

MEDICAL CONTESTED CASE HEARING NO 12049
M6-11-32928-01
M6-11-32967-01

DECISION AND ORDER

These cases are consolidated and 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 August 29, 2011 to decide the following disputed issues:

In Docket No. HW-09242944-02-CC-HW43:

Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is entitled to a lumbar L5-S1 epidural steroid injection (ESI) with lysis of adhesions for the compensable injury of (Date of Injury)?

In Docket No. HW-09242944-03-CC-HW43:

Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is entitled to chronic pain management 5 times a week for 2 weeks (80 hours) (97799) for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by DP, attorney. Claimant appeared and was assisted by DV, ombudsman. Dr. KB appeared as a witness.

BACKGROUND INFORMATION

These cases involve two separate requests for preauthorization of treatment for the Claimant, one for a lumbar ESI with lysis of adhesions and the other for CPM, that were reviewed by two separate IRO physician reviewers. The Claimant sustained a compensable injury to his lumbar spine, as well as an inguinal hernia, on (Date of Injury) while working for Excel Stamping & Manufacturing. The Claimant's treating doctor, Dr. GM, eventually referred the Claimant to Dr. KB, who is a board certified orthopedic surgeon. Dr. B diagnosed the Claimant's lumbar condition as a herniated disc at L5-S1 with radiculopathy. On April 30, 2010, Dr. B performed an ESI at the L5-S1 level of the Claimant's spine. Thereafter, Dr. B recommended a second ESI, and this request was denied by two Carrier utilization review agents. The denials were overturned by an IRO. The IRO physician reviewer, who is also a board certified orthopedic surgeon, reasoned that the Claimant meets the Official Disability Guidelines (ODG)

requirements for a second ESI because, among other things, he obtained at least 50 to 70% relief of his pain from the first ESI.

Dr. M also referred the Claimant to Dr. GW at the (Healthcare Provider). Dr. W recommended that the Claimant participate in 10 sessions (80 hours) of a chronic pain management program. This request was denied by two Carrier utilization review agents. The denials were overturned by a different IRO physician reviewer from the one who reviewed the request for a second ESI. The IRO physician reviewer, who is board certified in Physical Medicine and Rehabilitation, opined that the Claimant meets the ODG requirements for 80 hours of a CPM program and that such is medically necessary.

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 making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

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 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 [is] considered [a party] 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."

IRO Case No. 32928: ESI with Lysis of Adhesions

The ODG addresses the medical necessity of ESIs as follows:

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. (Koc, 2009)

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal

stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti, 2003) (CMS, 2004) (Delpont, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) (Buenaventura, 2009) Also see Epidural steroid injections, “series of three” and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for

short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009)

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless:
 - (a) there is a question of the pain generator;
 - (b) there was possibility of inaccurate placement; or
 - (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed.There should be an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
- (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

- (9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
- (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

The Carrier presented the testimony of a board certified orthopedic surgeon, Dr. CC, who testified that the Claimant has not met the criteria in the ODG for a repeat lumbar ESI because there is little evidence of radiculopathy, and that the evidence does not establish that the Claimant obtained 50-70% pain relief for at least 6 to 8 weeks from the first ESI. Dr. KB also testified. There was no objection to the testimony, reports or qualifications of Dr. Chenault or Dr. B. In contrast to Dr. C’s testimony, Dr. B testified that the Claimant did obtain 50-70% relief of his symptoms for 6 to 8 weeks from the first ESI. Dr. B also testified that the Claimant does have objective evidence of lumbar radiculopathy. It is determined from a review of the record in this case that the evidence is sufficient to establish that the Claimant has lumbar radiculopathy. The evidence shows that the conflict in the evidence regarding how much pain relief the Claimant received from the first ESI is at the heart of this issue. The primary evidence on this point consists of Dr. B’s records documenting the Claimant’s symptoms from before April 30, 2010 up through April 15, 2011, and his records are equivocal on this point and do not support a finding that the Claimant obtained 50-70% relief of his pain from the first ESI. The Claimant’s VAS pain score shortly before the first ESI on April 30, 2010 was 5/10, according to Dr. B’s records. After the ESI was performed on April 30, 2010, his pain score alternated between 4/10 and 5/10 up through April 2011, which does not demonstrate 50% or more pain relief for at least 6 weeks. In his October 19, 2010 record, Dr. B stated that the Claimant got “no relief” from the first ESI. After a careful review of the entire record, it is determined that the Carrier met its burden to show that the preponderance of the evidence-based medical evidence is contrary to the IRO’s decision regarding the performance of a repeat L5-S1 ESI. There was no evidence-based medicine presented to establish the medical necessity of a repeat lumbar ESI when the first ESI provided little or no relief.

