SOAH DOCKET NO. 453-04-2214.M2
TWCC MRD NO. M5-03-1984-01

ADVANTAGE HEALTHCARE SYSTEMS,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
AMERICAN MOTORISTS INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Advantage Healthcare Systems (Provider) challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) denying preauthorization of a six-week chronic pain management course to treat for ___ (Claimant) in connection with her shoulder and wrist injury. The MRD concluded that chronic pain management was not medically necessary to treat Claimant.

Based on the evidence, Provider failed to meet its burden of proof to show that a six-week course of pain management is reasonable or medically necessary to treat Claimant's compensable injury. Preauthorization for Provider to administer this treatment is denied.

The hearing in this matter convened on February 11, 2004, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra Church presiding. The record closed that day. Provider was represented by Mark H. Sickles, attorney. American Motorists Insurance Company (Carrier) was represented by Nick Kempisty, chief compliance officer for Carrier. The Commission did not participate in the hearing.

I. DISCUSSION

On ___, Claimant injured her right wrist and shoulder when a large basket or box of clothing fell on her right shoulder.

Notwithstanding the fact that Claimant has minimal physical symptoms remaining from her injury that three years, ago, Petitioner contented that she has developed an inability to accurately assess or manage any pain, including pain arising from her compensable injury. Provider also asserted that as Claimant is allergic to many of the commonly-used prescription pain medications, she must be treated with a non-medication-based program in order to achieve a successful return to work. Claimant has not worked since her date of injury. For its part, Carrier argued that Claimant presents no objective evidence of residual injury to her right shoulder and wrist, that her current anxiety, depression, and difficulty in managing pain arise from life events other than the compensable injury, and that Claimant magnifies her symptoms. Carrier noted too that Claimant's complaints of pain have broadened over time far beyond her initial complaints of pain in her right shoulder and wrist to include complaints of constant pain in both of her arms, her neck, back, and entire body.

Claimant's initial diagnosis was right carpal tunnel syndrome and right shoulder strain. Shortly after the injury she had full functional range of motion of her right shoulder and did not show any signs of nerve impingement. An EMG/nerve conduction study in September 2002 showed no evidence of cervical radiculopathy or ulnar nerve compression at her right elbow, although it showed indicators for a right carpal tunnel syndrome. There is no credible evidence anywhere in the record demonstrating that Claimant injured any part of her body other than her right wrist and shoulder as a result of the compensable injury. No bones of her arm or wrist were broken in the injury. During late 2001 Claimant also began to report pain in her *left* arm and wrist, as well as in her neck and lower back.

Over the course of her two and one-half years of treatment for her shoulder injury, Claimant has been treated by several doctors and received a variety of conservative treatments. Doctors examining her have differed widely in their diagnoses, although none has recommended surgery. Claimant was initially treated with physical therapy and the medications Celebrex and Norflex. No adverse drug reaction is noted. Approximately one month after the injury, Claimant changed treating doctors, to Anthony Esquibel, D.C. He administered various passive modalities, ultrasound, stretching, and manipulations, and also referred her for an orthopedic consultation.

On March 6, 2002, Patrick W. Donovan, M.D., recommended both steroid injections to her shoulder and to her wrist and administration of anti-inflammatory medication, particularly Daypro or Naprosyn. He classified her then-current complaints as "mild." Dr. Donovan's report does not discuss possible drug allergies, nor is there any indication whether any of his recommendations were followed. Dr. Donovan's examination was the required medical examination (RME) performed on behalf of the Commission.

On December 2, 2002, Alan B. Hurshman, M.D., a Commission-designated doctor, diagnosed Claimant as having a right shoulder impingement, with a small supraspinatus tear, right carpal tunnel syndrome, right De Quervain tenosynovitis, and right cubital tunnel syndrome. At that time he recommended a four-to-six-week regimen of treatment combining injections and physical therapy. It is unknown whether Claimant underwent either physical therapy or injections in 2002. However, in March 2003 Claimant did receive a right shoulder steroid injection. A series of stellate ganglion blocks administered in May 2003 apparently reduced or eliminated reflex sympathetic dystrophy (RSD) which apparently had begun to develop.[1] However, later examination showed no indications of that condition. Carrier Exh. 1, p. 27.

