MEDICAL CONTESTED CASE HEARING NO. 13072

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.

ISSUE

A contested case hearing was held on March 13, 2013, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to an additional 80 hours of a chronic pain management program 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 right upper extremity injury after slipping and falling from a backhoe on (Date of Injury), and underwent surgery on May 22, 2008. In addition to surgery, Claimant's medical treatment has consisted of physical therapy, psychotherapy, biofeedback, psychological testing, prescribed medication, and initial 80 hours of a chronic pain management program (CPMP) for his compensable injury. CD, D.C., is Claimant's treating doctor and recommended that Claimant undergo an additional 80 hours of a CPMP. Petitioner requested that Claimant undergo an additional 80 hours of a CPMP. Carrier's utilization review agents 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 identified as a physician who was a board certified specialist in physical medicine and pain management. The IRO determined that the requested additional 80 hours of a CPMP for the compensable injury was not medically necessary because the request did not conform to the ODG criteria for the CPMP and specifically did not meet ODG criteria number 10 for a CPMP. Petitioner appealed the IRO decision. Petitioner contended that Claimant met the ODG criteria, and that the determination of the IRO was incorrect. Nicole M. Mangum, 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 urther testified that she disagreed with the IRO decision and that she believed Claimant met the ODG criteria for a CPMP including criteria number 10. Dr. M noted that Claimant's preinjury physical demand level (PDL) was heavy duty and that Claimant's PDL was sedentary after his compensable injury. After completing the initial 80 hours of a CPMP, Dr. M stated that Claimant's PDL was light and anticipated that Claimant's PDL would be increased to medium after completing the additional 80 hours of the CPMP. Claimant testified that he desired to undergo the additional 80 hours of CPMP.

NHB, D.O., testified on behalf of Carrier. Dr. B indicated that he was board certified in anesthesiology and pain management and has an active practice in chronic pain management. Dr. B further indicated that he was familiar with the ODG criteria for the CPMP. Dr. B testified that he reviewed Claimant's medical records, documents concerning Petitioner's request for the additional 80 hours of the CPMP and the decision of the IRO. Dr. B further testified that he agreed with the IRO decision. Dr. B stated that Claimant had undergone an initial 80 hours of a CPMP and that he had reviewed the documentation that was submitted by Petitioner in its support of the request for the additional 80 hours of a CPMP. Dr. B further stated that Claimant did not meet criteria number 10 for CPMP under the ODG based on the documentation submitted by Petitioner. Dr. B opined that Claimant did not make subjective and objective gains under the initial 80 hours of a CPMP and cited the October 29, 2012, functional capacity evaluation in support of his opinion. Dr. B further opined that documentation that he reviewed from Petitioner indicated that the initial 80 hours of the CPMP made Claimant's compensable injury worse and that he was currently taking increased levels of prescribed medication.

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. M and B 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 10 for a CPMP, and

that the decision of the IRO was correct. Based on the evidence presented in the hearing, the preponderance of the evidence-based medical evidence is not contrary to the decision of the IRO that Claimant is not entitled to an additional 80 hours of a CPMP 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 right upper extremity injury on (Date of Injury).

   E. The IRO determined that Claimant is not entitled to an additional 80 hours of a chronic pain management program 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 IRO.

5. The requested additional 80 hours of a chronic pain management program 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 additional 80 hours of a chronic pain management program is not health care reasonably required for Claimant's compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to an additional 80 hours of a chronic pain management program for Claimant's 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 20th day of March, 2013.

Wes Peyton
Hearing Officer