Dr. C also testified that he does not understand the basis for the IRO’s decision finding that the lysis of adhesions is medically necessary, since such treatment is not recommended in the ODG. The ODG addresses the medical necessity of lysis of adhesions as follows:

Not recommended due to the lack of sufficient literature evidence (risk vs. benefit, conflicting literature). Also referred to as epidural neurolysis, epidural neuroplasty, or lysis of epidural adhesions, percutaneous adhesiolysis is a treatment for chronic back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space. Lysis of adhesions is carried out by catheter manipulation and/or injection of saline (hypertonic saline may provide the best results). Epidural injection of local anesthetic and steroid is also performed. It has been suggested that the purpose of the intervention is to eliminate the effect of scar formation, allowing for direct application of drugs to the involved nerves and tissue, but the exact mechanism of success has not been determined. There is a large amount of variability in the technique used, and the technical ability of the physician appears to play a large role in the success of the procedure. In addition, research into the identification of the patient who is best served by this intervention remains largely uninvestigated. Adverse reactions include dural puncture, spinal cord compression, catheter shearing, infection, excessive spinal cord compression, hematoma, bleeding, and dural puncture. Duration of pain relief appears to range from 3-4 months. Given the limited evidence available for percutaneous epidural adhesiolysis it is recommended that this procedure be regarded as investigational at this time. (Gerdesmeyer, 2003) (Heavner, 1999) (Belozzer, 2004) (BlueCross BlueShield, 2004) (Belozzer, 2004) (Boswell, 2005) (Boswell, 2007) (The Regence Group, 2005) (Chopra, 2005) (Manchikanti1, 2004) (Epter, 2009) This recent RCT found that after 3 months, the visual analog scale (VAS) score for back and leg pain was significantly reduced in the epidural neuroplasty group, compared to conservative treatment with physical therapy, and the VAS for back and leg pain as well as the Oswestry disability score were significantly reduced 12 months after the procedure in contrast to the group that received conservative treatment. (Veihelmann, 2006)

Preliminary suggested criteria for percutaneous adhesiolysis while under study:

- The 1-day protocol is preferred over the 3-day protocol.
- All conservative treatment modalities have failed, including epidural steroid injections.
- The physician intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The physician documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

The IRO does not address the lysis of adhesions portion of the treatment in its decision, other than to state that such is medically necessary. Dr. Berliner's testimony is also silent on this

issue. For this reason, the Carrier met its burden to establish that the preponderance of the evidence-based medical evidence is contrary to the IRO decision that a lumbar L5-S1 ESI with lysis of adhesions is medically necessary in this case. For this reason, the Claimant is not entitled to an L5-S1 ESI with lysis of adhesions for the compensable (Date of Injury) injury.

IRO Case No. 32967: Chronic Pain Management

The ODG addresses the medical necessity of chronic pain management as follows:

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 have resulted in “Delayed recovery.” There should be evidence that a complete diagnostic assessment has been made, with a detailed treatment plan of how to address physiologic, psychological and sociologic components that are considered components of the patient’s pain. Patients should show evidence of motivation to improve and return to work, and meet the patient selection criteria outlined below. While these programs are recommended (see criteria below), 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) 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) See Biopsychosocial model of chronic pain.

