SOAH DOCKET NO. 453-02-3524.M2
MDR Tracking No. M2-02-0598-01

POSITIVE PAIN MANAGEMENT, PETITIONER	§	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	§	**OF**
	§	
SPRING INDEPENDENT SCHOOL DISTRICT, RESPONDENT	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Positive Pain Management (Petitioner) appealed the decision of the Texas Workers' Compensation Commission's (Commission) designee, an independent review organization (IRO), in MDR Docket No. M2-02-0598-01 which denied preauthorization for a chronic pain management (CPM) program for a workers' compensation claimant (Claimant). Petitioner's request for the CPM had been denied by the Spring Independent School District (Respondent) as not being medically necessary healthcare. This decision finds preauthorization for the CPM should be granted.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened August 7, 2002, at the State Office of Administrative Hearings, 300 W. 15th Street, Austin, Texas, with Administrative Law Judge (ALJ) Ann Landeros presiding. Petitioner was represented by its attorney, Peter Rogers. Respondent was represented by its attorney Jon Grove. The Commission chose not to participate in the hearing. By agreement of the parties, the record was left open for submission of written evidence and argument. After receipt of the written submissions, all the parties' exhibits were admitted into the record, which closed August 28, 2002.

II. DISCUSSION

A. Background Facts

In_____, Claimant fell and injured her lower back while working as a ___ in Respondent's school. Her injuries were compensable under the Texas Workers' Compensation Act (Act). At the time of the compensable injury, Respondent, as a self-insurer, was responsible for Claimant's workers' compensation insurance coverage.

In January 2002, Claimant's treating doctor, Thomas Cartwrigt, M.D., referred her to Petitioner's CPM program and requested Respondent preauthorize that service. After Respondent denied preauthorization as medically unnecessary, Petitioner requested medical dispute resolution from the Commission. Pursuant to 28 TEX. ADMIN. CODE (TAC) § 133.308, the request was handled by the an IRO selected by the Commission. The IRO upheld Respondent's denial of preauthorization, stating:

> It is determined that the 20 day pain management functional/restoration program is not medically necessary to treat this patient's condition.
>
> This patient has had physical and behavioral aspects of treatment and those are major components of the 20 day restoration/functional program. Since there has been no significant improvement with the major components of the 20 day program, there is likely to be little gained from the program. (Pet. Exh. 7).

Petitioner timely appealed the IRO decision.

Petitioner has the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i). Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a). Health care includes all reasonable and necessary medical services including a medical appliance or supply. TEX. LAB. CODE ANN. §401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31). The decision of an IRO is to

be given presumptive weight. 28 TAC 133.3080(v). Certain types of healthcare, including chronic pain management programs require preauthorization from the carrier. 28 TAC § 134.600(h).

C. Claimant's Medical History

In June 1999, Claimant described her back pain as ''constant, piercing, and unremitting'' to anesthesiologist Dr. Kenneth Alo. (Pet. Exh. 6). In November 2000, Dr. Alo sent Claimant for a discogram with CT scan. That procedure resulted in a diagnosis of lumbar discopathy with disc disruption syndrome. The post-discogram CT examination revealed no focal annular tears at the L4-5, L4-3, or L2-3 levels; a mild annular bulge without annular tear, nerve root impingement or stenosis at theL4-5 level; and a normal appearance at the L5-S1 level of her spine. (Pet. Exh. 6). Claimant subsequently had an unknown number of injections to block pain, one of which afforded considerable, but temporary, pain relief. She also had massage and exercise therapy.

In June 2001, orthopedic surgeon Dr. Cartwright diagnosed Claimant with mild restriction of lumbar flexion and extension with pain at the extremes. He found she had no neurological involvement in her back and leg pain. According to Dr. Cartwrigt, Claimant was not a surgical candidate. He recommended use of a chair with adjustable lumbar support, psychological counseling, biofeedback, stabilization exercises, and a pain management program. (Pet. Exh. 6). Dr. Cartwright also released Claimant to return to work on July 26, 2001, noting:

> I have told her that she simply is going to have to try working again. If she is unable to do so, then she will need to either retire or change jobs, perhaps to an older grade where there is going to be less bending, lifting and twisting. (Pet. Exh. 6).

