MEDICAL CONTESTED CASE HEARING NO. 09100
M6-09-16361-01

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 February 18, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions) for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was represented by PR, attorney. Respondent/Carrier appeared and was represented by DP, attorney.

BACKGROUND INFORMATION

Claimant sustained a full-thickness rotator cuff tear to his right shoulder. He underwent surgery once. It was not successful. A second surgery was attempted but was unable to be performed due to the severity of the muscle tear. Claimant entered the PRIDE program under the supervision of Dr. TM. Among other programs, Claimant underwent 10 sessions of functional restoration to restore strength and functionality to his shoulder and arm. After those sessions, it was then requested Claimant be authorized ten more sessions. This was denied. Claimant appealed the decision for an IRO review. The IRO doctor upheld the denial and Claimant requested a medical contested case hearing.

Texas Labor Code Section 408.021 provides 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 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. Texas Labor Code Section 401.011 (22a). Evidence based medicine means the use of the current best qualified 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. Texas Labor Code Section 401.011 (18a). In accordance with the above statutory guidance, Rule 137.100 directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines, and such treatment is presumed to be reasonably required.

The Official Disability Guidelines state the following regarding functional restoration programs and shoulders:

> There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003)

Additionally, the Official Disability Guidelines state the following regarding chronic pain management programs:

> Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders.

Finally, the Official Disability Guidelines cite these criteria to be met to enroll in a chronic pain management program:

> **Criteria for the general use of multidisciplinary pain management programs:**
> Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:
> (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to

restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f) Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;

(2) The patient has a significant loss of ability to function independently resulting from the chronic pain;

(3) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;

(4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided;

(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;

(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;

(7) Negative predictors of success above have been addressed;

(8) These programs may be used for both short-term and long-term disabled patients. See above for more information under *Timing of use*;

(9) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program;

(10) Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;

(11) At the conclusion and subsequently, neither re-enrollment in nor repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury. Psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with

> outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach.
> (BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs.

The parties presented copies of the chronic pain management program recommendations and criteria. The copies show how the Official Disability Guidelines have been updated. In Claimant's copy of the Official Disability Guidelines, one of the criteria was "(8) The worker must be no more than 2 years past the date of injury. Workers that have not returned to work by two years may not benefit." The Official Disability Guidelines were updated on February 17, 2009, (the day before the hearing) and changed to reflect "(8) These programs may be used for both short-term and long-term disabled patients. See above for more information under *Timing of use*." Under the old criteria, Claimant would have been immediately ineligible because he was injured more than three years ago. Under the current criteria, the date of injury is no longer a restriction for him.

The IRO doctor determined Claimant was not a candidate for this treatment because one would not expect Claimant would be able to return back to the job given his shoulder problem and it was unclear if a functional restoration program will have benefit regarding this right shoulder with a completely torn rotator cuff to his right shoulder. Finally he stated this treatment is unnecessary and not needed based upon medical records.

Claimant relied upon Dr. TM. He testified why the program would benefit Claimant. He testified few chronic pain patients can return to their old jobs. Claimant would need the ability to return to a modified, medium duty job. Claimant needs this program to increase strength elsewhere in his upper extremity, not just the right shoulder. He needs pain management skills. The program would increase his physical and functional levels. The program would teach him how to coordinate his right arm efforts with his functional left arm. Claimant needs this specific treatment. Dr. TM testified PRIDE has proven itself to be a facility where "there is access to programs with proven successful outcomes" as required by the Official Disability Guidelines for this type of treatment.

Finally, Dr. TM testified he published a study comparing shoulder injuries to low back injuries and the efficacy of functional restoration programs for shoulder rehabilitation. The study is in evidence, Claimant Exhibit 5. It was published in 1999. Dr. TM testified the study has been updated as of 2007 and is in the process of being published. Those studies support the efficacy of functional restoration therapy for upper extremities. Claimant argued these studies are the required evidence-based medicine studies needed to support Claimant's request for treatment beyond the recommendations of the Official Disability Guidelines.

Dr. MD testified for the Carrier. He testified Claimant should not have this program, and even if it were his patient he would not recommend the therapy. Per the Official Disability Guidelines Criterion No. 4, if surgery was a possibility, the requested treatment was not recommended (even though under cross-examination Dr. MD testified surgery probably would not help). Claimant's functional impairment was due to the complete rotator cuff tear, not chronic pain as required in Criterion No. 2. Finally, he testified Claimant did not demonstrate significant efficacy as documented by subjective and objective gains. Claimant's medical records are lacking in showing documented progress and efficacy. There are some therapy records showing he

increased his ability on two lifts by one to two pounds. Dr. MD testified this was not a significant gain as required by Criterion No. 9 but only a modest gain at best.

The Official Disability Guidelines simply do not recommend the program for shoulders. In two separate sections it notes "There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003)" Claimant failed to provide evidence based medicine in support of his position. The ODG does not recommend the program for shoulders. Claimant is not entitled to a chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions).

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.

   D. The Independent Review Organization doctor determined Claimant should not have a chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions) for the compensable injury of _____.

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. A chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions) 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 a chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions) is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to a chronic pain management program for the right shoulder five times a week for a total of two weeks (10 sessions) 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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RUSSELL RAY OLIVER, PRESIDENT
6210 HIGHWAY 290 EAST
AUSTIN, TX 78723.

Signed this 20th day of February, 2009.

KEN WROBEL
Hearing Officer