MEDICAL CONTESTED CASE HEARING NO. 18013

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. For the reasons discussed herein, the Administrative Law Judge (ALJ) determines that Claimant is not entitled to morphine 60 mg T.I.D.

ISSUES

A contested case hearing was held on April 17, 2018 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the claimant is not entitled to morphine 60 mg T.I.D.?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by SB, ombudsman. Respondent/Carrier appeared and was represented by GP, adjuster.

EVIDENCE PRESENTED

The following witnesses testified:

For Claimant: Claimant.

For Carrier: None.

The following exhibits were admitted into evidence:

ALJ's Exhibits ALJ-1 and ALJ-2.

Claimant's Exhibits C-1 through C-4.

Carrier's Exhibits CR-1 through CR-D.

BACKGROUND INFORMATION

Claimant contested the determination of the IRO doctor who determined that she was not entitled to Morphine 60 mg T.I.D. (three times a day, totaling 180mg per day). She relied on the medical records of Dr. WS, her treating doctor. Carrier argued that Claimant offered insufficient

evidence-based medical studies or an opinion based on those parameters to overcome the IRO decision, which is based on the Official Disability Guidelines (ODG).

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." The ODG addresses the necessity for Opioid use:

> CRITERIA FOR USE OF OPIOIDS
>
> Therapeutic Trial of Opioids
>
> 1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:
>
> (a) Are there reasonable alternatives to treatment, and have these been tried?

(b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?

(c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome? Specific questions about current use of alcohol, illegal drugs, other prescription drugs, and over-the counter drugs should be asked. Obtaining a history of personal and/or family substance abuse issues is important. See Substance abuse (tolerance, dependence, addiction). See Opioids, screening for risk of addiction. (*Webster, 2008*) (*Ballyantyne, 2007*)

(d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression, or a previous history of substance abuse). Patients may misuse opioids prescribed for pain to obtain relief from depressed feelings, anxiety, insomnia, or discomforting memories. There are better treatments for this type of pathology. (*Sullivan, 2006*) (*Sullivan, 2005*) (*Wilsey, 2008*) (*Savage, 2008*)

(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

2) Steps to Take Before a Therapeutic Trial of Opioids:

(a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.

(b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.

(c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.

(d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work

activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.

(e) Pain related assessment should include history of pain treatment and effect of pain and function.

(f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.

(g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. (*Sullivan, 2006*) (*Sullivan, 2005*) (*Wilsey, 2008*) (*Savage, 2008*) (*Ballyantyne, 2007*)

(h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

(i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See Guidelines for Pain Treatment Agreement. This should include the consequences of non-adherence.

(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs.

3) Initiating Therapy

(a) Intermittent pain: Start with a short-acting opioid trying one medication at a time.

(b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of “rescue” opioids. The need for extra opioid can be a guide to determine the sustained release dose required.

(c) Only change 1 drug at a time.

(d) Prophylactic treatment of constipation should be initiated.

(e) If partial analgesia is not obtained, opioids should be discontinued.

4) 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 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. (*Webster, 2008*)

(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. (*Sullivan, 2006*) (*Sullivan, 2005*) (*Wilsey, 2008*) (*Savage, 2008*) (*Ballyantyne, 2007*)

5) Recommended Frequency of Visits While in the Trial Phase (first 6 months):
   (a) Every 2 weeks for the first 2 to 4 months
   (b) Then at approximate 1 ½ to 2-month intervals

Note: According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. (California, 1994)

6) When to Discontinue Opioids: See Opioid hyperalgesia. Also see Weaning of Medications. Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.
   (a) If there is no overall improvement in function, unless there are extenuating circumstances
   (b) Continuing pain with the evidence of intolerable adverse effects; lack of significant benefit (persistent pain and lack of improved function despite high doses of opiates- e.g. > 120 mg/day morphine equivalents)
   (c) Decrease in functioning
   (d) Resolution of pain
   (e) If serious non-adherence is occurring
   (f) The patient requests discontinuing
   (g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.
   (h) Many physicians will allow one “slip” from a medication contract without immediate termination of opioids/controlled substances, with

the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.

