MEDICAL CONTESTED CASE HEARING NO. 09107
M6-09-17201-01

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 March 19, 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 entitled to chronic pain management program x80 hours for 10 days for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by NW, ombudsman. Petitioner/Carrier appeared and was represented by LW, attorney. Respondent/Subclaimant appeared and was represented by Dr. MW.

BACKGROUND INFORMATION

Claimant injured her low back when she was checking out a customer at a cash register. She did not know what she was about to lift and was not prepared to lift a box of dumbbells. Since that time she has undergone a pain injection, physical therapy, medications and several doctor visits. She remained in constant pain. Claimant did work light duty with her Employer. The pain caused her to seek more and new treatment. She began treatment with (Healthcare Provider). She went through a work-hardening program. It was not effective so she was put into a multi-disciplinary chronic pain management program. She went through 10 days of the program. Her doctors believe she needs another 10 days. The Carrier disputed this. The IRO doctor agrees with the Claimant's doctors.

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 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 Official Disability Guidelines discusses multidisciplinary 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.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)

(b) Multidisciplinary pain clinics

(c) Pain clinics

(d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) 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) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007)

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 know how, 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.

In this case, the IRO doctor notes Claimant missed several days of the program so there may be a motivational issue but notes she did make that up and the treating doctors indicate she was motivated and compliant when she was there. (Claimant testified she had the flu so she missed a few days but made those up when she was better.) He notes psychological issues associated with her back pain. He states one of the requirements for a chronic pain management program is documented subjective and objective gains. He notes these gains were adequately addressed. "It is based upon the patient's improvements noted in the conference reports that the reviewer supports the need for the additional treatments. The patient meets the Official Disability Guidelines."

Carrier called upon Dr. DG to testify the IRO doctor utilized the Official Disability Guidelines incorrectly and Claimant should not have been entitled to the first round of a chronic pain management program much less be allowed a second round. He was not persuasive in many respects but he did note many plausible inconsistencies in Claimant's medical records versus the criteria required for participation in a chronic pain management program, supporting his opinion Claimant should not be allowed to continue her participation in the program. He addressed the

criteria one by one noting Claimant could not meet Criteria 1, 2, 6, 7, and 9. He based his opinions on Claimant's FCE being invalid to start with, three doctors found her to have a minor lumbar sprain/strain with no functional loss before she got to this clinic/program, Claimant was working light-duty and had a full-duty release before entering the program, and most importantly there is no documentation of objective or subjective gains after the first 10 visits. He stated all of the criteria are required to be met and, in his opinion, Claimant was unable to meet several.

Dr. KW testified for (Healthcare Provider). He testified Claimant did meet all the criteria and that Dr. DG was confusing the use and meaning of the Official Disability Guidelines when he used the discussion session to define the criteria. Dr. KW testified Claimant fit Criterion 1 with at least five sub-requirements, and met the other criteria as documented under the behavioral, medical and psychosocial documentation in evidence. He sated these documents are the same as those the IRO doctor relied upon and used to rule in favor of the treatment. Dr. KW noted specifically how there was documentation of subjective and objective gains after the first 10 visits. While the analog pain scale remained the same, he testified the program does not focus on pain levels but functional restoration. He noted that additionally other scales showed significant improvement, even if the analog pain scale did not. He stated a patient may never be relieved of pain, but if their functional restoration is improved, their social and psychological well-being will improve, hopefully making them able to better perform their ADLs and return to work.

The crux of the issue is the determination of "significant" in Criterion 2 and 9. The IRO doctor addressed these issues noting Claimant "has psychological issues associated with the back strain described in several of the notes. One of the requirements for extension of a pain management program beyond an initial 10 sessions is based on subjective and objective gains. These gains were adequately described in the pain clinic reports." While there is a significant difference in opinions between Dr. DG and Dr. KW, the IRO doctor has reviewed the same records these two doctors reviewed and opined Claimant and (Healthcare Provider) provided adequate documentation showing Claimant meets all the criteria required by the Official Disability Guidelines for the continued 80 hours over ten sessions. The Carrier did not meet its burden of proof to overcome the IRO decision.

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 have chronic pain management program x 80 hours for 10 days.

2. Carrier delivered to Claimant and Subclaimant 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. The chronic pain management program x 80 hours for 10 days is 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 x 80 hours for 10 days is health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to chronic pain management program x 80 hours for 10 days for the compensable injury of _____.

ORDER

Carrier 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 **(EMPLOYER)** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TX 78701-3232.

Signed this 23rd day of March, 2009.

KEN WROBEL
Hearing Officer