Apparently, Claimant did return to work for some period of time, but eventually left her job due to ongoing back pain. She participated in at least ten biofeedback sessions during the first part of 2001, but Respondent declined to preauthorize additional sessions in June 2001. (Pet. Exh. 6). around that time, Claimant was treated by psychologist Dr. Stephen Loughead for her depression. In August 2001, after several months of treatment, Dr. Loughead rated her GAF at 50. (Pet. Exh 6). In October 2001, she underwent a psychiatric assessment, which confirmed her prior diagnosis of major depression. Dr. Alo noted in November 2001 that Claimant was taking the following

medications: Ultram, Darvocet, Soma, Celexa, Celebrex, and Neurotin. Additionally, the psychiatrist had prescribed Ambien and Prozac for her psychiatric condition.

By November 2001, Dr. Alo believed Claimant needed a CPM program. He apparently referred her to Petitioner for an evaluation because in December 2001, Petitioner's employee Ron Ziegler, Ph.D., performed a psychological evaluation on Claimant to assess her psychological suitability for participation in Petitioner's CPM program. At that time, Dr. Ziegler diagnosed Claimant with "typical depression, moderate difficulties producing lifestyle disruption and psychological difficulties, and rated her GAF as 55. (Pet. Exh. 6). Despite her prior therapies, Claimant continued to suffer from pain in her leg and back that she describes as ''sharp, pulling, tender, tight, and continuous.'' Her pain interferes with her ability to lift, perform household chores, or take care of her personal hygiene. (Pet. Exh. 6).

D. Petitioner's Position

Dr. Ziegler found Claimant would benefit from the CPM program due to her: poor coping skills for pain; complaints of chronic pain; failure of conservative care (injections, physical therapy, medication, and individual counseling) to reduce her pain significantly; and her adoption of an invalid lifestyle based on helplessness. Dr. Ziegler felt individual treatments would not be effective in the face of Claimant's poor coping skills and negative attitudes. He noted:

> Upon completion of such a program, we can expect her subjective pain complaints to be significantly minimized. We would also expect to see a significant improvement in her coping skills and her negative emotionality. She is endorsing symptoms of depression, anxiety and a sleep disturbance, all of which are secondary to her on-the-job injury. One of the dangers at the present time is that she is at significant risk for further developing her excessive sense of disablement. She may be beyond normal tissue healing time. We would expect to see her belief system shift from being dependent and helpless to being independent and autonomous. (Pet. Exh. 6)

Drs. Ziegler and Alo described, in a letter dated January 8, 2001,[1] the components of the requested twenty-day CPM program, which included a daily regime of four hours of physical

[1] The date appears to be in error. Based on other correspondence, it is assumed this letter was sent in

rehabilitation, two hours of individual psychotherapy, one or two hours of educational group therapy, medication management, and several sessions a week of EMG biofeedback training. The letter outlined specific goals for each therapy along with the expected outcomes. (Pet. Exh. 6).

In a letter dated January 31, 2002, regarding Respondent's denial of preauthorization, Dr. Ziegler noted Claimant was then taking Lipitor, Celexa, Ultram, and Darvocet. (Pet. Exh.6).

E. Respondent's Position

Respondent relied on the IRO decision and the opinions of its medical utilization reviewers to assert that a CPM is not medically necessary health care for Claimant. Respondent's experts did not examine Claimant in person, but reviewed various medical records to form their opinions. One of Respondent's experts mentioned the ''guidelines'' in his written assessment in 2002, indicating he also continues to rely on the repealed MFG criteria.

In 1999, Respondent's expert Dr. Zvi Kalisky, M.D., after reviewing Claimant's medical records, wrote:

> This patient has been having lower back pain since a fall injury on_____. She has exhibited highly significant subjective symptoms and claim of disability. However, her MRI has shown minimal disk bulging with no disk herniation or root compression. The patient has admitted being depressed and apparently expressed suicidal ideation. She has been taking large amounts of various medications. . . . There is no identifiable organic lesion in the lumbar spine which could explain this patient's pain and which could be affected by the proposed [epidural steroid] injections. (Resp. Exh. 3).