On August 28, 2003, Allen S. Kent, M.D., an orthopedic surgeon, recommended against surgery for Claimant, stating that her diffuse symptoms and lack of objective evidence of cervical radiculopathy made a successful surgical outcome unlikely. Dr. Kent concluded that Claimant demonstrated chronic pain syndrome with some, but not clear, evidence of right shoulder impingement. He recommended a comprehensive, multidisciplinary pain program for her treatment.

In contrast, on August 11, 2003, Jack A. Kern, M.D., recommended against further treatment except for strengthening of her upper right arm through a home exercise program. He also recommended that Claimant be released to work, with restrictions on pushing, pulling, or overhead activities. He found her arm and hand mobility and strength to be equal as between her right and left

[1] Reflex sympathetic dystrophy syndrome, also known as, complex regional pain syndrome (CRPS) is a chronic condition characterized by severe burning pain, pathological changes in bone and skin, excessive sweating, tissue swelling, and extreme sensitivity to touch. Definition source, website of the National Institute of Neurological Disorders and Stroke.

sides, without any signs of decreased activity of her right hand. Dr. Kern agreed that Claimant is not a surgical candidate. Carrier Exh. 1, pp. 25-29. He found no evidence of RSD.

In May 2002, Dr. Neal Griffin, D.C., became Claimant's treating doctor and requested preauthorization for a chronic pain management course. On September, 17, 2003, in requesting approval for the pain management program, Dr. Griffin, diagnosed Claimant as having carpal tunnel syndrome, internal derangement of the shoulder region, and an unspecified disorder of the autonomic nervous system. He concluded that Claimant showed pain that has persisted beyond the expected tissue hearing time, and physical, or mental impairment greater than expected on the basis of the medical diagnosis. Dr. Griffin supported his recommendation by a mental health evaluation in August 2003 which showed Claimant had some anxiety and also moderate to severe depression. She reported she had been restricting her activities due to both a fear of re-injury and to her perception of being in constant, whole-body pain. Pet. Exh. 1, pp. 28-38.

Dr. Griffin asserted that Claimant is allergic to many prescription pain medications. However, the extent of these allergies is unclear.[2] Claimant was treated early on with Celebrex and Norflex, which she reported did not help the pain, although she did not report an allergic reaction to those drugs. She has reported adverse reactions to Ultram, Aleve, Darvocet, and Vicodin. In March 2003, Dr. Hurshman recommended a trial of medication to treat Claimant's neuropathic pain. There is no indication that such a trial, if undertaken, was unsuccessful due to Claimant's allergic reaction. In March 2003, the doctor administering the shoulder injections in the notes that Claimant had no known drug allergies. Provider Exh. 1, p. 17.

The medical evidence supports a conclusion that Claimant's continuing reports of whole-body pain two years after her accident are well beyond the objective evidence of residual physical injury. However, the ALJ does not agree that Provider met his burden of proof to show that the Claimant's enduring complaints of pain arise out of the compensable injury. Provider bases its case

[2] George Esterly, a licensed professional counselor employed by Provider, conducted the mental health evaluation. Claimant's apparent severe drug allergies, one of the arguments advanced by Provider for a chronic pain management program, is not touched upon in Mr. Esterly's evaluation. Indeed, his recommendation for pain management lists *reduction in dependence on pain medication* as one of the reasons the program would help Claimant. Provider Exh. 1, p. 30. Such stock phrasing reduced the credibility of this report.

primarily on self-reporting by the Claimant. However, the ALJ was unable to give Claimant's statements much, if any, credence due to the numerous inconsistencies from throughout her history. She professes a desire to cease drug use, but is apparently taking only Advil for pain management, an over-the-counter medication she said in August 25, 2003, was "no help." Provider Exh. 1, p. 22. The evidence in this case also suggests that Claimant came to the injury with problems in coping with pain since Claimant has consistently asserted from day one of treatment for her injury that nothing-no treatment, therapy, or medication-has helped her injury to any degree. Provider Exh. 1, p. 19. Claimant has also been inconsistent in her self-reporting of her mental health symptoms.

