

In the ORS 656.327 Medical Treatment Dispute of

**JOHN HART, JR., Claimant**

Contested Case No: H05-012

**PROPOSED AND FINAL ORDER**

July 12, 2005

OIGA FOR HOME INDEMNITY CO.

c/o PUBLIC RISK CONSULTANTS, Petitioner

JOHN HART, JR., Respondent

Before Daina Upite , Administrative Law Judge, Administrative Hearings

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**HISTORY OF THE CASE**

Insurer appeals an administrative order issued on December 28, 2004 by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services (department or director). On March 7, 2005, Administrative Law Judge Daina Upite conducted a hearing in Salem, Oregon. Petitioner OIGA, for Home Indemnity Co., (Insurer) appeared by and through its attorney, Courtney Kreutz. Respondent, John Hart, Jr., (Claimant) was represented by attorney James Niedermeyer. Claimant testified. Kevin Kane, D.O., also testified on behalf of Claimant. The record closed at the end of the hearing on March 7, 2005.

**ISSUE**

Whether the prescription medications Effexor and MS Contin are appropriate for Mr. Hart's compensable condition.

**EVIDENTIARY RULINGS**

Workers' Compensation Division (WCD) Exhibits 1 through 222 were received without objection.

**FINDINGS OF FACT**

(1) Claimant sustained a compensable injury on August 11, 1987 when he fell off a ladder while installing cable TV equipment. (Exs. 5, 12, 13.) Claimant was treated at Emanuel Hospital on the day of injury for fractures of his left wrist and right elbow. (Ex. 5.) Dr. Gregory Irvine performed open reduction/internal fixation surgery of the right radial head fracture-dislocation. (Ex. 8.) Dr. Jerry Nye performed surgery on the left wrist for lunate dislocation. (Exs. 10 at 1; 40 at 1.) On August 20, 1987, the insurer, Scott Wetzel Services, Inc., accepted a disabling injury claim for the August 11, 1987 injury. (Ex. 13.)

(2) Claimant was released to return to light duty work October 20, 1987. (Ex. 30.) A right radial head excision was performed in April 1988, and arthroscopic surgery was performed on claimant's right elbow in September 1988 to remove a loose body. (Exs. 36, 43.) Claimant was determined to be medically stationary July 19, 1989, and the claim was closed August 23, 1989 with an award of permanent disability for left wrist and right arm. (Ex. 60.)

(3) In December 1991, claimant sought treatment from Paul Puziss, M.D., orthopedic surgeon, for left wrist and shoulder pain, and right elbow pain. Dr. Puziss prescribed physical therapy and claimant improved, but in August 1992, claimant had increased left wrist and shoulder pain. (Exs. 67, 74, 77- 81.) On April 26, 1993, Dr. Puziss performed an arthroscopic left acromioplasty and coracoacromial ligament resection and bursectomy, as well as an intra-articular debridement of a torn portion of biceps tendon. The post-operative diagnosis was partial tear of left biceps tendon, chronic left shoulder impingement, and subacromial bursitis. (Ex. 84.) Dr. Puziss prescribed physical therapy, but claimant had persistent pain, as well as clicking or popping, in the shoulder. (Ex. 93.) By a stipulated order dated July 7, 1993, the insurer accepted an aggravation claim. (Ex. 94.)

(6) Claimant began treating with Robert A. Berselli, M.D., orthopedic surgeon, in November 1993 due to continued left shoulder pain, which Dr. Berselli diagnosed as chronic rotator cuff tear. On January 27, 1994, Dr. Berselli performed a left shoulder rotator cuff repair. (Exs. 112 at 1-2, 119.) Dr. Berselli prescribed physical therapy and claimant's left shoulder improved. (Exs. 112, 122-25.) Based on Dr. Berselli's assessment, the insurer closed the claim May 16, 1994 and found claimant to be medically stationary as of April 27, 1994. (Exs. 126, 128.) The insurer amended its acceptance February 2, 1995 to include left shoulder rotator cuff tear and left biceps tendon partial tear as part of the original claim, as well as fracture/dislocation of right radial head and perilunar dislocation of left wrist. (Exs. 136, 137.) On November 16, 1995, Dr. Berselli performed an anterior transposition of the right ulnar nerve to treat tardy ulnar palsy. (Ex. 156.) The insurer determined that claimant was medically stationary again on September 5, 1996. (Ex. 170.)

