MEDICAL CONTESTED CASE HEARING NO. 10020
M6-09-20104-01

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 July 30, 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, 80 hours for the compensable injury of _____?

PARTIES PRESENT

Petitioner appeared and was assisted by MW, Ed.D., MBA, J.D., lay representative. Claimant appeared and was assisted by NW, ombudsman. Respondent/Carrier appeared and was represented by LW, attorney.

BACKGROUND INFORMATION

On _____, Claimant sustained a compensable injury to her lumbar spine when she lifted a heavy item while checking out a customer at a cash register. Claimant was diagnosed with a lumbosacral sprain/strain, low back pain and chronic pain syndrome. Subsequently, she was treated at (Healthcare Provider) where she attended a work hardening program and two ten day sessions of a multi-disciplinary pain management program. Claimant's doctors requested another eighty hours of chronic pain management. The request for chronic pain management was denied by Carrier. Petitioner is seeking reversal of an adverse determination by the IRO that Claimant is not entitled to eighty hours of chronic pain management.

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. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The ODG cites these criteria to be to enrolled 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 in the following circumstances:
> (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.
> (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
> (3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be

performed; (d) An evaluation of social and vocational issues that require assessment.
(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trail may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.
(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.
(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.
(10) 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 they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
(12) Total treatment duration should generally not exceed 20 full-day (160 hours) 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 160 hours requires a clear rationale for the specified extension and

reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
(13) At the conclusion and subsequently, neither re-enrollment in 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 (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a "stepping stone" after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.
(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.
(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.
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. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.

The IRO reviewer, a licensed anesthesiologist, concluded that Claimant did not meet the criteria as outlined in the ODG for the pain management program recommended. The IRO indicated that following the Claimant's completion of twenty sessions of chronic pain management she did not return to work and she had "…an increase in pain analog scale of 2 points", and no progress toward narcotic detoxification. The reviewer stated that the "…goals relating to chronic pain management are "coping" and "control of diagnosed emotional and behavioral sequelae of the pain problem are not empirically supportable." And this is "…specifically proscribed in this type of patient because such strategy 'may reinforce psychological, environmental, and psychosocial factors' that promotes 'chronic pain states'." In addition, the reviewer indicated that the request for additional chronic pain management does not present any acute medical problem, clinical

limitation, or evidence of modified treatment plan for addressing an unusual issue to justify extending Claimant's chronic pain management program beyond twenty sessions.

At the contested case hearing, Petitioner called Dr. W, Ph.D., M.Ed. He is a licensed psychologist and has been the Clinical Director at _____ for the past sixteen years. Dr. W addressed the criteria one by one noting that Claimant met all of the ones that applied to her case and indicated that the last five were post program issues and not really patient criteria. He disagreed with the IRO's goals of the program and stated that the overriding goal of the program was functional restoration and for Claimant to overcome previous factors that contributed to her disability. Furthermore, according to Dr. W, the IRO erred in stating that Claimant had twenty session of chronic pain management because Claimant was entitled to twenty consecutive days of chronic pain management which she did not receive. He explained that Carrier authorized the initial ten sessions of pain management in October of 2008, and even though Claimant made reasonably good progress an additional ten sessions were denied, so an IRO was requested. The IRO was in favor of the ten sessions and this was upheld at a medical contested case hearing. This delay resulted in Claimant beginning the second ten sessions the end of April of 2009 and completing the program in May of 2009. He stated that continuity in treatment of a chronic pain management program was critical for any kind of positive outcome. He stated that what improvement Claimant gained in the first ten sessions was lost by the second ten sessions because of the seven month gap in the continuation of the program. According to Dr. W, the overriding goal of continued chronic pain management was for Claimant to return to full duty work.

Carrier called Dr. G, M.D. Dr. G testified that a review of the records indicated that compared to day ten of the chronic pain management program Claimant attended in October of 2008 to day twenty of the May 2009 program she made no significant improvement. Her physical function had not changed, depression and pain were worse, and her medication changed from Darvocet to hydrocodone, a more potent opiate. According to Dr. G, there was no provision in the ODG to have twenty consecutive days of chronic pain management. If her doctor believed twenty consecutive days of a chronic pain management program was necessary for success, there would be an endless request for chronic pain management programs without any substantial goals or improvement. Furthermore, even though the two programs Claimant attended were not consecutive, there should have been objective gains made by Claimant that were maintained. Dr. G concluded it would not be medically necessary to approve additional chronic pain management because no significant gains have been made in the prior two programs.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See* Black vs. Food Lion, Inc., 171 F.3rd 308 (5th Cir. 1999); E.I. Du Pont De Nemours and Company, Inc. v. Robinson, 923 S.W.2d 549 (Tex. 1995). Evidence is considered in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; and (7) the experience and skill of the person who applied the technique on the occasion in question. Kelly v. State, 792 S.W.2d 579 (Tex.App.-(City) 1990). Health care providers are directed to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be reasonably required. (28 Tex. Admin. Code § 137.100 (Rule 137.100).

In this case, Claimant made no significant improvement after attending two sessions of chronic pain management. Furthermore, there was no evidence of any acute medical problem, clinical limitation, or a modified treatment plan for addressing an unusual issue to justify extending Claimant's chronic pain management program beyond twenty sessions. The ODG does not recommend that twenty days pain management sessions must be consecutive. Petitioner's argument does not amount to evidence based medicine in support of the proposed treatment. While Claimant may have met some of the criteria for chronic pain management outlined by the ODG, she clearly failed to meet Criteria (12) and (13). Claimant has failed to provide sufficient documentation to justify further chronic pain management; the program recommended is comparable to the two prior programs she already attended and she had no lasting benefit from the programs. Therefore, the requested eighty hours of chronic pain management does not meet the criteria set out in the ODG. Based on a review of the expert testimony and studies offered, the preponderance of the evidence is not contrary to 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 (Self-Insured), Employer.

   C. The IRO determined that the requested services were not reasonable and necessary health care for the compensable injury of _____.

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. Chronic pain management, 80 hours 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, 80 hours is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to chronic pain management for the compensable injury _____.

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 **(SELF-INSURED)** and the name and address of its registered agent for service of process is

CSC
(STREET ADDRESS)
(CITY), TX (ZIP CODE)

Signed this 26th day of August, 2009.

Sarah Wiegand
Hearing Officer