While she reported severe insomnia to Provider's mental health evaluator on September 9, 2003, approximately two weeks earlier, on August 25, 2003, she reported no insomnia at all and "no" on seven other indicia of depression. Claimant has asserted she did not have a short temper, although three months earlier said she was irritable and got angry easily. In short, Provider did not present credible evidence that provided a clear causal link from the injury to Claimant's mental health and coping problems.

Further, the ALJ concluded that Provider failed to demonstrate that aftereffects of the compensable injury have significantly interfered with Claimant's activities of daily living. This is one of four necessary elements an injured worker must demonstrate to qualify for a pain management course.[3] The evidence regarding this element is based entirely on Claimant's self reporting. Based on other inconsistencies in her self-reporting, this is not a credible source of evidence to determine the level of interference. The actual change in frequency of activities or the limitations on her ability to perform her activities of daily living was not thoroughly documented, nor were Claimant's activity levels before and after the injury compared. Physical examination in both March 2002 and August 2003 failed to show muscle atrophy, or disparity between her limbs consistent with reduced use of her right arm. Her arms showed equal mobility and flexibility. This is inconsistent with her reports that she unable to do "anything." In short, Provider failed to demonstrate that the aftereffects of the injury have significantly interfered with Claimant's activities of daily living.

[3] *See Medical Fee Guideline* (MFG) 28 TEX. ADMIN. CODE §134.201, Single and Interdisciplinary Programs, pp. 36-41 (repealed effective January 1, 2002).

Provider also failed to establish that Claimant would be an appropriate candidate for the pain management program requested. It was undisputed that she self-manifests pain and cannot assess her true pain levels accurately. Her incapability due to her perceived pain has been-and likely will continue to be-reinforced by her family's behavior. Provider Exh. 1, pp. 28-38. While treatment for the family as a unit is *referenced* in Provider's plan, there is no indication that the chronic pain management would include her family, or that Carrier would, or even could, pay for what appears to be a component essential for success in Claimant's case. Provider Exh. 2. Claimant herself acknowledged her goal is to find a cure, not learning to live with a chronic condition. Provider Exh. 1, p. 29. She has consistently maintained that no therapy, treatment, or medication has provided even the slightest relief in over two years. Carrier Exh. 1, p. 19-20. In short Provider failed to explain how Claimant would be a person likely to benefit from its standard chronic pain management program by decreasing her dependence on the health care system or by improving her functioning.

In sum, Provider failed to meet its burden of proof to show that Claimant's chronic pain resulted from her compensable injury, or that Claimant is a person who would benefit from a chronic pain management course. The chronic pain management program requested would not be reasonable or medically necessary to treat Claimant's compensable injury.

II. FINDINGS OF FACT

1. On ___, ___ (Claimant) suffered a compensable injury to her right shoulder and wrist when a box or bin full of clothing fell on her right shoulder.

2. American Motorists Insurance Company (Carrier) was the responsible insurer.

3. Immediately after the injury, Claimant was treated conservatively with pain medication and physical therapy. She initially complained only of right arm pain, and demonstrated a full functional range of motion of her arm shortly after the injury. She was later treated with passive modalities, stretching, and manipulations.

4. In September 2002, Claimant did not have a cervical radiculopathy or ulnar nerve compression at her right elbow, although did show signs of carpal tunnel syndrome.

