MEDICAL CONTESTED CASE HEARING NO. 09075
M6-08-12820-01

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 November 21, 2008, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to 1-2 office visits per year and the oral medications Klonopin (1mg), Neurontin (300 mg) and Darvocet N-100 for the compensable injury of _____?

PARTIES PRESENT

Claimant appeared and was assisted by ombudsman, KF. Carrier appeared and was represented by attorney, PM.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained an injury to his low back in the course and scope of his employment as a night stocker for (Employer) on _____. Claimant treated conservatively with medication, physical therapy and injections and was diagnosed with lumbar degenerative disc disease, a herniated disc at L3-4, and left L4 radiculitis by the designated doctor. He was found to be at MMI on February 7, 2001 with a 13% impairment rating.

In August of 2002, Claimant began treating with Dr. E, a rehabilitation and occupational medicine doctor. Dr. E noted that Claimant had returned to work on a part-time basis and reported pain from his back to his right leg. Dr. E ordered medications, including all three listed in the current dispute, work hardening, continued alternate duty, diagnostic testing and follow-up visits. Claimant continued to see Dr. E approximately every three to six months.

In 2007, Dr. E outlined Claimant's treatment plan as follows: office visits 1 to 2 times per year to monitor medications, exercise program and work status and blood studies as needed. The medications for treatment of his chronic pain syndrome were Klonipin (1 mg at h.s), Neurontin (300 mg. t.i.d.), and Darvocet-N 100 (1 q. 4-6 h. p.r.n.).

A PRME doctor, Dr. M, opined that the treatment plan was not medically necessary to treat Claimant's condition.

The carrier denied the office visits and medications. The first utilization review doctor, Dr. T, a pain management and occupational and preventive medicine doctor, noted the PRME on file and opined

that the medical necessity of the treatment plan had not been established. .

The utilization review doctor who reviewed the request on reconsideration, Dr. G, a preventive medicine/occupational medicine doctor, also denied the requested treatment plan. He cited the *ODG* and noted Claimant's chronic subjective low back pain complaints and opined that there were no signs of radiculopathy on physical examination. He opined that the *ODG* would not support "chronic benozos or opioids for chronic non-specific low back pain" and there were no signs of radiculopathy necessitating the need for Neurontin. He concluded that since the medications were not medically necessary and their use was not supported by the *ODG*, office visits for the purpose of prescribing those medications were not necessary. The reviewing doctor stated that he spoke to Dr. E and he did not feel that the claimant needed the medications at that time. Based on the clinical information submitted and citing the *ODG*, the doctor denied the requested medications and office visits.

An IRO reviewer (physical medication and rehabilitation doctor) reviewed the records and upheld the adverse determinations of the utilization review doctors. The IRO denied the medications and office visits citing the *ODG*. The IRO doctor noted that the *ODG* do not support the chronic use of the requested medications. The reviewer noted that Claimant had a history of lumbar radiculopathy which appeared resolved; and, the most current examinations did not support the presence of an active radiculopathy necessitating the use of the requested medications. The reviewer agreed with Dr. G that the office visits were not warranted as the necessity for the medications had not been established.

Dr. E opined that while the *ODG* do state that the majority of people with lumbar injuries will improve over a period of two to three months, Claimant falls into the category of patients who do not fully recover from their back injuries and his treatment plan should be analyzed under the chronic pain chapter of the *ODG*.

DISCUSSION

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. **Section 401.011(22-a)** defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." "Evidence based medicine" is further defined, by **Section 401.011(18-a)** as 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 making decisions about the care of individual patients.

The Division of Workers' Compensation has adopted treatment guidelines under Division **Rule 137.100**. That rule requires that health care providers provide treatment in accordance with the current edition of the *Official Disability Guidelines (ODG)*, and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. The *ODG* allows for the use of all of the medications requested, with specific limitations and requires documentation of improved function and activity as well as efficacy in pain control for use of the medications.

The *ODG* Treatment Guidelines for chronic pain medications discuss the requested medications as follows:

> **Medications for subacute and chronic pain** Recommended as indicated below. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others. (Chou, 2006) There are multiple medication choices listed separately (not all recomended). See Anticonvulsants for chronic pain; Antidepressants for chronic pain; Antidepressants for neuropathic pain; Antidepressants for non-neuropathic pain; Anxiety medications in chronic pain; Anti-epilepsy drugs (AEDs); Anti-Inflammatories; Benzodiazepines; Boswellia Serrata Resin (Frankincense); Buprenorphine; Cannabinoids; Capsaicin; Cod liver oil; Curcumin (Turmeric); Cyclobenzaprine (Flexeril®); Duloxetine (Cymbalta®); Gabapentin (Neurontin®); Glucosamine (and Chondroitin Sulfate); Green tea; Herbal medicines; Implantable drug-delivery systems (IDDSs); Injection with anaesthetics and/or steroids; Insomnia treatment; Intrathecal drug delivery systems, medications; Intravenous regional sympathetic blocks (for RSD, nerve blocks); Ketamine; Methadone; Milnacipran (Ixel®); Muscle relaxants; Nonprescription medications; NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk; Opioids (with links to multiple topics on opioids); Pycnogenol (maritime pine bark); Salicylate topicals; Topical analgesics; Uncaria Tomentosa (Cat's Claw); Venlafaxine (Effexor®); White willow bark; & Ziconotide (Prialt®).
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> **Benzodiazepines (Klonopin)**Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic,

anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) See also Anxiety medications in chronic pain; & Insomnia treatment.

Gabepentin (Neurotin) Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. See Anti-epilepsy drugs (AEDs) for general guidelines, as well as specific Gabapentin listing for more information and references.

Opiods (Darvocet-N) *Recommendations for general conditions:*
- *Chronic back pain*: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassement 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)

As noted previously herein, "health care reasonably required" means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

The utilization review doctors and the IRO doctor denied the requested medications and office visits citing the relevant provisions of the *ODG*, specifically the fact that there was no clinical evidence of continuing radiculopathy to justify the long-term use of the medications. It is incumbent on the Claimant, therefore, to provide evidence-based medicine sufficient to overcome the presumption afforded the *ODG* and the opinions of the doctors correctly applying the *ODG*.

Other Evidence Based Medicine

When weighing medical evidence, the hearing officer must first determine whether the doctor giving the expert opinion is qualified to offer it, but also, the hearing officer must determine whether the opinion is relevant to the issues in the case and whether the opinion is based upon a reliable foundation. An expert's bald assurance of validity is not enough. *See* ***Black v. Food Lion, Inc.***, 171 F.3rd 308 (5th Cir. 1999); ***E.I. Du Pont De Nemours and Company, Inc. v. Robinson***, 923 S.W.2d

549 (Tex. 1995). When determining reliability, the hearing officer must consider the evidence in terms of (1) general acceptance of the theory and technique by the relevant scientific community; (2) the expert's qualifications; (3) the existence of literature supporting or rejecting the theory; (4) the technique's potential rate of error; (5) the availability of other experts to test and evaluate the technique; (6) the clarity with which the theory or technique can be explained to the trial court; and (7) the experience and skill of the person who applied the technique on the occasion in question. ***Kelly v. State***, 792 S.W.2d 579 (Tex. App.-Fort Worth 1990).

Claimant failed to present an evidence-based medical opinion from a competent source to overcome the IRO's decision. The medications prescribed by Dr. E departed from the *ODG* in several respects, specifically in the lack of documentation of their effectiveness in controlling Claimant's pain and improving his function and activity. Further, the reports of Endsley do not provide the necessary documentation to support the long-term use of the prescribed medications for Claimant's compensable injury. There is not any current medical documentation to support further long-term use of the medications. In fact, according to the utilization review doctor, even Dr. E did not think the Claimant needed the medications at the time he discussed the case with the reviewer. Dr. E's records, without sufficient reference to the *ODG* or other evidence-based medicine justifying departure from the *ODG,* do not meet the requisite evidentiary standard required to overcome the IRO. The preponderance of the evidence is not contrary to the IRO decision and the requested medications and office visits do not meet the criteria set out in the *ODG*.

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 he sustained a compensable injury.

   C. The IRO determined that the requested office visits and medications were not reasonable and necessary health care services for the compensable injury of _____.

2. 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.

3. Claimant's treating pain management doctor prescribed 1-2 office visits per year and the oral medications Klonopin (1mg), Neurontin (300 mg) and Darvocet N-100 for the compensable injury of _____.

4. The *ODG* allows for the use of all of the medications requested, with specific limitations and requires documentation of improved function and activity as well as efficacy in pain control

for use of the medications..

5. The IRO decision upheld the Carrier's denial of the requested medications because the requesting doctor's records lacked documentation regarding radiculopathy and efficacy and improvement with the use of the medications.

6. The requested medications are not consistent with the *ODG* criteria for the requested medications for subacute and chronic pain.

7. The requested prescriptions are 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of IRO that 1-2 office visits per year and the oral medications Klonopin (1mg), Neurontin (300 mg) and Darvocet N-100 are not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled to 1-2 office visits per year and the oral medications Klonopin (1mg), Neurontin (300 mg) and Darvocet N-100 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 Section 408.021.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701

Signed this 16th day of January, 2009.

Erika Copeland
Hearing Officer