MEDICAL CONTESTED CASE HEARING NO 12085
M6-11-35112-01

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 continued from November 7, 2011, and held on January 9, 2012, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to 10 sessions of a chronic pain management program over 2 weeks for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner appeared and was represented by RML, attorney. Claimant appeared and was assisted by MP, ombudsman. Respondent/Carrier appeared and was represented by RFJ, attorney

BACKGROUND INFORMATION

Claimant, a heavy equipment operator, sustained a compensable injury after slipping and falling from a backhoe on (Date of Injury). The medical records indicated that Claimant has received treatment to his right elbow, right wrist, and cervical spine following his injury. Claimant underwent surgery on May 22, 2008, for right carpal tunnel syndrome and right radial tunnel syndrome. Claimant has not undergone surgery for his cervical spine, and is not a candidate for surgery of the cervical spine. Claimant has undergone physical therapy, surgery, psychotherapy and prescribed medication. FJB, M.D., is Claimant's treating doctor, and recommended that Claimant undergo 10 sessions of a chronic pain management program (CPMP). Petitioner requested that Claimant undergo 10 sessions of a CPMP. Carrier's utilization review denied Petitioner's request, and Petitioner requested an IRO review.

DISCUSSION

Texas Labor Code §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 §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 §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 §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 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."

With regard to chronic pain management programs, the ODG provides as follows:

> **"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)."

The IRO reviewer was a medical doctor who was a board certified specialist in anesthesiology and pain management. The IRO determined that the requested 10 sessions of a CPMP was not medically necessary because the request did not conform to the ODG criteria for the CPMP, including number 2, 8, and 9 of the ODG for CPMP. Petitioner appealed the IRO decision. Petitioner contended that Claimant met the ODG criteria, and that the determination of the IRO was incorrect. NMM, Ph.D., testified on behalf of Petitioner. Dr. M testified that she was a clinical health psychologist and was Petitioner's clinical supervisor. Dr. M further testified that

she disagreed with the IRO decision and that she believed Claimant met the ODG criteria for a CPMP, including criteria number 2, 8, and 9. Dr. M noted that Claimant had exhausted all medical treatment, and had improved with physical therapy, surgery, medications, and several sessions of psychotherapy and that there was an absence of other options likely to result in significant clinical improvement and met criteria number 2. Dr. M conceded that Claimant's treating doctor, Dr. B, had recommended that Claimant undergo epidural steroid injections (ESIs) prior to undergoing a CPMP. According to Petitioner's request for reconsideration, Dr. B chose not to pursue ESIs and decided to pursue a CPMP. In regard to criteria number 8, Dr. M stated that all negative predictors of success in the CPMP had been identified, and there were no negative predictors of success that needed to be addressed prior to Claimant's undergoing the CPMP. Concerning criteria number 9, Dr. M acknowledged that Claimant had been continuously disabled for more than 24 months but that the outcomes for the necessity of undergoing a CPMP were clearly identified. Dr. M noted that Claimant's preinjury physical demand level (PDL) was heavy duty and that his current PDL was light duty. Dr. M opined that the realistic goal of the CPMP was to improve and increase Claimant's PDL from light duty to medium duty with the anticipation that Claimant could return to work. Claimant testified that he desired to undergo the CPMP and that he would rely on Petitioner's recommendation.

NHB, D.O., testified on behalf of Carrier. Dr. B indicated that he was board certified in pain management and anesthesiology, and was familiar with the ODG criteria for a CPMP. Dr. B testified that he reviewed Claimant's medical records, documents concerning Petitioner's preauthorization request for the CPMP, and the decision of the IRO. Dr. B further testified that he agreed with the IRO decision. Dr. B stated that Claimant was not a candidate for a CPMP because he did not meet criteria number 1(b), 1(d), 1(e), 1(g), 3, 5, and 9 under the ODG. Dr. B acknowledged that out of the seven criteria listed under criteria number 1, that Claimant did meet criteria number 1(a), 1(c), and 1(f), but did not meet criteria number 1(b), 1(d), 1(e), 1(g). Dr. B conceded that under criteria number 1 Claimant would satisfy the criteria listed under criteria number 1 if he met three out of the seven listed criteria, but that he remained of the opinion that Claimant did not qualify under criteria number 1. Dr. B opined that Claimant did not have physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain in regard to criteria number 1(b), and there was no support in the documentation that there was a failure to restore preinjury function to Claimant after a period of disability as required under criteria number 1(d). Dr. B further opined that the psychological tests that were administered to Claimant were determined to be invalid and there was no credible psychological tests that indicated Claimant had psychosocial issues that limited his function or recovery after the incident on (Date of Injury), as required under criteria number 1(e). In regard to criteria number 1(g), Dr. B stated that he reviewed the documentation to determine what medications that Claimant was prescribed and taking, and that he determined there was evidence of improvement in Claimant's pain and function and Claimant was not intolerant, dependent, or abusing pain medications.

