MEDICAL CONTESTED CASE HEARING NO. 11081
M6-10-29964-01

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 December 10, 2010, with the record closing on December 15, 2010, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to chronic pain management program, 10 sessions, for the compensable injury of _____?

PARTIES PRESENT

Petitioner appeared and was represented by RL, attorney. Claimant appeared and was assisted by JT, ombudsman. Respondent/Self-Insured appeared and was represented by TW, attorney.

BACKGROUND INFORMATION

Claimant sustained a compensable right shoulder injury on _____. She was referred to Dr. Y, an orthopedic surgeon. He performed surgery on the shoulder on April 28, 2009. Claimant continued to suffer with pain and limited use of the shoulder and switched doctors to Dr. V, an orthopedic surgeon. He performed shoulder surgery on February 4, 2010, which also did not help. After the surgery Claimant had physical therapy and 12 sessions of psychotherapy, followed by 10 sessions of work hardening, according to the information provided with the request for chronic pain management which is the subject of this hearing. The IRO doctor, an MD board certified in physical medicine and rehabilitation and in pain management, upheld the denial of the request.

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

focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the 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. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The ODG provides as follows concerning predictors of negative efficacy of treatment for a chronic pain management program:

> ***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)

The ODG provides the following criteria for use of outpatient chronic pain management programs:

> **Criteria for the general use of multidisciplinary pain management programs:**
> Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:
> (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal

contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.
(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

The IRO doctor noted criterion 13) for use of a pain management program, and observed that there was little to justify the requested chronic pain management program as medically necessary after the prior limited progress with the work hardening program.

Dr. M, a PhD psychologist and director of Petitioner's work hardening and chronic pain management programs, testified for Petitioner. She was familiar with Claimant, her treatment, the request for chronic pain management, and the proposed interdisciplinary pain program plan. She also qualified as an expert on the ODG at least as it applies to chronic pain management and work hardening.

Dr. M maintained the requested chronic pain management program was justified by the failure of the work hardening program. She pointed out that, while criterion 13) states "At the conclusion (of a pain management program) 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…" and "A chronic pain program should not be considered a 'stepping stone' after less intensive programs", it also provides that "prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated". She testified Claimant met the relevant ODG criteria, discussing them one by one. She said a chronic pain management program is basically a work hardening program plus psychological care, so it would not make sense to complete pain management, then go through work hardening, however it would make sense to go through a pain management program after unsuccessful work hardening. It was pointed out to Dr. M that Claimant had 12 sessions of psychotherapy before the work hardening, and she responded that in pain management the idea is to combine the two at the same time.

Claimant testified and recalled that the work hardening program was 10 sessions conducted over about eight weeks and ending six weeks before the hearing, which would be around October 29, 2010. If so, Claimant had not begun work hardening when petitioner requested the chronic pain management program on July 29, 2010, and had not completed it when the IRO review was done on October 6, 2010, in which case the request and the IRO decision were based on an incorrect understanding of a key fact.

Claimant demonstrated a poor memory for dates and details. There was no other evidence showing the beginning and ending dates of the work hardening program. The Hearing Officer decided to hold the record open until December 17, 2010 at 5:00 pm for the parties to furnish documentary evidence establishing the time period during which the work hardening program occurred.

Self-Insured sent in work hardening records from (Healthcare Provider), which were received and admitted into evidence, and the record closed, on December 15, 2010. These records

indicated Claimant participated in two courses of work hardening, 10 visits from May 24, 2010 through June 10, 2010 and nine visits from July 1, 2010 through October 15, 2010, which would explain the apparent conflict in the evidence.

Self-Insured did not call a witness, relying instead on the pre-authorization reviews and the IRO decision.

The evidence based medicine in this case is the ODG. The IRO decision is based on the idea that the ODG criteria were not met. Dr. M provided credible expert testimony showing the criteria were met, discussing them one by one in the context of this case. The preponderance of the evidence based medical evidence is contrary to the decision of the IRO.

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 (Self-Insured), Employer.

   C. On _____ Claimant sustained a compensable injury.

   D. The Independent Review Organization determined Claimant should not have the requested treatment.

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

3. Chronic pain management program, 10 sessions, is 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 is proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that chronic pain management program, 10 sessions, is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to chronic pain management program, 10 sessions, for the compensable injury of _____.

ORDER

Self-Insured is liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance Self-Insured is **(SELF-INSURED)**, and the name and address of its registered agent for service of process is

CITY SECRETARY
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 15th day of December, 2010.

Thomas Hight
Hearing Officer