In April 2002, psychiatrist Dr. Edwin Johnstone gave his opinion that Claimant ''is the worst kind of candidate'' for a CPM program based on a review Dr. Ziegler's December 2001 assessment and letter of appeal. (Res. Exh. 2). In April 2002, Dr. Johnstone wrote:

> At you request I have reviewed the voluminous medical records on this patient with consideration of her treating psychologist's recent request for approval of even more

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January 2002 in support of the preauthorization request.

> psychotherapy sessions despite a clear lack of benefit from a very extended period of treatment in the hands of a presumably highly expert therapist working within the framework of a multi disciplinary team of presumably skilled professionals employing the best diagnostic testing, invasive procedures, analgesic regimens, antispasmodic medication, anti-inflammatories, psychotropics, biofeedback training, and prescribed conditioning exercises. The patient is long past MMI and has had treatment well beyond the guidelines. Her treating psychologist continues to declare that she is continuing to make progress, but she is now out of work and expressing expanding complaints. It is not reasonable to persist with efforts that are yielding diminishing and possibly deleterious results. . . .I recommend that [Claimant] receive . . . no more ''pain management'' from Dr. Alo. This patient may never be a good responder to any treatment, but her medication regime should be revised considerably in one last try for a good response. (Res. Exh. 2).

In June 2002, Dr. Johnstone gave a more detailed explanation when he restated his opinion that Claimant did not need further treatment. He wrote:

> Despite Dr. Loughead's claim [in March 2001] that the patient is better able to manage the pain and depression, these are contradictory indications that she is experiencing continuation or worsening of her mood state as well as continuing weight gain and that she is experiencing continuation or worsening of the pain rather than a reduction of the pain. . . .There are no indications that despite the attempts to train the patient to modify physiologic functions that that [biofeedback] has had any result in improving her clinical status. . . .there is no indication whatsoever that these activities are therapeutic [psychotherapy, biofeedback] in the sense that they are benefitting the patient.

F. CPM Criteria

Although Petitioner's requested preauthorization for the CPM in January 2002, just days after the repeal of the Commission's 1996 Medical Fee Guideline (MFG), the MFG's criteria for admission to a chronic pain management program is relevant to this proceeding because it was still in effect when Petitioner assessed Claimant's suitability for the program. The Commission's former Mental Health Guideline (MHG), also in effect when Claimant's assessment occurred, contained specific referral criteria for CPM program. See 28 TAC § 134.1000(i)(3)(B) (West 2002)(repealed by statute effective January 1, 2002); (Res. Exh. 1). Because both Petitioner's and Respondent's experts used the criteria to assess Claimant's suitability, the ALJ found the Commission's former MFG and MHG criteria relevant to this case.

Under the 1996 MFG, chronic pain syndrome was defined as ''any set of verbal or nonverbal behaviors that involves the complaint of enduring pain; differs significantly from the injured workers' premorbid status; has not responded to previous appropriate medical, surgical, and/or injection treatments; and interferes with the injured worker's physical, psychological, social, and/or vocational functioning.'' The MFG required the admission criteria for a CPM program allow participation by persons who have chronic pain syndrome who are likely to benefit from the program and who are not prohibited from participation by medical, psychological, or other conditions. The MHG looked at the patient's GAF (under 90 with any psycho-social stressor); failure to respond to outpatient physical therapy or mental health treatment; pain behavior that disrupts daily living activities; threat of significant and permanent loss of functioning requiring major readjustments; pain well beyond expected healing tissue time; and risk of development of an excessively disabled lifestyle including inability to work.

