MEDICAL CONTESTED CASE HEARING NO. 20005

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 Administrative Law Judge determines that Claimant is not entitled to a prescription for Oxycontin 20 mg ER for the compensable injury of (Date of Injury).

ISSUE

A contested case hearing was held on January 13, 2020, with the record closing on January 27, 2020, 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 Oxycontin 20 mg ER for the compensable injury of (Date of Injury)?

The record was held open to allow for the modification and admission of ALJ's Exhibits 1 and 2. On January 27, 2020, the record was closed.

PARTIES PRESENT

The Petitioner/Claimant appeared and was assisted by AW, ombudsman.
The Respondent/Carrier appeared and was represented by RJ, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

Claimant/Petitioner: Claimant.

Carrier/Respondent: None.

The following exhibits were admitted into evidence:

Administrative Law Judge's Exhibits ALJ-1 and ALJ-2.

Claimant/Petitioner: Exhibits C-1 through CL-5.

Carrier/Respondent: Exhibits CR-A through CR-H.

DISCUSSION

The compensable injury of (Date of Injury) consists of a C3, C4, and C5 fractures. Claimant was treated with surgery, physical therapy (PT), leg braces, and pain medication. Claimant testified that the requested Oxycontin 20 mg ER is the best remedy for his pain with fewer side effects than other pain medications. Claimant explained that Tramadol did not relieve his pain and that morphine made him "zone out." According to Claimant, the requested mediation increases his mobility and reduces his pain level from a level of 8 of 10 down to 5 of 10. Claimant testified that, without the requested medication, pain related to the compensable injury prevents him from sleeping more than two hours a night. Claimant acknowledged that, in addition to Oxycontin 20 mg ER, he takes Hydrocodone to treat his back pain.

On May 8, 2019, Claimant was seen by LC, physician assistant (PA)/HB, M.D., to treat his chronic pain syndrome, which was associated with Claimant's surgery to treat the compensable injury. Dr. B noted that Claimant would need Oxycontin for an extended period of time and prescribed PT for an additional three months.

On May 23, 2019, RK, M.D. completed a utilization review decision letter denying the requested prescription. Dr. K noted that, per the Official Disability Guidelines (ODG), opioids are not generally recommended for chronic pain or musculoskeletal diagnosis. He determined that Claimant's combined use of both Oxycontin and Norco substantially exceeds the 50 mg threshold for risk of morbidity or mortality from continued opioid use. Dr. K noted that, on October 11, 2018, Claimant's urine drug screening results were positive and included Hydromorphone, Hydrocodone, Oxycodone, and Oxymorphone. As of October 11, 2018, Claimant's treatment included Oxycontin, Hydrocodone, Lyrica, Norco, Ibuprofen, Topamax, and Gabapentin.

Dr. K stated that Claimant's medication request included limited discussion of any specific functional benefit of continued opioid used. He opined that non-opioid and non-pharmacological options were not exhausted before opioid use was continued. Dr. K explained that the overall rationale for continued opioid use was unclear and that continued opioid use was not medically necessary. He recommended weaning Claimant off opioids.

On June 13, 2019, NM, M.D., affirmed Dr. K's decision. Dr. N opined that Claimant's evidence did not demonstrate objectives gains with ongoing use of Oxycontin. Carrier denied Claimant's request for a prescription for Oxycontin 20 mg ER. Claimant sought review by an IRO reviewer.

The IRO reviewer was identified as a licensed Texas doctor who is board certified in physical medicine and rehabilitation with a sub-specialty certification in pain medicine. The IRO reviewer determined that the requested medication was not medically necessary for treatment of Claimant's medical condition due to the lack of clear evidence that ongoing Claimant's use of Oxycontin resulted in functional improvement. The IRO reviewer noted that ongoing use of

opioids can result in reduced effectiveness. The IRO reviewer stated that Claimant's baseline pain level with the medication was very high. Claimant's examination records indicated that, after taking Oxycontin, Claimant repeatedly reported that his pain level was 7 of 10. In addition, the IRO reviewer noted that, contrary to recommended guidelines for long term use of narcotics medications, Claimant's records did not include a recent risk assessment or urine drug test for compliance measures.

On November 5, 2019, Dr. B issued a letter stated that opioids were the best option to control Claimant's chronic pain. He stated that Claimant was well controlled in accordance with Centers for Disease Control guidelines for opioid use. Dr. B explained that Claimant, "is currently at 90 MME with his effective use of Oxycodone ER 20mg BID and Hydrocodone for [b]reak through pain at 10/325 mg TID." He noted that, over the years, other opioid medications failed Claimant due to neuropathic pain and intolerable side effects. Dr. B stated that Claimant's Hydrocodone dose could not be increased due to the increasing toxicity of acetaminophen.

Texas Labor Code §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 §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 §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. *See* Texas Labor Code §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 §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 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."

For the requested medical treatment, the ODG provides:

ODG Criteria for use of opioids:

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. > 100 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 difficulty 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*)**.**

Claimant presented his testimony and medical records, including medical reports and a November 5, 2019 letter from Dr. B, in support of his position that the preponderance of the evidence was contrary to the IRO's decision. Considering the reports of Dr. K, Dr. M, and the IRO reviewer, the ALJ finds that Claimant did not meet his burden of proof to overcome IRO decision by a preponderance of the medical evidence. Claimant did not present persuasive medical evidence to establish that he met the ODG requirements for the requested medication to treat Claimant's chronic pain syndrome. Claimant failed to establish that requested Oxycontin 20 mg ER improved his functioning and pain. Therefore, the ALJ determined that Claimant was not entitled to Oxycontin 20 mg ER.

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. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Workers' Compensation Division of the Texas Department of Insurance.

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

   C. On (Date of Injury), Claimant sustained a compensable injury in the form of C3, C4, and C5 fractures.

   D. On (Date of Injury), Employer provided workers' compensation insurance through Employers Insurance Company of Wausau, Carrier.

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 Administrative Law Judge's Exhibit Number 2.

3. Claimant does not meet the requirements of the ODG for a prescription for Oxycontin 20 mg ER.

4. A prescription for Oxycontin 20 mg ER is not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Workers' Compensation Division of the Texas Department of Insurance 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 the Claimant is not entitled to a prescription for Oxycontin 20 mg ER for the compensable injury of (Date of Injury).

DECISION

The preponderance of the evidence is not contrary to the decision of the IRO that the Claimant is not entitled to a prescription for Oxycontin 20 mg ER for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with Texas Labor Code §408.021.

The true corporate name of the insurance carrier is **EMPLOYERS INSURANCE COMPANY OF WAUSAU**, and the name and address of its registered agent for service of process is:

CORPORATION SERVICES COMPANY
211 EAST 7th STREET, STE. 620
AUSTIN, TEXAS 78701

Signed this 27th day of January, 2020.

Rabiat Ngbwa
Administrative Law Judge