MEDICAL CONTESTED CASE HEARING NO. 09209
M6-09-17798-01

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 not entitled to 80 hours of chronic pain management/functional restoration program for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was represented by CS, attorney. Carrier appeared and was represented by attorney, SL.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained a compensable injury to her neck and right upper extremity while attempting to stop a box from falling from a top rack. As a result of her injury, she underwent cervical laminectomy and resection of an ependymoma from C2-C7 on April 7, 2007. She developed a post-surgical staph infection and underwent irrigation and debridement on June 7, 2007. Claimant underwent post-surgical physical therapy sessions and 180 hours of chronic pain management, which she completed in August of 2008. Claimant testified that her symptoms have worsened since completion of her therapy and chronic pain management. Dr. V, one of Claimant's pain management doctors, ordered 80 additional hours of a chronic pain management and functional restoration program for treatment of Claimant's compensable injury.

The carrier's first utilization review doctor, a pain management doctor, denied the requested chronic pain management program citing the *ODG* and opined that the proposed treatment was not necessary as Claimant had undergone 21 sessions of chronic pain management as well as 6 aftercare sessions with no significant functional improvement or lasting benefit. He concluded that there was no established clinical indication or medical necessity for the requested additional hours of chronic pain management.

The second utilization reviewer, a psychologist, also cited the *ODG* in recommending denial of the requested 80 hours of chronic pain management. That reviewer noted that there was documentation of many of the selection criteria set out in the *ODG* for chronic pain management programs; however, she concluded that there was no documentation or a durable, lasting benefit from the previous pain management program.

The IRO reviewer was a Fellowship Trained pain management doctor who is board certified in anesthesiology. The reviewer listed the extensive records reviewed and upheld the adverse determinations of the utilization review doctors. The IRO reviewer denied the requested 80 hours of chronic pain management/functional restoration program citing the *ODG* provisions regarding chronic pain management. The reviewer opined, from a review of the clinical record, that Claimant had no significant functional improvement or sustained clinical benefit from the prior sessions of chronic pain management program. The reviewer cited the *ODG* recommendation that no more than twenty sessions of a chronic pain management program is medically necessary absent extenuating or extraordinary circumstances. The reviewer cited the fact that Claimant had no lasting decrease in her pain score and her pain complaints all returned within weeks of completion of the initial chronic pain management program. The reviewer opined that Claimant's continuing pain was not a result of extraordinary or extenuating circumstances; rather it was caused by a failure in treatment. The reviewer cited an FCE which noted submaximal, inconsistent and nonphysiologic efforts and responses as further reason for Claimant's failure to improve. Finally, the reviewer noted that Claimant was still being evaluated for primary and secondary levels of treatment, thereby excluding consideration of a tertiary level of treatment such as a chronic pain management program. The reviewer concluded that there was no justification in either the *ODG* or normally accepted standards of medical care for the Claimant to receive any further chronic pain management program sessions.

Claimant offered a February 12, 2009 MRI of the cervical spine, which revealed a spinal cord lesion at C4 which might represent post-operative changes or a residual tumor as well as multilevel degenerative disc disease causing reversal of the cervical lordosis. She also offered the records of Drs. P and V, pain management doctors to whom she had been referred by her treating doctor. Those doctors recommended continued physical therapy and chronic pain management, as those treatment options had helped Claimant's symptoms in the past. Claimant also offered letters from the pain clinic coordinator and a licensed professional counselor working for the pain clinic, recommending the additional chronic pain management program and citing Claimant's improvement with the program in the past as justification for the additional sessions.

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, therefore, 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.)

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.

All of the doctors who reviewed the requested physical therapy and the IRO doctor denied the requested additional 80 hours of chronic pain management citing the relevant provisions of the *ODG*, specifically the fact that Claimant had already undergone more than the recommended number of sessions of chronic pain management with no documented or sustained improvement, and there was no medical documentation that warranted a departure from the *ODG* standard of care. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the *ODG* and the opinions of the doctors correctly applying the *ODG*.

Other Evidence Based Medicine

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. Food Lion, Inc.***, 171 F.3rd 308 (5th Cir. 1999); ***E.I. Du Pont De Nemours and Company, Inc. v. Robinson***, 923 S.W.2d 549 (Tex. 1995). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2)

the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. ***Kelly v. State***, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. Drs. S and Dr. V, Claimant's pain management doctors, may well be qualified to render an opinion regarding conservative neck treatment. The treatment proposed by those doctors, however, is a departure from the *ODG*. The pain clinic coordinator and licensed professional counselor's opinions do not amount to evidence-based medicine in support of the proposed treatment. While Claimant may have met some of the selection criteria for chronic pain management outlined by the ODG, she clearly failed to meet Criteria (12) and (13). Claimant has not provided sufficient documentation to justify further chronic pain management, when the program anticipated is identical to program she has already attended and she sustained no lasting benefit from that program. The Claimant did not present evidence-based medicine to overcome the IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested 80 hours of chronic pain management/functional restoration 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 she sustained a compensable injury.

   C. The IRO determined that the requested services were not 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 80 hours of chronic pain management/functional restoration program for treatment of the compensable injury.

4. For chronic neck pain, the *ODG* sets out a recommended number of chronic pain management program sessions and the circumstances under which additional sessions may be medically necessary.

5. Claimant has undergone more than the recommended number of chronic pain management program sessions for treatment of her cervical spine with no sustained or lasting benefit.

6. The IRO decision upheld the Carrier's denial of the requested 80 hours of chronic pain management/functional restoration program because the Claimant had already undergone more than the number of sessions recommended by the *ODG* and the medical evidence did not justify additional chronic pain management.

7. The requested service is not consistent with the *ODG* criteria for chronic pain management/functional restoration programs for cervical spine pain.

8. The requested 80 hours of chronic pain management/functional restoration program 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 not contrary to the decision of IRO that 80 hours of chronic pain management/functional restoration program is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to 80 hours of chronic pain management/functional restoration 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 **NEW HAMPSHIRE INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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

Signed this 6th day of August, 2009.

Erika Copeland
Hearing Officer