MEDICAL CONTESTED CASE HEARING NO. 11086
M6-10-29785-01

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 1, 2010 and continued for Claimant to show cause as to why he was not present. On January 3, 2011 the contested case hearing was held to conclusion to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is entitled to chronic pain management program X 80 hours (CPT 97799) for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Carrier appeared and was represented by JL, attorney. Neither Respondent/Provider nor Claimant appeared.

BACKGROUND INFORMATION

Although properly notified, Claimant failed to appear for the medical contested case hearing on December 1, 2010. Claimant requested a hearing in response to a 10-day letter that was rescheduled for January 3, 2011. Claimant failed to appear on January 3, 2011 to show cause as to why he was not present on December 1, 2010. The ombudsman reported that Clamant was no longer a client of Respondent and Respondent did not want to participate. Petitioner/Carrier presented evidence that it is entitled to the relief it seeks.

Claimant has a history of cervical fusions with residual numbness affecting the left upper extremity. He sustained a compensable left elbow injury on _____. Claimant underwent surgery to the olecranon bursa with some relief on February 8, 2008. On July 8, 2010 Dr. B diagnosed chronic elbow and left wrist pain and referred Claimant for cognitive behavioral rehabilitation. On July 14, 2010 Dr. M, requested a chronic pain management program to address the psychological aspect of the injury at (Healthcare Provider 1). Utilization reviews on July 22, 2010 and August 5, 2010 denied the request. On September 2, 2010, Dr. L, (Healthcare Provider 2), authored a letter of appeal stating that Claimant was not provided with any form of therapy to wean him off narcotic medication and requested a 10 day participation in an interdisciplinary functional restoration/detox program. Claimant was noted to have had several months of therapy, epidural steroid injections, and medications, but had ongoing pain which he felt was due to his medications and requested assistance to wean himself from them.

On September 28, 2010 the IRO reviewer, a board certified orthopedic surgeon, reviewed Claimant's medical records, and determined that the chronic pain management program x 80 hours (CPT 97799) was medically necessary. The IRO reviewer cited the current edition of the

ODG concerning outpatient multidisciplinary pain rehabilitation programs and determined that Claimant met the ODG criteria.

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. 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 is 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 cites the criteria for the general use of multidisciplinary pain management programs, including chronic pain management programs, 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 (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.
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."

In accordance with Division Rule 133.308(t), Petitioner/Carrier, the appealing party of the IRO decision, had the burden of overcoming the IRO decision by a preponderance of evidence-based medical evidence. Carrier contended that Claimant did not meet the ODG criteria for the recommended chronic pain management/detox program and relied on the testimony of Dr. N, M.D, utilization reviewer. Dr. N testified that she was board certified in occupational medicine and disagreed with the determination of the IRO. Dr. N stated that she had reviewed Claimant's medical records and he had negative predictors for success as contained in the ODG. Specifically there was limited information on the clinical and functional status of Claimant, a lack of motivation to return to work, no evidence of opioids in multiple urine tests, lack of specific objective measureable outcomes for the stated therapy goals, evidence of inconsistency and sub-maximal effort on testing, co-morbid medical conditions of smoking and use of alcohol, and limited information on the utilization of pharmacotherapy as to doses, frequencies, and objective responses to current medications. Carrier met its burden of proof to overcome the decision of the IRO.

The preponderance of the evidence-based medical evidence is contrary to the decision of the IRO that Claimant is entitled to a chronic pain management program x 80 hours (CPT 97799) for the compensable injury of _____.

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).

C. Claimant sustained a compensable injury on _____.

D. The IRO determined that Claimant is entitled to chronic pain management program x 80 hours (CPT 97799) for the compensable injury of _____.

2. The Division sent a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent for service with the 10-day letter to the claimant at Claimant's address of record. That document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant did not have good cause for failing to appear at the contested case hearing.

4. The preponderance of the evidence is contrary to the decision of the IRO that chronic pain management program x 80 hours (CPT 97799) 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. Chronic pain management program x 80 hours (CPT 97799) is not health care reasonably required for the compensable injury of _____.

DECISION

Chronic pain management program x 80 hours (CPT 97799) is not health care reasonably required 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 §408.021.

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

CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TX 75201

Signed this 4th day of January, 2011.

Judy L. Ney
Hearing Officer