MEDICAL CONTESTED CASE HEARING NO. 14073

## 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 has proven that the preponderance of evidence is contrary to the Independent Review Organization (IRO) opinion that Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit are not health care reasonably required for the compensable injury of (Date of Injury).

## STATEMENT OF THE CASE

A prehearing for this medical contested case hearing was held on April 24, 2014. No agreement was reached and on June 16, 2014, Phillip Brown, a Division hearing officer, held a medical contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit for the compensable injury of (Date of Injury)?

## PARTIES PRESENT

Claimant appeared and was assisted by DM, ombudsman. Carrier was represented by PP, attorney. The Employer was represented by SB, lay person.

## EVIDENCE PRESENTED

The following witnesses testified:

For the Claimant: Claimant and Dr. AJ, Jr.

For the Carrier: None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits: HO-1 through HO-4

Claimant's Exhibits; C-1 though C-2

Carrier's Exhibits: CR-A through CR-E

## DISCUSSION

Claimant is 52 years old and sustained a compensable injury to her low back on (Date of Injury). She currently suffers from arthritis, back problems, restricted motion, joint pain, muscle stiffness and weakness, tingling and numbness, and left upper extremity complex regional pain syndrome (CRPS). Her left arm has become deformed as a result of contractures caused by CRPS and she has difficulty walking without falling. She suffers debilitating pain which significantly disrupts activities of daily living. She has tried everything from a failed spinal cord stimulator, failed intrathecal pump, over 50 injections, and various types of medications in an effort to control her pain and restore physical functioning. Claimant has been treated with Oxycontin for over 10 years, and the Oxycontin 20 mg #90 and Oxycontin 40 mg #90 provide her enough relief to have some level of functioning. She presented credible testimony that, without the medication, Claimant will not get up to go to the restroom, or groom or feed herself. Claimant's treating doctor, AJM, Jr., testified. He has been treating Claimant for over 10 years. He described the purpose for the medications at issue in this hearing and the positive results Claimant has received from this treatment.

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, 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."

Opioids for back pain

See Opioids for chronic pain.

Opioids for chronic pain

Recommendations for general conditions:

- Neuropathic pain: Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. See Opioids for neuropathic pain.

- Chronic back pain: Appears to be efficacious but limited for short-term pain relief. Long-term efficacy is unclear (>16 weeks), and there is also limited evidence for the use of opioids for chronic low back pain. (Martell-*Annals*, 2007) Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-*Annals*, 2007) (Chou, 2007) There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. (Deshpande, 2007)

- Headaches: not recommended, in particular, due to the risk of medication overuse headache. (Lake, 2008) (Olesen, 2006) See Medication overuse headache.

- Osteoarthritis: Not recommended as a first-line therapy. Recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Under study for long-term use as there is a lack of evidence to allow for a treatment recommendation. If used on a long-term basis, the criteria for use of opioids should be followed. See Opioids for osteoarthritis for citations.

- Nociceptive pain: Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury, with the most common example being pain secondary to cancer).

- Mechanical and compressive etiologies: rarely beneficial.

Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (≤70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-*Annals*, 2007) Current studies suggest that the “upper limit of normal” for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. (Ballantyne, 2006) (AMDG, 2007)

There are several proposed guidelines for the use of opioids for chronic non-malignant pain, but these have not been evaluated in clinical practice, and selection of the patient that will best respond to this treatment modality remains difficult. (Nicholas, 2006) (Stein, 2000) One of the most recent of these guidelines is the Agency Medical Director’s Group (AMDG) Guidelines from Washington State. This guideline includes an opioid dosing calculator. (AMDG, 2007)

Outcomes measures: It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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. (Nicholas, 2006) (Ballantyne, 2006) A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. (Eriksen, 2006)

Tolerance and addiction: Opioid tolerance develops with the repeated use of opioids and brings about the need to increase the dose and may lead to sensitization. It is now clear that analgesia may not occur with open-ended escalation of opioids. It has also become apparent that analgesia is not always sustained over time, and that pain may be improved with weaning of opioids. (Ballantyne, 2006) (Ballantyne, 2003) See Substance abuse (tolerance, dependence, addiction).

Behavior reinforcement: A major concern in the use of opioids has been that a focus on this treatment without coordination with other modalities, such as psychosocial or behavioral therapy, may simply reinforce pain-related behavior, ultimately undermining rehabilitation that has been targeted at functional restoration. (Ontario, 2000) It has been shown that pain behavior can be reinforced by the prescribing of opioids, generally on an unintentional basis by the patient. (Fordyce, 1991)

Overall treatment suggestions: Current guidelines suggest the following:

- A trial of opioids as a first step in treatment, and the steps involved are outlined in the Criteria for Use of Opioids. The trial includes an initiation phase that involves selection of the opioid and initial dose. (VA/DoD, 2003)

- There is then a titration phase that includes dose adjustment. At this phase it may be determined that opioids are not achieving the desired outcomes, and they should be discontinued.

- The final stage is the maintenance phase. If pain worsens during this phase the differential to evaluate includes disease progression, increased activity, and/or new or increased pre-existing psychosocial factors that influence pain. In addition, the patient may develop hyperalgesia, tolerance, dependence or actual addiction.

