

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 May 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 not entitled to chronic pain management program for 10 days/sessions for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Subclaimant and Claimant appeared and were represented by JC, attorney. Respondent/Carrier appeared and was represented by PS, attorney.

BACKGROUND INFORMATION

On _____, Claimant was walking down wet stairs, slipped and fell, landing on her buttocks. Claimant underwent medical treatment consisting of oral medications, x-rays, physical therapy, injections, and ultimately underwent lumbar spinal surgery on September 21, 2006, which included having titanium cages placed at two levels, L4-5 and L5-S1. Post-surgery, Claimant had physical therapy and work hardening, but was unable to complete work hardening. Claimant's treating doctor has recommended 10 days/sessions of chronic pain management, which was denied by Carrier, and the denial was upheld by the IRO.

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.

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.

On the date of this medical contested case hearing, the ODG provides the following with regard to chronic pain management:

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](#)) ([Gatchel, 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](#))

Timing of use: Early intervention is recommended (3 to 6 months post-injury) depending on identification of patients that may benefit from early intervention via a multidisciplinary approach. See [Chronic pain programs, early intervention](#). The probability of returning to work for those out over two years may be less than 1%, if such patients are not offered quality, comprehensive interdisciplinary functional restoration programming. In a high-quality cohort study, the short-term disabled group (4-8 months post-injury) achieved statistically higher RTW compared to the long-term disabled group (> 18 months post-injury), suggesting that early use of a functional restoration program is efficacious, but individuals with long-term disability still achieved respectable RTW justifying use of the program. ([Jordan, 1998](#)) ([Infante-Rivard, 1996](#)) ([TDI, 2007](#))

See also [Chronic pain programs, intensity](#); [Chronic pain programs, opioids](#); [Functional restoration programs](#); & [Chronic pain programs, early intervention](#).

The ODG further cites 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 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.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or 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.

At this contested case hearing, Petitioner/Subclaimant called Dr. M, PhD., whose qualifications place her at an expert level as to evidence based medicine and the ODG. Although Dr. M has not treated Claimant she studied Claimant's records and spoke to her at the initial evaluation and on May 18, 2009. Dr. M demonstrated a thorough familiarity with Claimant's course of treatment. Dr. M addressed each of the criteria stated above one by one and emphasized and explained how Claimant met each one. A detailed analysis of the criteria similar to that of Dr. M is provided in a report admitted into evidence from PB, M.S., C.R.C., L. P. C, who is the Clinical Director at Petitioner's clinic. Based on Dr. M's analysis, Claimant meets the necessary elements of the criteria to be entitled to the requested 10 hours/sessions of chronic pain management.

Carrier argued that the ODG in effect at the time the IRO issued its report should be followed. Actually on the date of the IRO report, the ODG was updated and no longer limited chronic pain management to injured workers having injuries less than two years old. The preponderance of the evidence is contrary to the decision of the IRO, and Claimant is entitled to the requested chronic pain management program.

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), and sustained a compensable injury.
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 preponderance of the evidence based medicine is contrary to the IRO decision.
4. Chronic pain management program for 10 days/sessions 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 contrary to the decision of the IRO that Claimant is not entitled to chronic pain management program for 10 days/session for the compensable injury of _____.

DECISION

Claimant is entitled to chronic pain management program for 10 days/sessions for the compensable injury of _____.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

The true corporate name of the insurance carrier is **(SELF-INSURED EMPLOYER)**, and the name and address of its registered agent for service of process is:

**SM
(STREET ADDRESS)
(CITY), TX (ZIP CODE)**

Signed this 20th day of May, 2009.

Cheryl Dean
Hearing Officer