MEDICAL CONTESTED CASE HEARING NO. 13100

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 June 3, 2013 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is entitled to a right ulnar nerve submuscular transfer for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by MP, attorney.
Respondent/Provider's presence was excused.
Respondent/Claimant appeared and was assisted by JH, ombudsman.

BACKGROUND INFORMATION

Claimant injured her right elbow on (Date of Injury). Claimant initially treated with Dr. B and was diagnosed with a right elbow contusion. Claimant was referred to Dr. M and diagnosed with medical epicondylitis and right cubital tunnel syndrome. Claimant received conservative treatment that consisted of exercise, splinting, medications, injections, and activity modification. On September 28, 2010 Dr. M performed a right subcultanious anterior transfer of the ulnar nerve. On November 10, 2010 Claimant return to full duty work. On June 25, 2012 Claimant returned to Dr. M complaining that the right elbow symptoms had returned. Dr. M recommended a revision surgery. Two utilization reviews (URs) were conducted. Both URs denied the request for the same reasons. The UR reviewers stated that there was no documentation of lower levels of care such as splinting, and anti inflammatory medications, as required by the treatment guidelines. Also the UR reviewers opined that there was no objective physical examination finding of subluxation of the ulnar nerve with range of motion of the elbow to support the procedure. Dr. M appealed the Self-Insured's decision to an IRO. The IRO overturned the Self-Insured's denial noting that Claimant has had the necessary conservation care, without significant relief. Self-Insured 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). A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is 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. (Division Rule 133.308(t)).

On the date of this medical contested case hearing, the ODG provides the following with regard to surgery for cubital tunnel syndrome (ulnar nerve entrapment):

> Recommended as indicated below (simple decompression in most cases). Surgical transposition of the ulnar nerve is not recommended unless the ulnar nerve subluxes on ROM of the elbow. Surgery for ulnar neuropathy at the elbow is effective at least 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 generally advised. (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)

Simple decompression vs anterior transposition: Transposition may only be required if the ulnar nerve subluxes on ROM of the elbow. Otherwise simple decompression is recommended. (Heithoff, 1999) (Posner, 1998) (Bartels, 2005) (Elhassan, 2007) Irrespective of the surgical method, roughly 90% of patients are satisfied with surgical treatment of the ulnar nerve entrapment. However, one specific group of patients (people with habitual ulnar luxation or subluxation of the ulnar nerve) experienced a distinctly better result when treated by anterior transposition than by simple decompression, so simple decompression of the ulnar nerve can be recommended in all patients without cubital (sub)luxation of the nerve, whereas people with a tendency of cubital (sub)luxation of the ulnar nerve should be treated by submuscular anterior transposition. (Bimmler, 1996) In this study, both simple decompression and anterior transposition resulted in improvement in over 80% of cases, but a higher percentage of full recovery was seen in the cases treated by simple decompression. (Chan, 1980) The results of simple decompression of the ulnar nerve are similar to transposition, so the former simpler method is recommended as the standard procedure. (Lugnegård, 1982) The advantages of simple decompression make it the procedure of choice

for most cases of ulnar neuropathy. (Nathan, 1992) The simpler procedure of neurolysis in situ is the treatment of choice, but submuscular transposition remains appropriate in certain circumstances. (Biggs, 2006)

ODG Indications for Surgery – Surgery 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.

Based on a careful review of the evidence presented in the hearing, Self-Insured failed to meet its burden of overcoming the IRO decision by a preponderance of the evidence-based medicine. Self-Insured relied upon the UR reports and Claimant's testimony to establish that the ODG indications for surgery were not met. Claimant's testimony is insufficient to establish that she has or has not complied with the ODG requirements for cubital tunnel surgery. Expert medical evidence is needed to establish that Claimant has failed the conservative treatment outlined in the ODG. The IRO decision is based on the ODG, a review of the medical records, and conversations with Dr. M. The evidence revealed that the Claimant met all of the necessary criteria for revision surgery of a right ulnar nerve submuscular transfer.

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 (Self-Insured), Employer.

C. Claimant sustained a compensable injury on (Date of Injury).

D. Dr. M performed a 2nd right ulnar nerve submuscular transfer on February 19, 2012.

E. The Independent Review Organization (IRO) determined that the Claimant is entitled to a right ulnar nerve submuscular transfer.

2. Carrier delivered to Claimant and Provider 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. Self-Insured failed to prove that Claimant did not meet the requirements in the ODG for a revised cubital tunnel surgery consisting of a right ulnar nerve submuscular transfer.

4. The requested right ulnar nerve submuscular transfer 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 not contrary to the decision of the IRO that a right ulnar nerve submuscular transfer is health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to a right ulnar nerve submuscular transfer for the compensable injury of (Date of Injury).

ORDER

Self-Insured is 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 **(SELF-INSURED)** and the name and address of its registered agent for service of process is

SELF INSURED
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 3rd day of June, 2013.

Judy L. Ney
Hearing Officer