MEDICAL CONTESTED CASE HEARING NO. 20008

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC). For the reasons discussed herein, the Administrative Law Judge determines that chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is not health care reasonably required for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A medical contested case hearing (MCCH) was held on June 11, 2020 by a Division administrative law judge (ALJ), Francisca N. Okonkwo, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is entitled to chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant appeared and was assisted by DV, ombudsman. Carrier appeared and was represented by RH, attorney. The hearing was held by teleconference in accordance with Commissioner Cassie Brown's March 24, 2020 memo to system participants regarding workers' compensation operations in light of COVID-19.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: LM.
For Carrier: None.

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 through ALJ-4.
Claimant's Exhibits C-1 through C-7.
Carrier's Exhibits CR-A through CR-V.

DISCUSSION

Claimant, a nurse assistant, sustained a work injury on (Date of Injury) while lifting and transferring a patient. In a DWC Decision and Order signed on October 18, 2019, the Administrative Law Judge determined that while Claimant's compensable injury consisted of a cervical sprain/strain, thoracic sprain/strain, right shoulder sprain/strain, and a right shoulder distal supraspinatus tendon strain, the (Date of Injury) compensable injury did not extend to or include the conditions of cervical disc herniation/protrusion at C5-C6, cervical disc herniation/protrusion at C6-C7, cervical radiculitis, lumbar disc bulge/tear at L4-L5, lumbar disc bulge at L5-S1, or lumbar radiculitis. In the Decision and Order, which is in evidence, it was noted that these conditions which were identified on MRI studies, were pre-existing ordinary disease of life findings which were not aggravated by the (Date of Injury) mechanism of injury.

The record shows that Claimant received conservative care for her injury, which included diagnostic testing, prescription medications, physical therapy, and 80 hours of chronic pain management program (CPMP). Claimant testified that she did not complete the full 80 hours due to financial hardship. Claimant also underwent a lumbar epidural steroid injection on October 10, 2018. Additional treatment determined to be medically necessary and recommended by Dr. AT, the Medical Director of (Provider), included 80 more hours of CPMP, three times weekly. Sedgwick Utilization Review performed a peer review of the medical information, determined that this additional healthcare service did not meet with established standards of medical necessity, and denied the CPMP.

Claimant appealed the denial to an Independent Review Organization (IRO) and in its Notice of Independent Review Decision dated March 4, 2019, the IRO overturned the denial. The IRO determined that 80 additional hours of CPMP was medically necessary and in accordance with medical judgment, their clinical experience, and Official Disability Guidelines (ODG). Claimant testified that she only attended 2 sessions of the program due to financial hardship.

Carrier requested this MCCH to dispute the IRO's decision. Carrier argued that Dr. T requested CPMP specifically for the diagnoses of lumbar radiculopathy and cervical radiculopathy. Carrier further argued that these conditions are not part of the (Date of Injury) compensable injury. Carrier contends that the IRO's Decision was based on non-compensable conditions and that the additional CPMP is not medically necessary treatment for the compensable injury. Initially, the MCCH case was put on hold pending the resolution of the extent of injury dispute.

With regard to chronic pain program, the ODG lists the following criteria:

> **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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (*Sanders, 2005*) If treatment duration more than 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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.

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*)

As previously indicated, it was determined that Claimant's compensable injury consisted of cervical, thoracic, and right shoulder sprain/strains. On September 5, 2019, designated doctor (DD), RH, DC, determined that Claimant reached maximum medical improvement (MMI) for these injuries on November 16, 2018 with a 0% impairment rating (IR). Dr. H noted that Claimant sustained soft tissue injuries and was treated conservatively in keeping with ODG treatment guidelines. Dr. H agreed with the opinion of the prior DD, MW, DC, that as of November 16, 2018, all additional treatment recommendations, to include medications, cervical and lumbar epidural steroid injections and a multidisciplinary chronic pain management program were being directed to treat conditions which were determined to be non-compensable and not related to the (Date of Injury) work injury event. See CR-5, pages 16-18.

All of the medical records in evidence were considered. The medical evidence presented did not support Claimant's position. The preponderance of evidence-based medical evidence is contrary to the IRO's finding that chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is health care reasonably required for the compensable injury of (Date of Injury).

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. The Texas Department of Insurance, Division of Workers' Compensation has jurisdiction in this matter.

   B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

C. On (Date of Injury), Claimant was the employee of (Employer), Employer.

D. On (Date of Injury), Employer provided worker's compensation insurance through Arch Indemnity Insurance Company, Carrier.

E. Claimant sustained a compensable injury on (Date of Injury).

F. Carrier has accepted a cervical sprain/strain, thoracic sprain/strain, and a right shoulder sprain/strain as the compensable injury.

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

3. The (Date of Injury) compensable injury extends to and includes a right shoulder distal supraspinatus tendon strain, but does not extend to or include cervical disc herniation/protrusion at C5-C6, cervical disc herniation/protrusion at C6-C7, cervical radiculitis, lumbar disc bulge/tear at L4-L5, lumbar disc bulge at L5-S1, or lumbar radiculitis.

4. The Independent Review Organization determined that Claimant is entitled to chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure.

5. The preponderance of evidence based medical evidence is contrary to the IRO's finding that chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is health care reasonably required for the compensable injury of (Date of Injury).

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 evidence based medical evidence is contrary to the decision of the IRO that chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is health care reasonably required for the compensable injury of (Date of Injury).

4. Chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Chronic pain program, additional 10 sessions/80 units 3Xs a week, 97799 unlisted physical medicine/rehabilitation service or procedure is not health care reasonably required for the compensable injury of (Date of Injury).

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 **ARCH INDEMNITY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3218

Signed this 18th day of June, 2020.

FRANCISCA N. OKONKWO
Administrative Law Judge