MEDICAL CONTESTED CASE HEARING NO. 09192
M6-09-19118-01 & M6-09-20316-01

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.

ISSUES

A contested case hearing was held on June 12, 2009 to decide the following disputed issues:
In Case Number (Docket No. 1):

1. Is the preponderance of the evidence contrary to the decision of the IRO dated April 7, 2009 that the claimant is entitled to treatment in the form of oxycontin medication 40 mg 2 tabs bid for the compensable injury of _____.

Carrier is Petitioner in this case and Claimant is Respondent.

In Case Number (Docket No. 2):

1. Is the preponderance of the evidence contrary to the decision of the IRO dated June 9, 2009 that the claimant is not entitled to treatment in the form of oxycontin medication 40 mg 2 tabs bid for the compensable injury of _____.

Claimant is Petitioner in this case and Carrier is Respondent.

PARTIES PRESENT

Claimant appeared and was assisted by MP, Ombudsman. Carrier appeared and was represented by JC, attorney.

BACKGROUND INFORMATION

Claimant is a 51-year-old former truck driver who sustained low back and neck injuries on _____ while unloading a waste bin. The cable to the bin snapped causing the cab of the truck to violently bounce up and down, causing injury to Claimant. Claimant underwent surgery for laminectomy and discectomy at L5-S1 on July 9, 1992. When Claimant's symptoms increased, he underwent two surgeries for 360 degree spinal fusion on September 22, 1993, and September 27, 1993. This increased symptoms also, and Claimant underwent additional surgery for hardware removal on January 16, 1996, which caused yet another increase in symptoms. Claimant is diagnosed as having failed back syndrome with chronic pain. Claimant was hospitalized for opioid detoxification in March, 2005 and participated in a chronic pain management program in May, 2005 after which he was maintained on Loritab for pain. However, subsequent pain management physicians prescribed Oxycontin for better control of pain, and his treating physician for the last year, Dr. M, contends that Claimant continues to need this medication, resulting in the prescriptions which are contested in this case. Claimant had an

EMG/NCV on October 17, 2008 which was negative for radiculopathy, and an MRI on October 20, 2008 which showed a degenerative disc at L1-2 without impingement, and the L5-S1 surgical changes with granulation tissue. Claimant has not returned to work since the accident and no further surgery is proposed.

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.

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.

> Opioids for back pain
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> See Opioids for chronic pain.
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> Opioids for chronic pain
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> Recommendations for general conditions:
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> - 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 a 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

Low Back Chapter:

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 April 7, 2009, a physical medicine specialist serving as IRO reviewer in this case determined that continued oxycontin medication is justified in this case stating: "The use of a long acting opiate medication is appropriate for a claimant with chronic pain syndrome, as there is nothing to offer this claimant other than medical management with the use of medication. The claimant has not shown aberrant behavior with the use of this medication and is properly monitored by one provider". On June 9, 2009, another physical medicine specialist reviewed a subsequent prescription for the same dosage of oxycontin, and determined that continued use of oxycontin is not medically necessary. The ODG criteria for continuation of chronic long term medical management with opioids was cited as requiring evidence of functional improvement. The reviewer stated that no evidence was presented in the medical record that shows that the medication is making Claimant more functional than he would be without the medication. At the hearing, Dr. M testified by telephone in support of the continued use of oxycontin in Claimant's case. He contended that the forms he has the Claimant fill out at each visit document the efficacy of the medications and functional improvement. Carrier required medical examiner Dr. Dr. MC testified by telephone that the forms on which Claimant reported his response to medication only show a one or two degree of pain relief on a scale of 10, while he contended that at least a 50% degree of relief would be needed to be a significant response. Claimant contended at the hearing that he did not understand the pain scale, and that he actually did have 50% relief of pain with use of oxycontin. There was no documentation in the medical records of a measurement of baseline function or objective evidence noted of functional improvement with use of oxycontin. Claimant attempted to supply this evidence by his oral testimony at the hearing that he was able to get around much better while on the medication, and attend to some tasks around his home and yard which he was unable to do without the medication. The requirements of the ODG relating to response to the medication and functional improvement documented in the medical records were not met in this case.

In the first case, Carrier met its burden of proof by showing that evidence based medical evidence does not support the decision of the IRO. Claimant did not meet his burden in the second case to show that the preponderance of evidence based medical evidence was contrary to the IRO decision.

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).

   C. Claimant sustained a compensable injury on _____.

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. In (Docket No. 1) the IRO determined on April 7, 2009 that Claimant is entitled to treatment in the form of oxycontin 40 mg. 2 tabs bid for treatment of the compensable injury of _____.

4. In (Docket No. 2) the IRO determined on June 9, 2009 that Claimant is not entitled to treatment in the form of oxycontin medication 40 mg. 2 tabs bid for treatment of the compensable injury of _____.

5. Medical records fail to document significant pain relief or improvement in function as a result of use of oxycontin medication as required by the ODG.

6. Continued treatment in the form of oxycontin medication 40 mg. 2 tabs bid is not health care reasonably required 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 is proper in the (City) Field Office.

In Case Number (Docket No. 1)

   3. The preponderance of the evidence is contrary to the decision of the IRO dated April 7, 2009 that the Claimant is entitled to treatment in the form of oxycontin medication 40 mg. 2 tabs bid for treatment of the compensable injury of _____.

In Case Number (Docket No. 2):

   4. The preponderance of the evidence is not contrary to the decision of the IRO dated June 9, 2009 that Claimant is not entitled to treatment in the form of oxycontin

medication 40 mg. 2 tabs bid for treatment of the compensable injury of _____.

DECISION

In Case Numbers (Docket No. 1) and (Docket No. 2):

Claimant is not entitled to treatment in the form of oxycontin medication 40 mg 2 tabs bid for the compensable injury of _____.

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 **TRANSPORTATION INSURANCE COMPANY** and the name and address of its registered agent for service of process is:

C T CORPORATION SYSTEM
350 N. ST. PAUL STREET
DALLAS, TEXAS 75201

Signed this 17th day of June, 2009.

Warren E. Hancock, Jr.
Hearing Officer