MEDICAL CONTESTED CASE HEARING NO. 14075

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. For the reasons discussed herein, the Hearing Officer determines that Claimant is not entitled to a chronic pain management program (5x2x80 hours) for the right foot/ankle for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

On October 15, 2013, and continued on July 15, 2014, Ken Wrobel, a Division hearing officer, held a contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to a chronic pain management program (5x2x80 hours) for the right foot/ankle for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Provider appeared and was represented at each hearing by JM, attorney. Respondent/Carrier appeared and was represented at each hearing by BJ, attorney.

Claimant did not appear for the October 15, 2013, CCH. At the time of the October 2013 CCH, he informed the ombudsman program he was not interested in signing with them and that he was not going to appear for the hearing. A 10-day letter was sent to the Claimant. Claimant responded to the 10-day letter requesting a hearing. The hearing was continued until it was heard on July 15, 2014. Claimant again did not show for the hearing. The record was closed on that date.

EVIDENCE PRESENTED

The following witnesses testified:

For Petitioner: NM, Ph.D.
For Carrier: NT, M.D.
For Claimant: No one

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits HO-1 through HO-4
Claimant had no exhibits.
Petitioner's Exhibits C-1 through C-13
Carrier's Exhibits R-1 through R-11

DISCUSSION

Per the medical records in evidence, on (Date of Injury), Claimant sustained a crush injury to his right ankle/foot. Claimant has had surgery and conservative care, including work hardening for the compensable injury. The Petitioner has requested a chronic pain management program to benefit Claimant. Carrier denied the request. Both of Carrier's URAs found in favor of the denial. The IRO doctor also found in favor of denying 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. 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(s), "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."

On the day of the October 15, 2013 CCH, the Official Disability Guidelines, under the Pain Chapter, provides the following with regard to a chronic pain management program (which is not specific to the ankle):

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.

NM, M.D., testified on behalf of the Petitioner. She explained how the Claimant meets every one of the Official Disability Guidelines criteria for a chronic pain management program. NT, M.D. testified for the Carrier opining the request did not meet the Official Disability Guidelines requirements, and that the requested treatment is redundant as Claimant has already had all the physical treatment he can have that would benefit him.

Dr. T is referring to Criterion 13. It is evident the requested treatment would not be redundant as the chronic pain management program would provide focus on any psychological barriers that may be keeping Claimant from being able to return to work. This does not appear to be a request for a stepping stone from a work hardening program into a chronic pain management program. Dr. T's testimony on that matter is not persuasive.

The IRO doctor focuses on several criteria the IRO doctor opines were not met based upon the medical records reviewed. The IRO doctor stated there was no legible FCE to review and therefore no loss of function was documented. The FCE found in Carrier's R5p65-78 is difficult to read but certainly is not illegible. Additionally, the Official Disability Guidelines does not require an FCE. The medical records show a loss of function for over three months. Claimant was unable to work. He had injections in his ankle. He had surgery on September 12, 2012. On January 28, 2013, several disputed conditions were considered to be part of the compensable injury per a Designated Doctor. The Petitioner has provided evidence of how Claimant has met more then three of the other criteria required under Criterion 1.

Under Criterion No. 3 there are four requirements and the Petitioner only provides documentation for two of those in its pre-authorization request. The Petitioner does not explain why the other two criteria are or are not met. For Criterion 3, the Petitioner did not provide pertinent validated diagnostic testing to meet the Official Disability Guidelines requirement.

The IRO doctor stated the Petitioner did not meet Criterion 7. This criterion requires documentation of motivation. The written preauthorization report provided by Petitioner does not address this the way it addresses the other issues – by italicizing a response. Dr. Mangum addressed this in her testimony by stating Claimant showed motivation by trying to return to work, even though he was only able to work for two hours before having to leave. However, that was on January 16, 2012. Claimant stated in his psychological examination dated March 26, 2013, that he plans on returning to work in his same position as a welder. There are several psychological evaluations in evidence but there is no other documentation of motivation in evidence other than that statement by Claimant. This does not suffice to exhibit documentation of a motivation to change, a willingness to change his medication regimen, and his awareness that successful treatment may change any compensation.

Petitioner did not show by a preponderance of the evidence-based medical evidence that the proposed care is health care reasonably required for the compensable injury.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties who attended the CCHs 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), Claimant sustained a compensable injury.

   D. The Independent Review Organization doctor board certified by the American Board of Physical Medicine and Rehabilitation determined Claimant should not have a chronic pain management program (5x2x80 hours) for the right foot/ankle.

2. Carrier delivered Petitioner 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. A chronic pain management program (5x2x80 hours) for the right foot/ankle is not health care reasonably required for the compensable injury of (Date of Injury).

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

5. Claimant failed to appear for the October 15, 2013, contested case hearing. He responded to the 10-day letter sent after the October 15, 2013, hearing, and the hearing was ultimately reset to July 15, 2014. Claimant again did not appear.

6. Claimant did not have good cause for his failure to appear for the contested case hearings of October 15, 2013, and July 15, 2014.

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 not contrary to the decision of the IRO that a chronic pain management program (5x2x80 hours) for the right foot/ankle is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is not entitled to a chronic pain management program (5x2x80 hours) for the right foot/ankle 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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RICHARD GERGASKO, PRESIDENT
6210 HIGHWAY 290 EAST
AUSTIN, TEXAS 78723.

Signed this 15th day of July, 2014.

KEN WROBEL
Hearing Officer