Based on the overwhelming medical evidence Petitioner provided, Claimant met all the MFG and MHG criteria for admission into Petitioner's CPM program. She had been consistently diagnosed with a GAF under 55. She had demonstrated a chronic inability to manage her back pain, poor coping skills, and led an invalid lifestyle that left her unable to hold a job. Her reported pain levels far exceeded those expected from her corresponding physical malady. She was not a candidate for surgery and individual psychological counseling, biofeedback, and narcotic pain management had all failed to relieve her pain significantly.

> Petitioner showed that Claimant met the criteria under the former MFG and MHG for admission to a CPM program. Even if no longer the Commission's official guidelines, the MFG/MHG criteria used common-sense factors to assess a patient's need and suitability for a chronic pain management program and can be used to assess Claimant's needs in this case. The ALJ found the former MFG/MHG criteria reasonable and helpful in determining Claimant's suitability for the CPM program. The question remained whether the IRO used some other criteria that was more reasonable or helpful than the MFG/MHG criteria and which superseded that criteria.. Because the IRO did provide a record of the information used by its reviewer and because the IRO decision failed to state what criteria it used to determine the CPM program was not medically necessary healthcare for Claimant, the ALJ had no reason to believe the IRO decision was based on a criteria that was more reasonable, helpful, or valid that the criteria used by Petitioner to determine Claimant's suitability for the program.

G. Analysis

The fact that the Commission repealed its MFG and MHG did not change the nature or purpose of CPMs or make the criteria described therein less useful for deciding the suitability of such a program for a particular patient. The repeal simply ended the mandatory use of those guidelines. In this case both Petitioner and Respondent's experts used the guidelines to some extent to form their opinions. Because they were both helpful and the basis of the parties' analysis, the MFG and MHG were used by the ALJ as well.

Based on the definitions and criteria found in the Commission's former MFG and MHG, it is apparent that CPM programs are intended for patients whose pain is chronic, debilitating (at least in the sense that it restricts the patient from engaging in normal levels of activities of daily living), not responsive to traditional medical interventions, and without a corresponding physical pathology. It is, as Petitioner pointed out in argument, an multi disciplinary intervention intended to be used after other approaches have failed.

In this case, Claimant is a candidate for a CPM program. Dr. Cartwright and Respondent's expert Dr. Kalisky recognized she did not have a physical pathology that would be expected to cause such extreme physical and psychological pain as reported by Claimant. When administered separately to Claimant, facet injections, narcotic and psychotropic drugs, psychotherapy, and biofeedback have provided some, but not enough, relief. In critiquing her treatments as failing to elicit an adequate response, Dr. Johnstone helped prove Petitioner's point that a piecemeal approach to Claimant's problem has not worked. Even Dr. Johnstone recognized the danger of leaving Claimant with no other treatment than continue use of multiple narcotic and psychotropic drugs.

A CPM program is essentially a last step to dealing with chronic pain that has not been treated successfully. It is intended to bring together in an intense program many types of interventions in the hopes that a concentrated effort to reeducate the patient will result in the

acquisition of skills needed to manage chronic pain to the extent necessary to engage in normal activities of daily living. The intensity of the application of interventions distinguishes it from other types of therapy. The fact that therapies used jointly in a CPM program did, when administered independently, provide complete relief does not by itself mean a CPM program is not medically necessary.

The CPM program appears to be the last attempt to give Claimant the coping skills needed to return to work. Without it, there is little hope she will overcome her learned helplessness and invalid lifestyle and it is likely will remain drug dependent. Based on the record developed in this case, the IRO decision was not supported by the great weight of the evidence. The IRO reviewer failed to state what medical information was reviewed or what criteria was used to come to the stated conclusion. In stating that failure to previously have achieved ''significant benefit'' from ''major components'' of a CPM program, the IRO reviewer missed the point of a CPM program. Prior failure of multiple interventions is a requirement, not a disqualification, for admission to a CPM program.

Claimant suffers from chronic, debilitating pain that has not responded to multiple types of interventions. Petitioner met its burden to show that a CPM program is medically necessary healthcare for Claimant.

III. FINDINGS OF FACT

1. In_____, Claimant fell and sustained an injury to her lower back while working as a ___ in Respondent's school. Her injuries were compensable under the Texas Workers' Compensation Act (Act).

