MEDICAL CONTESTED CASE HEARING NO. 10181
M2-06-1106-01

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 on remand from Travis County District Court was held on May 11, 2010 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is entitled to twenty sessions of chronic pain management for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by SG, ombudsman. Petitioner/Carrier appeared and was represented by PM, attorney. Respondent/Provider appeared and was represented by YG, attorney.

BACKGROUND INFORMATION

Claimant sustained a left hand/wrist injury in the course and scope of her employment on _____. Claimant received physical therapy, injections, and medications for her injury. Claimant was diagnosed with carpal tunnel syndrome and DeQuervain's tenosynovitis. Surgery was recommended by Dr. V, but it was denied by the Carrier. Work Hardening was also recommended, but it was also denied by the Carrier. Carrier's denial of work hardening was upheld by an Independent Review Organization (IRO). Claimant was eventually recommended to undergo chronic pain management. The Carrier's utilization reviews denied the request and the Provider appealed its decision to an IRO. The IRO overturned the Carrier's denial. In a report dated May 10, 2006 the IRO stated that the twenty sessions of Chronic Pain Management were necessary because Claimant had failed all other forms of conservative care, surgery had been denied, and Claimant still had complaints and objective findings that needed to be addressed. The IRO also stated that Claimant met the criteria based on her diagnoses of depression and anxiety.

At the time of the IRO decision Texas Labor Code Section 413.031(k) controlled and parties aggrieved by the decision of the IRO were required to file a Petition in Travis County District Court. Therefore, Carrier appealed the IRO decision to Travis County District Court. House Bill 724 amended the process for appealing a medical fee or medical necessity case that was codified in Texas Labor Code Section 413.031(k). House Bill 724 provided for the bifurcated hearings process found currently in Texas Labor Code Sections 413.031(k-1) – (k-2) and 413.0311. These sections now allow for administrative hearings with either the Division of Workers' Compensation or the State Office of Administrative Hearings. To implement Texas Labor Code Section 413.0311, the Division adopted Rules 133.307 and 133.308.

The present case was pending resolution in Travis County District Court when the parties entered into an agreed judgment and requested an order of remand to the Division. In an order signed on January 11, 2010, the Travis County District Court Judge remanded the case to the Division of Workers' Compensation. Division Rule 133.308 applies to preauthorization, concurrent or retrospective medical necessity disputes that are remanded to the Division or filed on or after May 25, 2008. This case is decided in accordance with the current rules and applicable statutes.

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. 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 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."

In the present case, the Carrier has the burden of overcoming the decision of the IRO. To meet its burden of proof, Carrier presented the testimony of Dr. T, M.D. Dr. T is board certified in Occupational Medicine. Respondent/Provider presented the testimony of Dr. T (2), D.C. Carrier challenged the testimony of Dr. T (2) stating he did not have qualifications to testify as an expert in this matter. Provider responded to the objection by stating that he was a part of the multi-disciplinary team that had evaluated Claimant to determine the medical necessity of the chronic pain program. He also stated that he served as one of her treating doctors for several years. Both Carrier and Provider relied on the American College of Occupational and Environmental Medicine, Occupational Medicine Practice Guideline (second edition, 2004) (ACOEM) as evidence based medicine to support their opinions. Parties relied on the ACOEM guideline

because it was cited by the IRO to support its opinion which was issued prior to the Division's adoption of the Official Disability Guidelines. Neither side referenced the ODG in their arguments. The ACOEM guideline is organized by types of injuries and indicates the recommended treatment for each injury. Chapter 11 of the ACOEM guideline covers forearm, wrist, and hand complaints. The diagnoses listed in Chapter 11 for the forearm, wrist, and hand are ligament/tendon strain, tendinitis/tenosynovitis, DeQuervain's syndrome, Carpal Tunnel Syndrome (CTS), Ganglion (aggravation), trigger finger, and regional hand and wrist pain.

With regard to Forearm, Wrist and Hand Complaints, the ACOEM guideline Chapter 11 provides as follows:

> "**Initial Care:** Comfort is often a patient's first concern. Nonprescription analgesics will provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate (that is, if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods may be added. Clinicians should consider the presence of medical diseases such as diabetes, hypothyroidism, Vitamin B complex deficiency, and arthritis. Side effects, cost, and provider and patient preferences should guide the clinician's choice of recommendations. Initial treatment of CTS should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. For patients with mild-to-moderate CTS who opt for conservative treatment, studies show that corticosteroids may be of greater benefit than nonsteroidal anti-inflammatory drugs (NSAIDs), but side effects prevent their general recommendation. Vitamin B6 is often used in CTS when it is perceived to be deficient, but this practice is not consistently supported by the medical evidence.
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> **Physical Methods:**
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> - Instructions in home exercise. Except in cases of unstable fractures or acute dislocations, patients should be advised to do early range-of-motion exercises at home. Instruction in proper exercise technique is important, and a physical therapist can serve to educate the patient about an effective exercise program.
> - Manipulation has not been proven effective for patients with pain in the hand, wrist, or forearm. Studies show that therapeutic touch is no better than placebo in influencing median-motor-nerve distal latencies, pain scores, and relaxation scores. Using a magnet for reducing pain attributed to CTS in no more effective than using the placebo device.
> - Physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short – to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist.
> - Most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. The exception is corticosteroid injection about the tendon sheaths or, possibly, the carpal tunnel in cases resistant to conservative therapy for eight to twelve weeks. For optimal care,

