MEDICAL CONTESTED CASE HEARING NO. 13075

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 March 21, 2013 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 80 hours of chronic pain management for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner appeared and was represented by ML, attorney. Respondent/Carrier appeared and was represented by RJ, attorney. Claimant appeared without representation.

BACKGROUND INFORMATION

Claimant sustained compensable injury to multiple body parts on (Date of Injury), when he fell coming down stairs. His treatment included left shoulder surgery to address an ACL tear, physical therapy, and work hardening. Petitioner Injury 1 of (City) requested pre-authorization for 80 hours of chronic pain management. The IRO doctor, a medical doctor board certified in anesthesiology and pain management, upheld the previous denials, and Petitioner appealed.

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. 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 a party 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 the following criteria for the general use of multidisciplinary pain 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.

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.

The IRO doctor thought the requested treatment was not medically necessary, noting that Claimant had completed a work hardening program, and the ODG does not recommend re-enrollment in the same or a similar rehabilitation program. The IRO doctor also noted that Claimant did not have any significant psychological barriers manifested as depression or anxiety based on psychological examinations, and that Claimant had weaned himself off of all of his medications (including narcotics), so that aspect of chronic pain management would not be utilized.

Dr. NM, a clinical psychologist and director of the pain management program for Injury 1 of (City), testified for Petitioner. She was familiar with the ODG guidelines and the criteria for the general use of multidisciplinary pain programs. She said each criterion was addressed in the request for preauthorization (P-2) and met. She responded to the IRO doctor's specific concerns at some length.

Dr. M explained that chronic pain management is different from work hardening in that chronic pain management puts more focus on psychological factors hindering improvement in physical function. ODG criterion (13) 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.

Dr. M opined that Claimant had psychological conditions that limited improvement in physical function: pain disorder and fear avoidance of physical activity. Depression or anxiety is not required. The ODG criterion that applies here is (3)(c), which provides that pertinent areas to be addressed in chronic pain management include but are 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.

Dr. M pointed out that Claimant in fact had not weaned himself off of narcotic medication. There was a report from Dr. BE dated July 17, 2012 that said he had done so (R-9). However, a report from Dr. SG dated October 31, 2012 states Claimant was still narcotic dependent and includes hydrocodone in the list of medications Claimant was prescribed.

Dr. NB, an anesthesiologist, testified for Carrier. He discussed criterion (1), which requires evidence of three or more elements from a list of (a) through (g). He opined that (a), (c), (e), and (g) were not present. Dr. M differed with him concerning (e), "psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors". His opinion with respect to (g), "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", was based on the idea that Claimant had weaned himself off of narcotic medication. In any event, at least three of the elements were present.

Dr. B also opined that pain management was unnecessary because Claimant was able to perform at the physical demand level required by his pre-injury job, based on an FCE done on May 17, 2012 (P-3, pages 46-59). An FCE done on October 31, 2012 concluded that Claimant was not capable of performing the pre-injury job and recommended chronic pain management (P-10). The pre-authorization request was dated November 6, 2012.

Petitioner met its burden to overcome the IRO decision by the preponderance of evidence based medical evidence.

There was no objection to the testimony, reports, or qualifications of any doctor.

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

   C. On (Date of Injury) Employer provided workers' compensation insurance with Wausau Business Insurance Company, Carrier.

   D. On (Date of Injury) Claimant sustained a compensable injury.

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

2. Carrier delivered to Petitioner and 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 Hearing Officer's Exhibit Number 2.

3. 80 hours of chronic pain management 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 the evidence is contrary to the decision of the IRO that 80 hours of chronic pain management is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to 80 hours of chronic pain management for the compensable injury of (Date of Injury).

ORDER

Carrier is 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 of the Act.

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

CORPORATION SERVICES COMPANY
211 EAST 7th STREET, SUITE 620
AUSTIN, TEXAS 78701

Signed this 21st day of March, 2013.

Thomas Hight
Hearing Officer