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. These pain rehabilitation programs (as described below) combine multiple treatments, and at the least, include psychological care along with physical and/or occupational therapy (including an active exercise component as opposed to passive modalities). 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.

Outcomes measured: Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to “demedicalize” treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See Opioids for chronic pain.)

Outcomes (in terms of body parts)

Neck and Shoulder: There are limited studies about the efficacy of chronic pain programs for neck, shoulder, or upper extremity musculoskeletal disorders. (Karjalainen, 2003) This may be because rates of cervical claims are only 20-25% of the rates of lumbar claims. In addition, little is known as to chronicity of outcomes. Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with cervical spine disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes. Cervical patients were statistically less likely to have undergone pre-rehabilitative surgery. (Wright, 1999)

Multidisciplinary back training: (involvement of psychologists, physiotherapists, occupational therapists, and/or medical specialists). The training program is partly based on physical training and partly on behavioral cognitive training. Physical training is performed according to the “graded activity” principle. The main goal is to restore daily function. A recent review of randomized controlled studies of at least a year’s duration found that this treatment modality produced a positive effect on work participation and possibly on quality of life. There was no long-term effect on experienced pain or functional status (this result may be secondary to the instrument used for outcome measure). Intensity of training had no substantial influence on the effectiveness of the treatment. (van Geen, 2007) (Bendix, 1997) (Bendix, 1998) (Bendix2, 1998) (Bendix, 2000) (Frost, 1998) (Harkapaa, 1990) (Skouen, 2002) (Mellin, 1990) (Haldorsen, 2002)

Intensive multidisciplinary rehabilitation of chronic low back pain: The most recent Cochrane study was withdrawn from the Cochrane (3/06) as the last literature search was performed in 1998. Studies selected included a physical dimension treatment and at least one other treatment dimension (psychological, social, or occupational). Back schools were not included unless they included the above criteria. There was strong evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function when compared to inpatient or outpatient nonmultidisciplinary rehabilitation. Intensive (> 100 hours), daily interdisciplinary rehabilitation was moderately superior to noninterdisciplinary rehabilitation or usual care for short- and long-term functional status (standardized mean differences, -0.40 to -0.90 at 3 to 4 months, and -0.56 to -1.07 at 60 months). There was moderate evidence of pain reduction. There was contradictory evidence regarding vocational outcome. Less intensive programs did not show improvements in pain, function, or vocational outcomes. It was suggested that patients should not be referred to multidisciplinary biopsychosocial rehabilitation without knowing the actual content of the program. (Guzman, 2001) (Guzman-Cochrane, 2002) (van Geen, 2007) (Bendix, 1997) (Bendix, 1998) (Bendix2, 1998) (Bendix, 2000) (Frost, 1998) (Harkapaa, 1990) (Skouen, 2002) (Mellin, 1990) (Haldorsen, 2002)

Multidisciplinary biopsychosocial rehabilitation for subacute low back pain among working age adults: The programs described had to include a physical component plus either a psychological, social and/or vocational intervention. There was moderate evidence of positive effectiveness for multidisciplinary rehabilitation for subacute low back pain and that a workplace visit increases effectiveness. The trials included had methodological shortcomings, and further research was suggested. (Karjalainen, 2003)

Role of opioid use: See Chronic pain programs, opioids.

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. (Dersh, 2007) The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. (Poleshuck, 2009) (Bair, 2008)

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) There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be “at-risk” for post-discharge problems. (Proctor, 2004) 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) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) (Dersh, 2007)

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing

with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

Studies suggesting limited results in patients with long-term disability: While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a “treated group” for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Psych/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the “treated patient” was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that

modest goals (improvement, not cure) be introduced. (Robinson, 2004)
(Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

Timing of use: Intervention as early as 3 to 6 months post-injury may be recommended depending on identification of patients that may benefit from a multidisciplinary approach (from programs with documented positive outcomes). See Chronic pain programs, early intervention.

Role of post-treatment care (as an outcome): Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a “new provider” is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed. (Proctor, 2004)

See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.

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 trial 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. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
- (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.