2. At the time of the compensable injury, Respondent, as a self-insurer, was responsible for Claimant's workers' compensation insurance coverage.

3. In January 2002, Claimant's treating doctor, Thomas Cartwrigt, M.D., referred her to Positive Pain Management's (Petitioner) chronic pain management (CPM) program.
4. Respondent denied Petitioner's request to preauthorize Claimant's participation in the CPM program.

5. After Respondent denied preauthorization as medically unnecessary, Petitioner requested medical dispute resolution from the Commission. Pursuant to 28 TEX. ADMIN. CODE (TAC) § 133.308, an IRO selected by the Commission rendered a decision on the medical review dispute.

6. The IRO upheld Respondent's denial of preauthorization, stating: ''It is determined that the 20 day pain management functional/restoration program is not medically necessary to treat this patient's condition. This patient has had physical and behavioral aspects of treatment and those are major components of the 20 day restoration/functional program. Since there has been no significant improvement with the major components of the 20 day program, there is likely to be little gained from the program.''

7. Petitioner timely appealed the IRO decision.

8. Pursuant to a notice of hearing sent by Commission staff, Petitioner and Respondent appeared and were represented at the hearing held in this matter on August 7, 2002.

9. Claimant suffers from chronic low back pain which has no corresponding spinal pathology that would explain the level of pain she reports.

10. Due to her back pain, Claimant cannot work.

11. Claimant suffers from major depression related to her chronic back pain and has developed an invalid lifestyle due to her feelings of helplessness. Her GAF at the time of Petitioner's request was 50.

12. Claimant has undergone epidural steroid injections, physical therapy, massage therapy, psychological counseling, biofeedback training, and taken narcotics and psychotropic drugs. While some of these interventions have provided some relief, none of them has be able to provide adequate, long-term pain relief.

13. Claimant is not a candidate for surgery.

14. CPM programs are intended for patients whose pain is chronic, debilitating (at least in the sense that it restricts the patient from engaging in normal levels of activities of daily living), not responsive to traditional medical interventions, and without a corresponding physical pathology.

15. A CPM program is an intense program that uses of many types of interventions to reeducate the patient and permit the acquisition of skills needed to manage chronic pain to the extent necessary to engage in normal activities of daily living.

16. A CPM program is distinguished from other types of programs in the intensity of the application of interventions, not in the types of therapy used.

17. The fact that therapies that are used jointly in a CPM program have not provided complete relief when administered in a less intense fashion is not by itself a disqualification for a CPM program.

18. Claimant is a candidate for a CPM program.

19. Petitioner's CPM program is a twenty-day program, which includes a daily regime of four hours of physical rehabilitation, two hours of individual psychotherapy, one or two hours of educational group therapy, medication management, and several sessions a week of EMG biofeedback training.

20. If Claimant successfully completes Petitioner's CPM program, it is expected that she will gain coping skills which will allow her to manage her pain so she can engage in activities of daily living and enhance her ability to obtain employment.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (Act), TEX. LABOR CODE ANN. §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX.ADMIN.CODE (TAC) § 133.305(g).

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Petitioner had the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i).

6. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

7. Health care includes all reasonable and necessary medical services, including a medical appliance or supply. TEX. LAB. CODE ANN. §401.011(19)(A). A medical benefit is a

payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

8. The IRO decision in this matter has presumptive weight. 28 TAC §133.308(v).

9. For a carrier to be liable for reimbursement, it must preauthorize a claimant's participation in a chronic pain management program. 28 TAC § 134.600(h).

10. Petitioner met its burden of proof to show that a chronic pain management program is reasonable and medically necessary healthcare for Claimant.

11. Petitioner's request for preauthorization for Claimant to participate in its twenty-day chronic pain management program should be preauthorized.

ORDER

It is ORDERED that Positive Pain Management's request for preauthorization of a twenty-day chronic pain management program for Claimant is granted.

SIGNED this 24th day of September, 2002.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS