing officer must determine whether the opinion is relevant to the issues at bar and whether it is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See Black v. Food Lion, Inc.*, 171 F.3d 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *See Black*, 171 F.3d 308. In determining reliability of the evidence, the hearing officer must consider the evidence in terms of

(1) general acceptance of the theory and technique by the relevant scientific community;
(2) the expert's qualifications;
(3) the existence of literature supporting or rejecting the theory;
(4) the technique's potential rate of error;
(5) the availability of other experts to test and evaluate the technique;
(6) the clarity with which the theory or technique can be explained to the trial court; and
(7) the experience and skill of the person who applied the technique on the occasion in question.

Kelly v. State, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990) *aff'd*, 824 S.W.2d 568 (Tex. Crim. App. 1992).

Additionally, "[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." *See* Division Rule 133.308 (t). "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." *Id.*

Accordingly, Petitioner, as the party appealing the IRO decision, had the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. In this case, Petitioner presented testimonial and documentary evidence. It was evident that Claimant had reflex sympathetic dystrophy (RSD) or complex regional pain syndrome (CRPS) to the right lower extremity. A reading of the IRO appears to indicate that the IRO reviewer opined that Claimant did not have CRPS. Petitioner presented his own testimony in stating that there are gaps in the ODG and explained that Claimant had RSD/CRPS to the right lower extremity. He further testified that the requested treatment is medically reasonable and necessary. As such, there was sufficient medical explanation that the requested treatment was medically reasonable and necessary. Therefore, the preponderance of the evidence is contrary to the decision of the IRO that Claimant is not entitled to lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) for the compensable injury of (Date of Injury).

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 (Date of Injury), Claimant was the employee of (Employer), the Employer.

   C. On (Date of Injury), Employer provided workers' compensation with Texas Mutual Insurance Company.

   D. On (Date of Injury), Claimant sustained a compensable injury.

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

3. The IRO determined that Claimant is not entitled to lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) for the compensable injury of (Date of Injury).

4. Lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) is 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 contrary to the decision of the IRO that Claimant is not entitled to lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to lumbar sympathetic block for right foot/ankle PT LOS 5 days (64510) for the compensable injury of (Date of Injury).

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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RICHARD J. GERGASKO
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723

Signed this 13th day of February 2013.

Julio Gomez, Jr.
Hearing Officer