MEDICAL CONTESTED CASE HEARING NO. 15031

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on February 18, 2015 to decide the following disputed issues:

1. Is the preponderance of the evidence-based medical evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to chronic pain management (CPM) 10 sessions (5 x 2, 80 hours) for the compensable injury of (Date of Injury)?

2. Did the Petitioner/Claimant, HC, timely file his appeal of the IRO decision herein dated September 29, 2014 regarding the medical necessity of CPM?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by SB, ombudsman. Respondent/Carrier appeared and was represented by SSC, attorney.

BACKGROUND INFORMATION

It was undisputed that the Claimant sustained a compensable lumbar injury on (Date of Injury) while working for (Employer). As a result of this injury, the Claimant underwent lumbar surgery at level L5-S1, including a laminotomy, discectomy and posterolateral fusion with instrumentation, performed by Dr. SE on April 11, 2014. Thereafter, the Claimant had post-operative physical therapy which improved his condition. On July 23, 2014, Dr. AP, who is the Claimant's treating doctor, noted that the Claimant had intermittent low back pain and that Dr. E had released the Claimant from his care on July 7, 2014, and Dr. P did not note any leg symptoms. Dr. P, who is affiliated with DCH, referred the Claimant to a psychologist, SH, Ph.D., to determine what transitional care is appropriate to improve the quality of the Claimant's life and to restore function. Dr. H saw the Claimant once, on July 26, 2014, and it is his opinion that the Claimant is an appropriate candidate for 10 sessions of CPM. On July 31, 2014, AS, D.C., who is also affiliated with DCH, sought pre-authorization for the Claimant to undergo 10 sessions of CPM. This request was denied by two Carrier utilization review agents (URAs), both of whom are of the opinion that some lower level of care, as in work conditioning or work hardening, may be indicated, but that CPM was not medically necessary at that time since the Claimant was not taking significant amounts of prescription medication, did not appear to have

severe psychological issues, and his primary issue was to restore function. The second URA also noted that the Claimant had recently undergone a fusion and was on minimal medications for it, and that she had had a successful peer-to-peer communication with Dr. S about the pre-authorization request. The Carrier denials were upheld by an IRO in a decision dated September 29, 2014. The IRO physician reviewer stated that Dr. P's records noted that the Claimant was more deconditioned than in pain. The IRO was of the opinion that CPM should be rejected at this time and that the Claimant should undergo work hardening with psychological support. The IRO noted that its decision was based upon the Official Disability Guidelines (ODG).

Jurisdiction

The question of whether the Petitioner/Claimant timely filed this appeal of the IRO decision dated September 29, 2014 is jurisdictional. Subject-matter jurisdiction is essential to the authority of a court to decide a case. *Bland ISD v. Blue*, 34 S.W.3d 547, 553-554 (Tex. 2000); *Texas Ass'n of Bus. V. Texas Air Control Bd.*, 852 S.W.2d 440, 443 (Tex. 1993). Without subject-matter jurisdiction, a court cannot render a valid judgment. *Dubai Pet. Co. v. Kazi*, 12 S.W.3d 71, 74-75 (Tex. 2000). Whether a court has subject-matter jurisdiction is a question of law. *Texas Dept. of Parks & Wildlife v. Miranda*, 133 S.W.3d 217, 226 (Tex. 2004). Subject-matter jurisdiction cannot be presumed and cannot be waived. *Continental Coffee Prods. Co. v. Cazarez*, 937 S.W.2d 444, 449 n.2 (Tex. 1996). Lack of subject-matter jurisdiction is fundamental error and can be raised at any time. *Sivley v. Sivley*, 972 S.W.2d 850, 855 (Tex.App.-Tyler 1998, orig. proceeding). The challenge to subject-matter jurisdiction can be raised for the first time on appeal. *Waco ISD v. Gibson*, 22 S.W.3d 849, 851 (Tex. 2000); *Tullos v. Eaton Corp.*, 695 S.W.2d 568, 568 (Tex. 1985). A court can inquire into its jurisdiction on its own initiative at any time, without a motion. *See Texas Workers' Comp. Comm'n v. Garcia*, 893 S.W.2d 504, 517 n.15 (Tex. 1995). For these reasons, the timeliness of the Petitioner/Claimant's appeal will be discussed first.

The undersigned raised the question of the timeliness of the Claimant's appeal of the September 29, 2014 IRO decision *sua sponte* when it came to the undersigned's attention that the Appeal Checklist, which was generated by the Division after the appeal was filed, states that the appeal was filed late. *See Hearing Officer Exhibit HO-2*. Division Rule 133.308(s)(1)(A) controls on this point, and it states in pertinent part:

> The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division.

This provision of Rule 133.308 was amended to be effective on May 31, 2012, so the applicable calculus for timeliness in this case looks at whether the appeal was filed on or before the 20th day

after September 29, 2014, which is the date that the IRO decision was mailed to the Claimant. The evidence shows that the IRO decision was mailed to the Claimant's correct address, and he is deemed to have received it on October 6, 2014, pursuant to Division Rules 102.3 and 102.4 (October 4, 2014 was a Saturday). Thus, in order for Claimant's appeal to be timely filed, it had to be filed on or before October 27, 2014 (October 26, 2014 was a Sunday). Claimant's appeal of the IRO decision (DWC-49 form) was filed with the Division one day late, on October 28, 2014. *See Hearing Officer Exhibit HO-2.*

The Claimant contended at the hearing that he did not receive the IRO decision until October 9, 2014, although he testified that he does not recall when he actually received it. According to his testimony, he received the IRO decision both through the mail and from Dr. P's office, but he cannot recall the dates upon which either of those occurrences took place. He also testified that his address that is reflected on the IRO decision is his current address and was his correct address throughout September and October of 2014. Based on the evidence, it is determined that the Claimant is deemed to have received the IRO decision on October 6, 2014 since it was mailed to him on September 29, 2014 at his correct address and, therefore, his appeal of the IRO decision had to be filed with the Division on or before October 27, 2014. Since the Claimant's appeal filed on October 28, 2014 is untimely, the Division does not have jurisdiction to render a decision on the merits of the appeal.

Medical Necessity

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(s), "[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."

In the Low Back Chapter, the ODG addresses the criteria to determine the medical necessity of chronic pain programs as follows:

> Chronic pain programs
>
> See the entry for Chronic pain programs in the Pain Chapter.

In the Pain Chapter of the ODG, it states 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). See Chronic pain programs, opioids; Functional restoration programs.

Dr. H, who is a psychologist, testified that based upon his visit with the Claimant on July 26, 2014, it is his opinion that relative to the psychological aspects of the Claimant's condition, the Claimant is an appropriate candidate for CPM. He admitted, however, that the psychological assessment is only part of the analysis, and that he cannot speak to the Claimant's physical condition since he is not a medical doctor. The IRO and both URAs, all of whom are medical doctors, note that the Claimant's condition warrants some level of rehabilitative care to restore functioning/conditioning, but they are in agreement that CPM, which is a higher level of care than work conditioning or work hardening, is not indicated at this time. The IRO also notes that the Claimant had returned to work in a light duty program and only stopped working in that capacity when the employer ended the program. The medical evidence shows that Dr. E released the Claimant from his care on July 7, 2014, noting that the Claimant "…has experienced a very good result from his surgery. He has continued to have some back pain, but he has not had any further leg symptoms." *See Carrier's Exhibit CR-C, p. 130.* After a careful review of the entire record, it is determined that the preponderance of the evidence-based medical evidence is not contrary to the IRO's decision. It is, therefore, determined that the record does not establish that the requested CPM is health care reasonably required for the Claimant's compensable (Date of Injury) injury.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

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 had workers' compensation insurance coverage with Travelers Indemnity Co. of Connecticut, Carrier.

D. On (Date of Injury), the Claimant sustained a compensable lumbar injury while in the course and scope of his employment with (Employer).

E. IRO decision #74456 dated September 29, 2014 upheld the Carrier's denial of the CPM in dispute.

2. The IRO decision dated September 29, 2014 was mailed to the Claimant at his correct address.

3. The Claimant is deemed to have received the IRO decision dated September 29, 2014 on October 6, 2014.

4. On October 28, 2014, the Claimant filed his appeal of the IRO decision dated September 29, 2014 with the Division.

5. Ten sessions of CPM (5 x 2, 80 hours) are not shown to be health care reasonably required for the Claimant's compensable (Date of Injury) injury.

6. The Carrier delivered to Claimant a single document stating the true corporate name of the Carrier, and the name and street address of the Carrier's registered agent, which was admitted into evidence as Hearing Officer's Exhibit Number 1.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, does not have jurisdiction to hear this case.

2. Petitioner/Claimant's appeal of the IRO decision dated September 29, 2014 is untimely.

3. Venue is proper in the (City) Field Office.

4. The preponderance of the evidence-based medical evidence is not contrary to the decision of the IRO that the Claimant is not entitled to 10 sessions of CPM (5 x 2, 80 hours) for the compensable injury of (Date of Injury).

DECISION

The Texas Department of Insurance, Division of Workers' Compensation, does not have jurisdiction to hear this case. Petitioner/Claimant's appeal of the IRO decision dated September 29, 2014 is untimely. The preponderance of the evidence-based medical evidence is not contrary to the decision of the IRO that the Claimant is not entitled to 10 sessions of CPM (5 x 2, 80 hours) for the compensable injury of (Date of Injury).

ORDER

The Carrier is not liable for the benefits at issue in this hearing. The Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021 of the Act.

The true corporate name of the insurance carrier is **TRAVELERS INDEMNITY COMPANY OF CONNECTICUT**, and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY d/b/a CSC-LAWYERS INCORPORATING SERVICE COMPANY
211 EAST 7TH STREET, STE. 620
AUSTIN, TX 78701-3218

Signed this 9th day of March, 2015.

Patrice Fleming-Squirewell
Hearing Officer