MEDICAL CONTESTED CASE HEARING NO. 08026
M6-07-9571-01

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.

ISSUE

A benefit contested case hearing was held on December 6, 2007, to decide the following disputed issue:

> Whether the preponderance of the evidence is contrary to the decision of the Independent Review Organization (IR0) that office visits once each quarter for the next year and current medications for the next year are not reasonable and necessary health care services for the compensable injury of ___?

PERSONS PRESENT

Claimant appeared and was represented by an (Attorney). Carrier appeared and was represented by an (Attorney).

BACKGROUND INFORMATION

On ___, Claimant sustained a compensable injury when she fell down a flight of stairs. Claimant sustained two fractures in her left hand/wrist, one fracture in her right hand/wrist, an injury to the left shoulder, bilateral elbows and cervical spine. Claimant has undergone surgeries to both wrists and her left shoulder and she has been subsequently diagnosed with bilateral cubital tunnel syndrome, carpal tunnel syndrome and depression secondary to the compensable injury. The Claimant's treating doctor, Dr. B, prescribed the following medications to treat the Claimant's compensable injuries: Aricept, Namenda, Zoloft, Lidoderm, Provigil, Celebrex, Robaxin, Darvocet, and Ambien. The Claimant's treating doctor has recommended continued use of the prescriptions and quarterly office visits.

The IRO concluded that the office visits each quarter for the next year were medically reasonable and appropriate if these office visits were for evaluation, assessment and treatment for the Claimant's cognitive deficits. The Claimant's treating doctor testified that the office visits were not only necessary for assessing the Claimant's need for prescriptions but also for evaluation of her mental health and on-going symptoms resulting from the compensable injury. The IRO reviewer also stated that further care and evaluation with regard to the Claimant's wrist, neck and other multiple musculoskeletal complaints did not seem to be reasonable and appropriate as this injury was incurred seven years ago. The IRO reviewer went on the state that the Claimant incurred sprains and strains of multiple musculoskeletal systems and sustained a left wrist fracture which most certainly should be "maximally medically improved" at this period of time. He/she noted that there were no clear cut neurologic deficits based upon the documentation. Dr. B explained why the office visits were necessary and the medical records in evidence document that the Claimant suffers from

neurologic deficits in the upper extremities. It is difficult to determine what medical records the IRO reviewer based his/her assessment and extent of the compensable injury on, but the Claimant does suffer from residual pain, deformities and neurological deficits from the compensable injury and the surgeries, as well as, a significant psychological component. The necessity for future office visits hinges solely on whether the evidence based medicine supports the Claimant's continued use of narcotics.

The IRO reviewer was also asked to address the necessity of the Claimant's nine prescriptions. The IRO reviewer stated that the use of Darvocet and Robaxin were not medically necessary or appropriate because chronic pain medicine is not appropriate unless administered by a pain specialist. The ODG state the following actions to be considered when prescribing opioids:

> **On-Going Management**. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. *The 4 A's for Ongoing Monitoring*: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy [sic] that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

The ODG goes on to consider opioids for chronic pain and state: "Chronic back pain: Appear to be efficacious for short-term pain relief, but long-term efficacy is unclear (>16 weeks). In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36%

to 56% (but the author warns that these statistics are limited by poor study design and publication bias)." (Martell-*Annals*, 2007)

Dr. B testified, in detail, as to his credentials in dispensing narcotics and his plan for treatment regarding the use of narcotics. Dr. B testified that he has been treating the Claimant for some time with these types of narcotics and that the Claimant showed no signs of addiction or abuse which is one of the concerns to consider in the ODG for chronic pain management and was also noted as a potential problem by the IRO reviewer. It appears from the evidence that Dr. B has followed the criteria in the ODG and is monitoring the Claimant's progress and side-effects effectively and appropriately. The ODG also gives criteria to consider when assessing long-term use of opioids which were addressed by Dr. B and suggest continued office visits with the prescribing physician every one to six months.

The IRO reviewer stated that Ambien certainly might be reasonable for insomnia but to be treated chronically for this is inappropriate. The reviewer did not explain why the continued use of Ambien would be inappropriate, however, Dr. B testified that the Claimant's chronic pain causes insomnia and the Ambien could be used "off label" for extended periods of time on an as needed basis. The reviewer noted that Lidoderm patches were much the same and that chronic treatment with this is not necessary and appropriate for these diagnoses and the length of time in which has past. Again, that is assuming that the reviewer's assessment of the compensable injury involves only sprains and strains of multiple musculoskeletal systems and a left wrist fracture.

Regarding the Claimant's psychological condition, the reviewer determined that Zoloft, Aricept and Provigil might be reasonable; however, there was no medical merit for such medicines on a long term basis in this instance. There was no further explanation as to why treatment for the Claimant's depression was unreasonable or unnecessary since she obviously still suffers from the psychological afflictions as a result of the compensable injury. It should be noted that Dr. B testified that the Aricept and Namenda were for treatment of a head injury (brain function/memory loss) and the parties agreed that any injury to the head was not part of the compensable injury. The IRO reviewer did not comment on the use of Namenda or Celebrex.

The IRO reviewer considered the ODG when making his/her recommendation regarding the Claimant's treatment. Dr. B testified that he also considered the ODG regarding prolonged use of prescription drugs. Dr. B testified that the Claimant's conditions were adequately controlled by the prescriptions, the Claimant did not exhibit signs of addiction or abuse nor did she have difficulty with drug interactions. Dr. B testified that the Claimant's advanced age (72) also impedes her ability to alleviate her symptoms and contributes to her depression which is not considered in the ODG. Dr. B also testified that the ODG considers an age base between 18 to 65 and that symptoms in older patients do not improve as quickly. Dr. B also testified that he based his opinions considering the ODG and evidence based literature. The greater weight of the evidence based medicine is contrary to the decision of the IRO that the quarterly office visits and prescriptions for Zoloft, Lidoderm, Provigil, Celebrex, Robaxin, Darvocet and Ambien were not reasonable and appropriate health care services for the compensable injury of ___. The prescriptions for Aricept and Namenda are not reasonable and necessary prescriptions 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) when she sustained a compensable injury.

2. The true corporate name of the insurance carrier is Church Mutual 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.

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

4. The preponderance of the evidence is contrary to the decision of IR0 that office visits once each quarter for the next year and current medications (with the exception of Aricept and Namenda) for the next year are not reasonable and necessary health care services 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 was proper in the (City) Field Office.

3. Office visits once each quarter for the next year and current medications (with the exception of Aricept and Namenda) for the next year are reasonable and necessary health care services for the compensable injury of ___.

DECISION

Office visits once each quarter for the next year and current medications (with the exception of Aricept and Namenda) for the next year are reasonable and necessary health care services for the compensable injury of ___.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act and the Commissioner's Rules.

Signed this 6th day of December, 2007.

Carol A. Fougerat
Hearing Officer