In regard to criteria number 3, Dr. B opined that Claimant had not undergone an adequate and thorough multidisciplinary evaluation that included valid diagnostic testing, a physical exam that ruled out conditions requiring treatment prior to initiating the program, and a thorough psychological examination. Dr. B noted that Claimant had undergone the Minnesota Multiphasic Personality Inventory-2-RF and the Battery for Health Improvement (BHI-2) and that these two psychological tests were determined to be invalid, inconsistent, and would exclude Claimant's participation in a CPMP until the inconsistencies were addressed. Dr. B further opined that Claimant did not meet criteria number 5, and noted that one of the primary reasons Petitioner was seeking treatment in the CPMP was to address possible substance abuse issues. Dr. B pointed out that Petitioner's request stated that Claimant was taking medications that included Ibuprofen 800 mg bid and Lyrica 75mg bid, and that titration of these medications would be a focus of the Claimant's participation in the CPMP. Dr. B opined that the medications Ibuprofen and Lyrica are prescribed in various dosages and are not medications that are addictive and require titration. Dr. B stated that Claimant was not a substance abuser based on the medical records that he reviewed, was not a candidate for a CPMP, and that Claimant could choose at any time to stop taking the medications. Dr. B further opined that Claimant did not meet criteria number 9, and noted that Claimant had been continuously disabled for greater than 24 months. Dr. B acknowledged that he was aware that the ODG issued a cautionary statement that patients such as Claimant that have been off work for over two years should not necessarily be precluded from participation in a CPMP. However, in Claimant's case, Dr. B opined that the outcomes for the necessity of use of a CPMP was not clearly identified based on the documentation that he reviewed.

Petitioner and Carrier cited the ODG criteria for a CPMP in support of their respective positions, and consideration was given to the opinions expressed by Drs. Mangum and Blauzvern during their testimony. Carrier established through the evidence in the record, including the testimony of Dr. B and the documentary evidence, that Claimant did not meet the ODG criteria number 3, 5, and 9 for a CPMP, and that the decision of the IRO was correct. Therefore, Petitioner did not establish that the preponderance of the evidence-based medical evidence is contrary to the decision of the IRO that Claimant is not entitled to 10 sessions of a CPMP over 2 weeks for the compensable injury. There was no objection to the testimony, reports, or qualifications of any doctor or witness.

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 (Date of Injury), Claimant was the employee of (Employer), Employer.

C. On (Date of Injury), Employer provided workers' compensation insurance with Liberty Insurance Corporation, Carrier.

D. Claimant sustained a compensable injury on (Date of Injury).

E. The Independent Review Organization determined that Claimant is not entitled to 10 sessions of a chronic pain management program over 2 weeks for the compensable injury of (Date of Injury).

2. Carrier delivered to Petitioner 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 2A.

3. 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 2B.

4. The preponderance of the evidence-based medical evidence is not contrary to the determination of the Independent Review Organization.

5. The requested 10 sessions of a chronic pain management program over 2 weeks is not health care reasonably required for 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the Independent Review Organization that the requested 10 sessions of a chronic pain management program over 2 weeks is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to 10 sessions of a chronic pain management program over 2 weeks the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury of (Date of Injury), in accordance with Texas Labor Code Ann. §408.021.

The true corporate name of the insurance carrier is **LIBERTY INSURANCE CORPORATION,** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701

Signed this 2nd day of March, 2012.

Wes Peyton
Hearing Officer