5. Claimant did not suffer any bone fractures or dislocation of her right shoulder, arm, or hand as a result of the injury. Claimant did not have injury to any level of her spine as a result of the injury.

6. From September 2001 through September 2003, Claimant has complained of left shoulder, left wrist, and neck pain, as well as pain in her lower back, in addition to her ongoing complaints of right shoulder and wrist pain.

7. Claimant claims she is in pain 100 per cent of the time, frequently has pain in all parts of her body, and stated that no therapy, medication, or treatment of any type provided to her since her date of injury has lessened her pain or improved her condition.

8. Claimant showed positive signs for pain magnification, in September 2003 was unable to accurately assess her actual pain levels, and self-manifests pain.

9. Claimant's family members and associates have reinforced Claimant's inability to manage her pain.

10. Diagnosis of Claimants shoulder injury have been inconsistent as to whether there has been impingement of nerves in either her arm or her hand, and whether these she has measurable radiculopathy in her right arm.

11. In March 2003, Claimant was given a right shoulder steroid injection.

12. In May 2003, Claimant underwent a series of stellate ganglion blocks to treat reflex sympathetic dystrophy (RSD) of the right hand. If the RSD condition existed in May 2003, the ganglion blocks apparently reduced or eliminated the RSD as there were no signs of this disorder present in August 2003.

13. Neither the steroid injection nor the ganglion blocks reduced Claimant's reports of pain.

14. In August 2003, Claimant was not a suitable candidate for surgery because of her diffuse shoulder symptoms and lack of objective evidence of cervical radiculopathy.

15. In August 2003, Claimant showed signs of chronic pain syndrome.

16. Claimant has reported allergies to many anti-inflammatory or pain-control medications. There is no evidence of trials of medications that were unsuccessful due allergic reactions.

17. Claimant has not worked since the injury on ___.

18. Claimant reported difficulty in performing many activities of daily living, including driving and household chores. There was no quantitative or descriptive comparison of the modifications or reductions she may have made in her activities of daily living after her shoulder injury, or comparison between her pre-injury and post-injury activity levels.

19. In 2003, Claimant was inconsistent in reporting whether she has a bad temper, insomnia, and other indicators of depression.

20. In August 2003, Claimant showed normal mobility in both elbows, wrists, shoulders and forearms, and no differential between her forearm muscles, as would be expected if one limb had significant inactivity. She had a mobile lumbar and cervical spine, and sat and stood erectly. Prior medical exams showed no gross muscle wasting or atrophy of either of Claimant's arms.

21. On September 17, 2003, Provider requested preauthorization for a six-week pain management course which had been recommended by Neal Griffin, D.C., Claimant's treating doctor.

22. After reconsideration of Provider's request, on October 20, 2003, Carrier denied preauthorization for the chronic pain management treatment on the basis it was not medically necessary.

23. Provider appealed the Carrier's denial of reimbursement to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission).

24. On December 15, 2003, based on the review by an Independent Review Organization (IRO), Medical Review of Texas, the MRD upheld Carrier's denial of preauthorization.

25. On December 17, 2003, Provider requested a hearing on the MRD decision on the reimbursement order.

26. On January 15, 2003, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted. The case was continued on motion of the parties.

27. Administrative Law Judge Cassandra Church conducted a hearing on the merits of this case on February 11, 2004, and the record closed that day.

III. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031 and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing, as specified in 28 TEX. ADMIN CODE §148.3.

3. Proper and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN.§§ 2001.051 and 2001.052.

4. Provider, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031 and 28 TEX. ADMIN CODE § 148.21(h).

5. Provider failed to meet its burden of proof to show that a six-week course of pain management is medically necessary to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

ORDER

IT IS ORDERED that preauthorization for Advantage Healthcare System to administer a six-week course of chronic pain management on behalf of ___ (Claimant) is hereby denied.

SIGNED March 12, 2004.

_____

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS