MEDICAL CONTESTED CASE HEARING NO. 09102
M6-09-17022-01

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.

ISSUE

A contested case hearing was held on February 24, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to ten eight-hour sessions of chronic pain management for the compensable injury of _____?

PARTIES PRESENT

Petitioner appeared and was represented by RL, attorney. Claimant appeared and was assisted by JB-T, ombudsman. Carrier appeared and was represented by PW, attorney.

BACKGROUND INFORMATION

On _____, Claimant sustained a compensable injury to his left upper extremity when he fell eighteen feet from a scaffold and landed on his left elbow. As a result of the fall, Claimant sustained a fracture to the left elbow, dislocation of the left elbow, and left ulnar nerve damage. Despite four surgeries, Claimant continues to have loss of sensation in three digits, loss of range of motion in the left elbow and wrist, and severe pain. Claimant unsuccessfully participated in a work hardening program and currently has not returned to gainful employment. Petitioner is seeking reversal of an adverse determination by the IRO that Claimant is not entitled to ten eight-hour sessions of chronic pain management.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines.

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines

(ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG.

On the date of this medical contested case hearing, the ODG provides the following with regard to chronic pain management:

> "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 put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, 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) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) 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) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) And there are limited studies about the efficacy of chronic pain programs for other upper or lower extremity musculoskeletal disorders."

The ODG further cites these criteria to be met to enroll in a chronic pain management program:

> "Criteria for the general use of multidisciplinary pain management programs:
> Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:
> (1) Patient with a chronic pain syndrome, with pain that persists beyond three months including three or more of the following: (a) Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances; (b) Excessive dependence on health-care providers, spouse, or family; (c) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (d) Withdrawal from social knowhow, including work, recreation, or other social contacts; (e) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (f)

Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression or nonorganic illness behaviors; (g) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;
(2) The patient has a significant loss of ability to function independently resulting from the chronic pain;
(3) Previous methods of treating the chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;
(4) The patient is not a candidate for further diagnostic, injection(s) or other invasive or surgical procedure, or other treatments that would be warranted. If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided;
(5) An adequate and thorough multidisciplinary evaluation has been made, including pertinent diagnostic testing to rule out treatable physical conditions, baseline functional and psychological testing so follow-up with the same test can note functional and psychological improvement;
(6) The patient exhibits motivation to change, and is willing to decrease opiate dependence and forgo secondary gains, including disability payments to effect this change;
(7) Negative predictors of success above have been addressed;
(8) These programs may be used for both short-term and long-term disabled patients. See above for more information under *Timing of use*;
(9) 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 these gains are being made on a concurrent basis. Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program;
(10) Total treatment duration should generally not exceed 20 full-day 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 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function;
(11) At the conclusion and subsequently, neither re-enrollment in nor 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. 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.
> (BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs."

At this contested case hearing, the Petitioner called Dr. LV, PhD., whose qualifications place her at an expert level to testify as to evidence based medicine and the ODG. Although Dr. LV has not treated Claimant, she studied Claimant's records and demonstrated a thorough familiarity with Claimant's course of treatment. Dr. LV went through the criteria stated above one by one and emphasized how Claimant had been unable to reach the treatment objectives including the unsuccessful work hardening program. A detailed analysis of the criteria similar to that of Dr. LV is provided in a report admitted in evidence from Dr. PB, M.S, C.R.C, L.P.C., who is the Clinical Director at Petitioner's clinic. Based on Dr. LV's analysis, Claimant meets necessary elements of the criteria to be entitled to the requested ten eight-hour sessions of chronic pain management.

Additionally, the Official Disability Guidelines state the following regarding chronic pain management programs:

> "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 put them at risk of delayed recovery. Patients should also be motivated to improve and return to work . . . ."

The testimony of Dr. LV supports that Petitioner is qualified to provide a chronic pain management program and that Petitioner has proven successful outcomes. Her testimony also supports the proposition that Claimant is motivated to improve and return to work.

Carrier argues that the ODG in effect at the time the IRO issued its report should be followed. At the time of issuance of the IRO Reviewer's Report, the ODG limited chronic pain management to injured workers having injuries less than two years old. However, the ODG in effect on the date of this hearing does not contain that restriction in that it now states, "These programs may be used for both short-term and long-term disabled patients." Carrier also argues that some of the criteria are not met including that Claimant does not have motivation to change and forego disability payments as well as that Claimant meets some of the criteria of other negative predictors. Carrier relies upon the findings of the advisers who issued the Adverse Determination Letters and the findings of a peer review doctor; the advisers and the peer review doctor did not address evidence based medicine.

The preponderance of the evidence is contrary to the decision of the IRO that the Claimant is not entitled to ten eight-hour sessions of chronic pain management.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

B. On _____, Claimant was the employee of (Employer), when he sustained a compensable injury.

2. Carrier delivered to Petitioner and 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 2.

3. Ten eight-hour sessions of chronic pain management are reasonably required health care for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

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

3. The preponderance of the evidence is contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to ten eight-hour sessions of chronic pain management for the compensable injury of _____.

DECISION

Claimant is entitled to ten eight-hour sessions of chronic pain management for the compensable injury of _____.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

The true corporate name of the insurance carrier is **DALLAS NATIONAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

MR. CHRIS NEHLS
DALLAS NATIONAL INSURANCE COMPANY
14160 DALLAS PARKWAY, SUITE 500
DALLAS, TEXAS 75254

Signed this 26th day of February, 2009.

Charles T. Cole
Hearing Officer