(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) See Substance abuse (tolerance, dependence, addiction). See also Implantable pumps for narcotics. See also Opioids in the Low Back Chapter. See Criteria for Use of Opioids

The Opioids in the Low Back Chapter provides as follows:

Opioids

Not generally recommended except for short use for severe cases, not to exceed 2 weeks. See the Pain Chapter for more information and studies. When used only

for a time-limited course, opioid analgesics are an option in the management of patients with acute low back problems. The decision to use opioids should be guided by consideration of their potential complications relative to other options. Patients should be warned about potential physical dependence and the danger associated with the use of opioids while operating heavy equipment or driving. The studies found that patients taking opioid analgesics did not return to full activity sooner than patients taking NSAIDs or acetaminophen. In addition, studies found no difference in pain relief between NSAIDs and opioids. Finally, side effects of opioid analgesics were found to be substantial, including the risk for physical dependence. These side effects are an important concern in conditions that can become chronic, such as low back problems. (Bigos, 1999) Recent studies document a 423% increase in expenditures for opioids for back pain, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) With opioid therapy for nonspecific low back pain compared with no opioids, the odds of chronic work loss were six times greater for claimants with schedule II ("strong") opioids; were 11-14 times greater for claimants with opioid prescriptions of any type during a period of >or=90 days; and 3 years after injury, costs of claimants with schedule II opioids averaged $19,453 higher than costs of claimants in the no opioids group. (Volinn, 2009) For more information, and Criteria for Use of Opioids, see the Pain Chapter.

Opioids, long-term assessment

CRITERIA FOR USE OF OPIOIDS

Long-term Users of Opioids (6-months or more)

(1) Re-assess
   (a) Has the diagnosis changed?
   (b) What other medications is the patient taking? Are they effective, producing side effects?
   (c) What treatments have been attempted since the use of opioids? Have they been effective? For how long?
   (d) Document pain and functional improvement and compare to baseline. 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. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument.
   (e) Document adverse effects: constipation, nausea, vomiting, headache, dyspepsia, pruritis, dizziness, fatigue, dry mouth, sweating, hyperalgesia, sexual dysfunction, and sedation.

(f) Does the patient appear to need a psychological consultation? Issues to examine would include motivation, attitude about pain/work, return-to-work, social life including interpersonal and work-related relationships.

(g) Is there indication for a screening instrument for abuse/addiction. See Substance Abuse Screening.

(2) Strategy for maintenance

(a) Do not attempt to lower the dose if it is working

(b) Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication.

(c) The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain (Wisconsin)

(3) Visit Frequency

(a) There is no set visit frequency. This should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months.

(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)

On February 13, 2014, a family medicine doctor serving as IRO reviewer in this case determined that Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit treatment are not health care reasonably required for the compensable injury. The reviewer felt that the clinical records he reviewed did not document toxicology results or long term opioid risk assessments, notwithstanding the presence of such evidence in the documents, as explained by Dr. M who had treated Claimant for over 10 years. The reviewer also opined that there was a normal physical examination on January 8, 2014, except for diminished sensation to light touch pin prick and position. The records, however, reflect a more complete description of the nature and extent of the neuropathic findings, as well as a specific reference to musculoskeletal lumbar pain radiating down to the legs (C-2, pp. 23-24). Additionally, the reviewer failed to note that there was sufficient documentation of a condition severe enough to justify ongoing use of the medication prescribed in this case. The reviewer also failed to note the repeated references in the records where pain coping skills had been identified and addressed (C-2, p. 26) and how weaning had been attempted (C-2, pp. 32, 41). The reviewer concluded that there was no specific overall functional improvement or pain reduction with the use of oxycontin to date shown in the records, while indicating that the patient continued to report good pain relief with the use of the medication. At the hearing, Dr. M testified by telephone in support of the continued use of

oxycontin in Claimant's case. He testified that the forms he has the Claimant fill out at each visit document the efficacy of the medications and functional improvement. He also testified about his attempts to have Claimant admitted into a program that might succeed in weaning Claimant off the medication. As regards the limited amount of documentation available for review by the examiner, Dr. M testified that he did not send all of the documentation because he was not being paid to do so. There were other incorrect statements in the documents relied on to support the IRO reviewer's decision to deny the requested treatment. The morbidities listed are incorrect insofar as the patient's prior medical history was concerned. Claimant did not have diabetic neuropathy (CR-C, p. 4), which, according to Dr. M's explanation, was a coding error that has since been corrected. Further, the amount of oxycontin being taken daily was listed as 270 mg per day (CR-C, p. 7), when, in fact, it was only 180, which was the dose required to be effective, according to the credible evidence from Dr. M, who had conferred with a pain management specialist. Notwithstanding an apparent bias toward insurance carriers and the Division insofar as an injured worker's access to healthcare is concerned, Dr. M did provide a credible basis for his opinion on necessity for the prescribed treatment that has a foundation in evidence-based medicine. He acknowledged the ODG requirements for the use of opioids in a patient such as Claimant and explained why Claimant's case falls outside the "guidelines". Based on the overall evidence, I find that Claimant met her burden to show that the preponderance of evidence is contrary to the IRO opinion that Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit are not health care reasonably required for the compensable injury of (Date of 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 the evidence whether or not the evidence is specifically discussed in this Decision and Order.

## 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 through Safeguard Insurance Company, Carrier.

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

   E. The Independent Review Organization determined that Claimant should not have Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit.

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 Hearing Officer's Exhibit Number 2.

3. The preponderance of evidence is contrary to the IRO opinion that Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit are not 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 Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit are not health care reasonably required for the compensable injury of (Date of Injury).

## DECISION

Claimant is entitled to treatment in the form of Oxycontin 40 mg #90, Oxycontin 20 mg #90, and an office visit for the compensable injury of (Date of Injury).

## ORDER

Carrier is liable for the benefits at issue in this hearing. Claimant also remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **SAFEGUARD 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, TX 78701-3232**

Signed this 30th day of June, 2014.

Phillip Brown
Hearing Officer