MEDICAL CONTESTED CASE HEARING NO. 09161
M6-09-17819-01

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 held on April 15, 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 Claimant is not entitled to ten days of a chronic pain management program (CPMP) for the compensable injury of _____?

PARTIES PRESENT

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

BACKGROUND INFORMATION

It is undisputed that Claimant sustained a compensable injury on _____, and that Claimant's injury included the lumbar spine. JSC, M.D., Claimant's treating doctor, provided Claimant with conservative medical care that included medication management, physical therapy, twenty sessions of work hardening, individual therapy, and a MRI. The MRI revealed that Claimant had an unremarkable lumbar spine with normal discs and no significant neural encroachment. Due to Claimant's ongoing subjective complaints of lumbar pain, Dr. JSC opined that Claimant would benefit from a CPMP, and referred Claimant to LMV, Ph.D. Dr. LMV, a psychologist with Petitioner, recommended that Claimant undergo ten days of a CPMP for the compensable injury of _____, and forwarded her preauthorization request to Carrier.

Carrier's utilization review determined that the ten days of a CPMP was not medically necessary for Claimant's compensable injury of _____, and denied Dr. LMV's request. Dr. LMV requested an IRO review on behalf of Petitioner. On January 27, 2009, the IRO reviewer, a clinical psychologist specializing in pain management, rendered a decision, determined that the ten days of a CPMP for the compensable injury of _____, was not medically necessary, and cited the current edition of the Official Disability Guidelines (ODG) concerning a CPMP.

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 §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 (EBM) or, if EBM 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 EBM if that evidence is available. EBM 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 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.

With regard to the low back, under Chronic Pain Management Programs (functional restoration), the ODG identifies numerous medical articles, studies, and authors conducted from 1972 through 2009, and provides 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."

The ODG cites a number of treatment modalities for a CPMP that are based on the biopsychosocial model that views pain and disability in terms of the interaction between physiological, psychological, and social factors, including lists of the types of programs, types of treatment, measured outcomes that include specific body parts, role of drug use, role of comorbid psychiatric illness, predictors of success and failure, role of disability duration, timing of use, and role of post-treatment care as an outcome.

The ODG further cites that there are fifteen criteria for the general use of multidisciplinary pain management programs, including CPMP, and 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 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 trail 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.
(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."

The IRO reviewer determined that the requested ten days of a CPMP for the compensable injury of _____, was not medically necessary because the request did not conform to the ODG criteria. Petitioner appealed the IRO decision. In accordance with Division Rule 133.308(t), Petitioner, the appealing party of the IRO decision, had the burden of overcoming the IRO decision by a preponderance of EBM evidence. In support of the disputed issue, Petitioner relied upon Claimant's testimony and medical records concerning the compensable injury of _____. Petitioner did not offer EBM evidence to overcome the IRO determination that the ten days of a CPMP for the compensable injury of _____, was not medically necessary.

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), and sustained a compensable low back injury on _____.

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. Petitioner recommended that Claimant undergo ten days of a chronic pain management program for the compensable injury of _____.

4. The Independent Review Organization determined that the ten days of a chronic pain management program for the compensable injury of _____, was not medically necessary.

5. Petitioner did not provide evidence-based medical evidence to overcome the determination of the Independent Review Organization.

6. The requested ten days of a chronic pain management program for the compensable injury of _____, is not health care reasonably required for Claimant's 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 not contrary to the decision of the Independent Review Organization that Claimant is not entitled to ten days of a chronic pain management program for the compensable injury of _____.

DECISION

Claimant is not entitled to ten days of a chronic pain management program for the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury of June 28, 2008, in accordance with Texas Labor Code Ann. §408.021.

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

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701

Signed this 12th day of May, 2009.

Wes Peyton
Hearing Officer