MEDICAL CONTESTED CASE HEARING NO. 09194
M6-09-18965-01

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 benefit contested case hearing was held on June 23, 2009, 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 entitled to 10 sessions in a chronic pain management program for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by attorney, BJ. Claimant appeared and was assisted by SL, ombudsman.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained an injury to his right wrist and hand on _____, while working as a driving instructor. He has undergone significant conservative treatment including medication and physical therapy as well as psychological therapy to help him deal with depression and anxiety attributed to his injury. He was diagnosed wrist fractures and trigger finger of the right hand as well as tenosynovitis and a small tear of the triangular fibrocartilage. He received injections and ultimately underwent a trigger finger release on May 8, 2008. Claimant underwent postoperative physical therapy and an aggressive active rehabilitative exercise program and strengthening in an effort to return him to his preinjury work activities as a truck driver. On September 11, 2008, Claimant underwent arthroscopic debridement of the triangular fibrocartilage tear and again underwent physical therapy and received medication. He continued with physical therapy and rehabilitation to strengthen his wrist.

From December through January of 2009, Claimant attended six sessions of individual psychotherapy, which improved his depression and anxiety. Following those sessions, Dr. T, Claimant's chiropractor, recommended chronic pain management for treatment of the compensable injury. He stated that Claimant had an apparent level of depression and anxiety, which made lasting improvement difficult due to a lack of effective coping strategies. He further attributed the depression to loss of functioning and independence.

In reviewing the request for chronic pain management, the first utilization reviewer cited the Pain Chapter of the *Official Disability Guidelines* (*ODG)* and determined that the requested service was

not medically necessary. He opined that Claimant had not exhausted lower levels of care. Specifically, he cited the fact that Claimant's depression and anxiety scores had gone down significantly with individual psychotherapy and a medication evaluation for psychological problems would be appropriate; however, chronic pain management was not necessary.

The utilization review doctor who reviewed the request on reconsideration also denied the requested treatment. That reviewer also cited the *ODG* and noted that Claimant had completed aggressive medical care including surgery. He also noted Claimant's progress with individual psychotherapy and opined that there was no need to move toward tertiary care at this time.

An IRO reviewer, a psychologist, reviewed the records and overturned the adverse determinations of the utilization review doctors. The IRO reviewer cited the *ODG* and acknowledged the reduction in Claimant's anxiety and depression following individual psychotherapy sessions; however, the reviewer noted no change in Claimant's functional abilities. The reviewer reasoned that the ostensible reason for the denials of the requested chronic pain management was the fact that psychotherapy was working and should be continued. The IRO reviewer stated that the *ODG* recommends a 10 session trial of chronic pain management to treat chronic pain as measured by increased functional abilities. The reviewer cited the *ODG* provision, which states "[i]t has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition." The reviewer opined that improved functional ability "was a critical aspect for the *ODG* and a trial of a more comprehensive program with return to work as a goal was supported as medically necessary."

A peer review doctor and board certified orthopedic surgeon disagreed with the IRO reviewer and testified that while Claimant did need treatment to focus on both the biologic and psychosocial aspects of his injury, those goals could be accomplished more cost effectively with work hardening and continued individual therapy rather than chronic pain management. He further opined that the requested service was a departure from the *ODG*.

DISCUSSION

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community."

"Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG),* and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced

sections of the **Texas Labor Code**.

ODG

The initial inquiry in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*.

The Pain Chapter of the *ODG* Treatment Guidelines discusses chronic pain management for functional restoration 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. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) 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) See Biopsychosocial model of chronic pain.
> ***Types of programs:*** There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. These pain rehabilitation programs (as described below) combine multiple treatments, and at the least, include psychological care along with physical and/or occupational therapy (including an active exercise component as opposed to passive modalities). The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):
> (1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:
> (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)
> (b) Multidisciplinary pain clinics
> (c) Pain clinics
> (d) Modality-oriented clinics
> (2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Outcomes measured: Studies have generally evaluated variables such as pain relief, function and return to work. More recent research has begun to investigate the role of comorbid psychiatric and substance abuse problems in relation to treatment with pain programs. Recent literature has begun to suggest that an outcome of chronic pain programs may be to "demedicalize" treatment of a patient, and encourage them to take a more active role in their recovery. These studies use outcomes such as use of the medical care system post-treatment. The role of the increasing use of opioids and other medications (using data collected over the past decade) on outcomes of functional restoration is in the early stages, and it is not clear how changes in medication management have affected outcomes, if at all. (See Opioids for chronic pain.)

...

Role of opioid use: See Chronic pain programs, opioids.

Role of comorbid psych illness: Comorbid conditions, including psychopathology, should be recognized as they can affect the course of chronic pain treatment. In a recent analysis, patients with panic disorder, antisocial personality disorder and dependent personality disorder were > 2 times more likely to not complete an interdisciplinary program. Personality disorders in particular appear to hamper the ability to successfully complete treatment. Patients diagnosed with post-traumatic stress disorder were 4.2 times more likely to have additional surgeries to the original site of injury. (Dersh, 2007) The prevalence of depression and anxiety in patients with chronic pain is similar. Cohort studies indicate that the added morbidity of depression and anxiety with chronic pain is more strongly associated with severe pain and greater disability. (Poleshuck, 2009) (Bair, 2008)

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be "at-risk" for post-discharge problems. (Proctor, 2004) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006)(McGeary, 2004) (Gatchel2, 2005) (Dersh, 2007)

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program.