Dr. C testified that in his opinion, the Claimant does not meet the ODG requirements for participation in a chronic pain management program because there is no documented treatment plan showing how the 80 hours in the program will be spent. Dr. B's testimony at the hearing focused upon the performance of a repeat lumbar ESI. The IRO determined that the Claimant did meet the criteria in the ODG for an 80-hour chronic pain management program, noting that the Claimant has exhausted available and more conservative treatment options. There is no conflict in the evidence regarding the fact that the Claimant has a chronic pain syndrome. There is a treatment plan in evidence from Dr. W, which is part of a comprehensive Behavioral Evaluation Report that she wrote, based on her evaluation of the Claimant on December 23, 2010. The IRO report refers to Dr. W's December 23, 2010 report, and notes that the evidence is well documented to show that the chronic pain management program is medically necessary for the Claimant. After a review of the entire record, it is determined that the Carrier did not meet its burden of proof to show that the IRO decision regarding chronic pain management is contrary to the preponderance of the evidence-based medical evidence. The Claimant, therefore, is entitled to participation in a chronic pain management program 5 times per week for 2 weeks (80 hours) (97799) for the compensable (Date of Injury) injury.

Even though all the evidence presented may not have been discussed in detail, 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 was proper in the (City)Office of the Texas Department of Insurance, Division of Workers' Compensation.
 - B. On (Date of Injury), Claimant was the employee of (Employer), Employer.

- C. On (Date of Injury), Employer had workers' compensation insurance coverage with Texas Mutual Insurance Co., Carrier.
- D. The Claimant sustained a compensable inguinal hernia and lumbar injury on (Date of Injury) while in the course and scope of his employment with (Employer).
2. Carrier delivered to Claimant 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 1.
 3. The Claimant does not meet the requirements of the ODG for an L5-S1 ESI with lysis of adhesions and Petitioner presented evidence-based medicine sufficient to overcome the determination of the IRO.
 4. An L5-S1 ESI with lysis of adhesions was not health care reasonably required for the Claimant's compensable injury of (Date of Injury).
 5. The Claimant meets the requirements of the ODG for chronic pain management 5 times per week for 2 weeks (80 hours) (97799) and Petitioner failed to present evidence-based medicine sufficient to overcome the determination of the IRO.
 6. Chronic pain management 5 times per week for 2 weeks (80 hours) (97799) is health care reasonably required for the Claimant's compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
2. Venue was proper in the (City) Office.

In Docket No. HW-09242944-02-CC-HW43:

3. The preponderance of the evidence is contrary to the decision of the IRO that an L5-S1 ESI with lysis of adhesions was health care reasonably required for the Claimant's compensable injury of (Date of Injury).

In Docket No. HW-09242944-03-CC-HW43:

4. The preponderance of the evidence is not contrary to the decision of the IRO that chronic pain management 5 times per week for 2 weeks (80 hours) (97799) is health care reasonably required for the Claimant's compensable injury of (Date of Injury).

DECISION

In Docket No. HW-09242944-02-CC-HW43, the Claimant is not entitled to an L5-S1 ESI with lysis of adhesions for his compensable injury of (Date of Injury).

In Docket No. HW-09242944-03-CC-HW43, the Claimant is entitled to chronic pain management 5 times per week for 2 weeks (80 hours) (97799) for his compensable injury of (Date of Injury).

ORDER

In Docket No. HW-09242944-02-CC-HW43, the Carrier is not liable for medical benefits pertaining to an L5-S1 ESI with lysis of adhesions. The Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

In Docket No. HW-09242944-03-CC-HW43, the Carrier is **ORDERED** to pay medical benefits pertaining to chronic pain management 5 times per week for 2 weeks (80 hours) (97799) in accordance with this decision, the Act and the implementing Rules.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is:

**RON WRIGHT, PRESIDENT
TEXAS MUTUAL INSURANCE COMPANY
6210 EAST HIGHWAY 290
AUSTIN, TX 78723**

Signed this 15th day of September, 2011.

Patrice Fleming-Squirewell
Hearing Officer