a clinician may always try conservative methods before considering an injection. DeQuervain's tendinitis, if not severe, may be treated with a wrist-and-thumb splint and acetaminophen, then NSAIDs, if tolerated, for four weeks before a corticosteroid injection is considered. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short lived. Trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after two injections by the primary care or occupational medicine provider."

With regard to potentially chronic or chronic injuries, the ACOEM guideline provide as follows:

"Persons returning to work in six months or less after injury tend to have the best outcomes. Persons who have been out of work for a year or more tend to have poor return-to-work outcomes. Research suggests that multidisciplinary care is beneficial for most persons with chronic pain, and likely should be considered the treatment of choice for persons who are at risk for, or who have, chronic pain disability. Flor et al. (1992) conducted a meta-analytic review of multidisciplinary pain treatment for chronic back pain, which concluded that chronic pain patients treated in multidisciplinary programs were functioning better than 75% of control patients who either received no treatment or who were treated by conventional unimodal approaches.

Multidisciplinary treatment was found to be superior to conventional physical therapy alone, had benefits that persisted over time, and was beneficial in improving return to work and decreasing use of health care. Because not all chronic pain patients may need intensive multidisciplinary interventions, some programs offer comprehensive multidisciplinary evaluations resulting in specific treatment recommendations for the patient."

Dr. T testified that a chronic pain program would involve work conditioning, address detoxification, physical therapy, and nutrition, access to social services, re-employment options, and psychological counseling. Dr. T testified that the ACOEM guidelines referenced above do not list chronic pain as a diagnosis for a wrist injury and there is no reference to chronic pain management as treatment for a wrist injury. Dr. T also testified that she did not believe that the depression and anxiety were related to Claimant's injury.

Dr. T also testified that the chronic pain management program was not medically reasonable and necessary in 2006 nor is it necessary currently. Dr. T stated that she served as a required medical examiner on the case and she also reviewed all of the medical records. Dr. T testified that Claimant had received significant conservative care despite having undergone diagnostic testing

that did not reveal any significant abnormalities. Dr. T also noted that Claimant's treatment had been ineffective through the date the request was made for pain management. Dr. T concluded that chronic pain management would not provide any medical benefit to the Claimant. Dr. T's testimony is bolstered by the records from the sessions which did not show any improvement in her pain levels. During the sessions Claimant consistently complained of an 8 out of 10 pain level. Dr. T also pointed out inconsistencies between the Functional Capacity Evaluation (FCE) performed at her direction which revealed a lack of effort by the Claimant and FCEs performed by Claimant's doctors to establish the need for further medical treatment. Dr. T stated that at the time the request for pain management was made, Claimant had been found to have reached maximum medical improvement and assigned a 0% impairment rating.

In response, Dr. T (2) testified that the pain management was reasonable and necessary for Claimant's diagnoses of depression and anxiety related to her injury. Dr. T (2) testified the diagnoses of left hand carpal tunnel syndrome and DeQuervain's tenosynovitis were supported by the records and these conditions were the cause of her depression and anxiety. Dr. T (2) testified that he based his opinion on his exams of the Claimant. He also based his opinion on the medical records of the licensed therapist in his office and the medical reports of the plastic surgeon, Dr. V. Although there are medical records that indicate diagnoses of left hand carpal tunnel syndrome and DeQuervain's tenosynovitis, the diagnostic tests do not support these conditions. The medical records in evidence indicate that MRIs of the left hand and left wrist that were performed on July 12, 2004 did not reveal any abnormalities and an EMG performed on March 21, 2006 revealed bilateral median nerve entrapment, greater on the right. The opinion of Dr. T (2) was considered, but was not persuasive. After considering all of the evidence presented, the Carrier has shown by a preponderance of evidence-based medicine that the chronic pain management program is not health care reasonably required for the compensable 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 _____, Claimant was the employee of (Employer).

   C. Claimant sustained a compensable injury on _____.

   D. The IRO determined that Claimant is entitled to twenty sessions of chronic pain management.

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. Twenty sessions of chronic pain management 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 contrary to the decision of the IRO that twenty sessions of chronic pain management is health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to twenty sessions of chronic pain management 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 **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET SUITE 620
AUSTIN, TX78701-3218

Signed this 25th day of May, 2010.

Jacquelyn Coleman
Hearing Officer