MEDICAL CONTESTED CASE HEARING NO. 09024

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 September 23, 2008, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to a chronic pain management program for the compensable injury of _____?

PARTIES PRESENT

Petitioner appeared without representation. Respondent/Carrier appeared and was represented by JF.

BACKGROUND INFORMATION

Claimant sustained a compensable injury to multiple body parts. Through the course of his initial treatment he became addicted to pain medications. Claimant had a two-week course of work hardening with his initial treating doctor. That did not work and he switched doctors to Dr. V. Dr. V requested and received authorization for two more weeks of work hardening. He had some success but Claimant was not at a proper functioning level. Claimant was not a surgical candidate so Dr. V requested 30 sessions of a chronic pain management program. The extended requested period was due to Claimant's comorbidity of injury to multiple areas and drug addiction. This was denied by the IRO on June 18, 2008, and is the subject of appeal sought in this hearing. The IRO doctor opined Claimant was a candidate for a chronic pain management program but not for 30 sessions and denied the request in its entirety. Meanwhile, on June 05, 2008, Dr. V again requested a chronic pain management program of 30 sessions, before the first request had proceeded through its course. Utilization Review denied it and it was eventually sent to an IRO. This time, on July 11, 2008, the IRO agreed to 10 of the 30 sessions. Dr. V began those sessions. Claimant showed documented improvement. Dr. V requested 20 more sessions and the Carrier agreed to 10 of those 20 requested sessions through their utilization review. Claimant is currently going through those 20 sessions and is showing improvement.

The parties were concerned about the ramifications of the second IRO request and its approval on the contest of the first denied request. The Petitioner is still requesting a chronic pain management program of 30 sessions and the initial IRO determination is still denying that treatment, regardless of the second authorization. Neither party has agreed to the other's position on the first request. That there is a second IRO does not eliminate the first IRO denial or the burden of proof on the Petitioner to show by evidence-based medicine his need for the chronic pain management program is more persuasive than the Official Disability Guidelines' recommendations.

As to the merits of the case, the requested chronic pain management program is the next and only option for the Claimant per Dr. V. He requested a 30 day program instead of the usual 20 days because of Claimant's comorbidities -- injuries to multiple body parts, i.e. neck, upper back, left shoulder, lower back, right knee and left elbow; depression and anxiety; and addiction to Lortab. However, the most important reason for the extended program per Dr. V is Claimant's fear/pain avoidance behavior. Dr. V explained in his request that withdrawal from Lortab takes at least 4-5 weeks, per the Official Disability Guidelines, in order to avoid significant withdrawal sickness.

The IRO doctor agreed due to the complexities of the case that a trial of a chronic pain program would be appropriate. However, he opined, thirty days was excessive. He opined the criteria for a chronic pain management program was met and such a program would benefit the Claimant but the request was excessive. He then denied the request in its entirety.

Official Disability Guidelines recommendations for outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

> (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement;
> (2) 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;
> (3) The patient has a significant loss of ability to function independently resulting from the chronic pain;
> (4) The patient is not a candidate where surgery or other treatments would clearly be warranted;
> (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; and
> (6) Negative predictors of success have been addressed.
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> The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005)
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> Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. 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. 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.

The Official Disability Guidelines recommends assessing the effects of interdisciplinary pain programs on patients who remain on opioids throughout treatment, and to determine whether opioid use should be a screening factor for admission to or continuation in a program:

> The limited research that is available indicates that daily opioid use, in low doses, does not decrease effectiveness of chronic pain programs. Early research also indicates that simultaneous dependency/addiction programs with pain programs may be a viable option. Limited studies allow for an evaluation of the role of the chronic use of opioids on treatment success in interdisciplinary pain programs:
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> (1) The original Mayer et al. studies (Mayer, 1985) (Mayer, 1987): The comparison group was comprised of patients who were denied treatment by their insurers. A third group were those patients who were non-completers (10%). Prior to the actual functional restoration program (FRP), the patients in the program were treated with an introductory 3-6 week session that included tapering of habituating medications. The results of this pre-treatment may be reflected in the fact that only 15% of the treatment group were taking opioids versus 48% in the non-treatment comparison group (significant at $P<0.05$). The final results showed that 87% of the treatment group was actively working after two years compared to 41% of the non-treatment group (with results based on patients that the researchers were able to contact after the time period). Only 13% of the group of patients who decided not to complete the program (the third group) returned to work at one year. The role of the program design that included tapering of medications on treatment results was not discussed.
> (2) Simultaneous opioid withdrawal and pain rehabilitation: Research evaluating simultaneous opioid withdrawal with pain rehabilitation programs (in an analysis of predominately female, non-workers' compensation patients), found that all patients that completed the program (regardless of opioid use on initial entry) showed decreased pain severity and catastrophyzing, although those taking opioids had significantly higher scores at the three-week discharge for these variables. (Rome, 2004)
> (3) Programs that don't emphasize opioid tapering: A more recent study of patient's receiving workers' compensation benefits in a program that did not stress opioid withdrawal found that at 6 months, 72.1% of opioid users returned to work versus 75.8% of non-opioid users, a non-significant difference. The mean dose of daily morphine equivalents was 28.63 mg (range 0.53 mg to 150 mg), which may limit the generalizability of the study. (Maclaren, 2006)

In this case, Dr. V provided a clear rationale for the specified extension for a 30-day program and reasonable goals to be achieved by Claimant for that period. He explained how 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. He explained and provided documentation of Claimant's chronic disability and other known risk factors such as injuries to multiple body parts, depression and anxiety, drug addiction and fear avoidance behavior. The IRO doctor agreed Claimant met all the criteria for a chronic pain management

program but disagreed with the requested sessions. The IRO doctor stated, "I believe that a chronic pain management program has the potential to benefit him, but the request is in excess of what is medically necessary."

The issue is the thirty sessions. A decision cannot state a claimant should receive 10 sessions or some other number as the second IRO doctor decided. The decision is one way or the other. While Dr. V provided clear rationale, it did not overcome the presumption given to the IRO decision. He explained the need for the treatment based upon the Official Disability Guidelines, but the IRO doctor also based his opinion on the Official Disability Guidelines. This was a battle between a providing doctor and an independent expert (the IRO doctor is a D.C. and D.O. and board certified chiropractic, physical medicine and rehabilitation, pain management). Dr. V did not provide evidence-based medicine to overcome the opinion of the IRO doctor.

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 determined Claimant should not have chronic pain management program.

2. Carrier delivered to 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. Chronic pain management program of thirty 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 chronic pain management program is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to thirty sessions of chronic pain management program 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 **INDEMNITY INSURANCE COMPANY OF NORTH AMERICA** and the name and address of its registered agent for service of process is

ROBIN M. MOUNTAIN
6600 CAMPUS CIRCLE DRIVE EAST, SUITE 300
IRVING, TX 75063.

Signed this 01st day of October, 2008.

KEN WROBEL
Hearing Officer