During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

Studies suggesting limited results in patients with long-term disability: While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a "treated group" for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Pysch/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N- =963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the "treated patient" was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced. (Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

Timing of use: Intervention as early as 3 to 6 months post-injury may be recommended depending on identification of patients that may benefit from a multidisciplinary approach (from programs with documented positive outcomes). See Chronic pain programs, early intervention.

Role of post-treatment care (as an outcome): Three variables are usually examined; (1) New surgery at the involved anatomic site or area; (2) Percentage of patients seeking care from a new provider; (3) Number of visits to the new provider over and above visits with the health-care professional overseeing treatment. It is suggested that a "new provider" is more likely to reorder diagnostic tests, provide invasive procedures, and start long-term analgesics. In a study to determine the relationship between post-treatment healthcare-seeking behaviors and poorer outcomes (using prospectively analyzed PRIDE data on patients with work-related musculoskeletal injuries), patients were compared that accessed healthcare with a new provider following functional restoration program completion (approximately 25%) to those that did not. The former group was significantly more likely to have an attorney involved with their case (22.7% vs. 17.1%, respectively), and to have had pre-rehabilitation surgery (20.7% vs. 12.1%, respectively). Return to work was higher in the group that did not access a new provider (90% vs. 77.6% in the group that did access). The group that did not access new providers also was more likely to be working at one year (88% vs. 62.2% in the group that accessed new providers). It should be noted that 18% of the patients that entered the program dropped out or were asked to leave. The authors suggested monitoring of additional access of healthcare over and above that suggested at the end of the program, with intervention if needed. (Proctor, 2004)

See also Chronic pain programs, intensity; Chronic pain programs, opioids; Functional restoration programs; & Chronic pain programs, early intervention.

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.

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

Both of the utilization reviewers denied the requested chronic pain management program, citing the fact that Claimant was improving with the individual therapy sessions. The peer review doctor acknowledged the need to address not only the psychological aspects, but also the functional/physical components of Claimant's injury, but opined that a chronic pain management program was overkill. He testified that Claimant could obtain satisfactory results with work

hardening and continued individual therapy. While acknowledging Claimant's improvement with individual psychotherapy, the IRO overturned the preauthorization denials and approved the requested chronic pain management program to address Claimant's functional/biologic deficits.

Under the Act, treatment provided pursuant to the *ODG* is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**. Mere citation to the *ODG*, however, does not carry the day. When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. The *ODG* section on chronic pain management is very comprehensive and provides an in depth analysis of the situations under which physicians should consider chronic pain management programs for treatment purposes. The guidelines also set out detailed and numerous selection criteria for general use of these programs in treatment of injuries. While Claimant clearly has chronic pain syndrome with evidence of loss of function for more than three months, and meets at least three of the other enumerated requirements, the medicals records presented do not show that he meets several of the other selection criteria required by the *ODG*.

The *ODG* make it clear that chronic pain management is the proverbial last resort for chronic pain patients. One of the selection criteria is that all previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The *ODG* require an extensive, adequate and thorough multidisciplinary evaluation to be done followed by a specific chronic pain management treatment plan. The *ODG* make it clear that "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…."

In the instant case, the IRO, while citing the *ODG* and concluding that a chronic pain management program might provide a more comprehensive program to increase Claimant's functional abilities, failed to address the numerous and extensive selection criteria required by the *ODG* to justify the necessity for Claimant to participate in such a program. The medical records do not show that all previous methods of treating Claimant's chronic pain have been unsuccessful. To the contrary, the individual psychotherapy sessions significantly reduced his anxiety and depression. Further, there is no comprehensive and thorough evaluation or plan outlining the type of program best suited to Claimant's needs or contemplated by the requesting doctor. In the instant case, based on the *ODG* and the testimony of the board certified orthopedic surgeon who performed the peer review, as well as the opinions from the utilization review doctors, the preponderance of the evidence-based medicine is contrary to the IRO decision and the requested chronic pain management program does not meet the criteria set out in the *ODG*.
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.

C. The IRO determined that the requested services were reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant's treating doctor recommended ten sessions in a chronic pain management program.

4. For treatment of the chronic pain, the *ODG* recommends chronic pain management programs only where a Claimant meets an exhaustive and extensive set of selection criteria.

5. The medical records do not show that Claimant meets the selection criteria required by the *ODG* for a chronic pain management program.

6. The IRO overturned the Carrier's denial of the requested chronic pain management sessions opining that the program might provide a more comprehensive program to increase Claimant's functional abilities.

7. The requested service is not consistent with the *ODG* criteria for a chronic pain management program.

8. The requested chronic pain management program (10 sessions) is not health care reasonably required 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of IRO that 10 sessions in a chronic pain management program is health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to 10 sessions in 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 in accordance with Section 408.021.

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

MR. RUSSELL OLIVER, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723.

Signed this 24th day of June 2009.

Erika Copeland
Hearing Officer