(i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. (*Weaver, 2002*)

(j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

(k) Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficultly weaning. See Opioids for chronic pain.

7) When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain

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

Opioids, dosing

• Recommend that caution be exercised at a morphine equivalent dose (MED) of 50 mg or greater. This is particularly emphasized in patients who are taking sedative drugs that increase respiratory and central nervous depression such as benzodiazepines, muscle relaxants and/or sedative hypnotics. The FDA issued a black box warning in regard to the concomitant use of opioid analgesics, benzodiazepines, and other sedative hypnotics. (*FDA, 2016*)

• Recommend that dosing not exceed 100 mg MED (morphine equivalents dosage/day). If exceeded, justification of doses higher than this should be provided, including evidence that treatment goals are being met and that there are no signs of adverse effects.

When prescribing for acute conditions, the lowest effective dose should be given for the anticipated time duration of pain severe enough to require opioids. The recommended

> time ranges from 3 to 7 days, with exceptions noted in cases of severe trauma or post-surgery. The recommended formulation should be immediate-release and not extended release/long-acting. (*Dowell, 2016a*). See Opioids, Acute Pain. (emphasis added)

The IRO reviewer agreed with two utilization review doctors and opined that the requested treatment did not meet ODG criteria. Specifically, the IRO reviewer noted that 60 mg T.I.D. (meaning 180 mg a day) markedly exceeds the maximum dosage recommended by ODG, as the ODG recommends a maximum of 100mg per day. The reviewer indicated there was no information that indicates that function is improving with this high of dose. Both utilization review doctors supported the IRO's opinion. Both doctors indicated they obtained insufficient information to exceed the maximum dosage of morphine recommended by the ODG.

Dr. S provided a report disagreeing with what he perceived was poor behavior on behalf of the Carrier. He noted that Claimant is entitled to lifetime medical for her conditions, and believed that the preauthorization process provided by the Carrier was designed to circumvent the lifetime guarantee. He believed that Morphine 60 mg T.I.D. was necessary. Dr. S referenced reports of Required Medical Examination (RME) doctors, but those reports were not in evidence at the contested case hearing. There was reference to a prior IRO review, which also was not in evidence. Dr. S appears to be very supportive of the need for the medication at the dose he prescribed; however, there is insufficient medical evidence provided to show that a dose that exceeds the ODG recommendation is medically necessary in this case. Dr. S correctly identifies the portion of the ODG for continuing opioids, citing Claimant's functional improvement requirement. However, absent is a justification in the records admitted at the hearing for a dosage that exceeds the ODG recommended dosage.

Claimant was a very sympathetic witness regarding her continued symptoms related to the compensable injury. She testified that the medication significantly improved her functioning. However, as noted above, this case involves a medical question and there was a lack of medical evidence substantiating the dose that her doctor has prescribed in light of the three reviewers who explained the dosage was excessive.

Claimant has the burden of proof on this case to show by the preponderance of evidence-based medical evidence that the disputed procedure is health care that is clinically appropriate and considered effective for his injury. Evidence-based medical evidence entails the opinion of a qualified expert that is supported by evidence-based medicine. The evidence presented at the hearing cannot be construed to constitute evidence-based medical evidence sufficient to overcome the decision of the IRO reviewer. As Claimant did not overcome the IRO decision by a preponderance of the evidence-based medical evidence, she has accordingly failed to meet her burden of proof.

The Administrative Law Judge 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. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

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 ALJ's Exhibit Number 2.

3. On (Date of Injury), Claimant was the employee of (Employer), Employer.

4. On (Date of Injury), Employer provided workers compensation insurance through Insurance Company of the State of Pennsylvania, Carrier.

5. On (Date of Injury), Claimant sustained a compensable injury.

6. The specific dosage of morphine 60mg T.I.D. is 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 not contrary to the decision of the IRO that Claimant is not entitled to morphine 60mg T.I.D.

DECISION

Claimant is not entitled to morphine 60mg T.I.D 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 **INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA,** 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 78701-3218

Signed this 26th day of April, 2018.

BRITT CLARK
Administrative Law Judge