(7) On July 1, 1998, claimant began treating with Kevin Kane, D.O. for chronic disabling pain and mood disturbance, with complaints of left wrist, left knee, head, and neck pain, as well as intermittent loss of balance, disturbed sleep, mood and concentration deficits. Claimant retired on medical disability in early 1998. (Ex. 175 at 1.) Dr. Kane assessed crushed left wrist with residual contractures and pain; left shoulder rotator cuff tear and distal clavicle excision with residual contractures and pain; right radial head fracture, non-union, and subsequent excision with residual contracture and pain; traumatic brain injury and structural injury to the head and neck with residual contractures and pain; as well as major depression, severe chronic somatic pain with sub-optimal analgesia, fibular head dysfunction of the left knee, diabetes, and glaucoma. Dr. Kane recommended a trial of anti-depressant therapy and more potent analgesics. He gave claimant an Effexor starter pack on a trial basis. (Ex. 175 at 3.)

(8) Claimant continued to treat with Dr. Kane, who prescribed anti-depressant medication and analgesics, as well as other medications. Claimant was involved in motor vehicle accidents on June 28, 2001 and September 24, 2002. By March 27, 2003, Dr. Kane declared that claimant was medically stationary with respect to the motor vehicle injuries, with no permanent sequelae. (Ex. 175 at 4-42.)

(9) On June 23, 2003, Dr. Kane noted that claimant was doing well and enjoyed good functional analgesia with his current medications, with no untoward side effects. Dr. Kane's impression was chronic intractable somatic pain from remote fractures, very well compensated

currently. He recommended continuing all current medications, including OxyContin, Soma, Effexor, Neurontin, and Tegretol. (Ex. 175 at 43-44; *see also* at 45-52.)

(10) On March 9, 2004, Brent Burton, M.D., medical toxicology and occupational medicine, reviewed records at the request of the insurer and authored a report regarding the appropriateness and efficacy of claimant's current prescription medications. (Ex. 186 at 1.) Dr. Burton recommended weaning claimant off narcotic analgesics. Specifically, he recommended against use of OxyContin, a potent analgesic that Dr. Burton considered contraindicated for treating chronic pain, except in the setting of malignancy. He concluded that OxyContin was not appropriate for claimant because it was prescribed based solely on claimant's subjective complaints. (*Id.* at 12-14.) Dr. Burton also advised that Effexor is an antidepressant medication, and its only approved use is for psychiatric conditions. (*Id.* at 14.)

(11) On May 15, 2004, Helen Sherman, R.Ph., Pharm.D., a clinical pharmacist consultant, evaluated the efficacy and appropriateness of claimant's prescription medications at the request of the insurer. (Ex. 191.) Dr. Sherman described OxyContin as a strong narcotic analgesic with a high potential for abuse, addiction, and physical dependence, which is indicated for severe pain unrelieved by other treatment modalities. Dr. Sherman did not find evidence of drug-seeking behavior by claimant, but she observed that claimant was very likely physically dependent on the medication due to chronic use. Dr. Sherman could not correlate claimant's need for OxyContin with his work injury, noting that claimant did not use any narcotic medications chronically prior to 1998, and that Dr. Kane prescribed the medications based entirely on claimant's subjective symptoms. Dr. Sherman identified the medication Effexor as an antidepressant used only for psychological conditions (*i.e.*, depression). (*Id.* at 6-10.) Dr. Sherman recommended either establishing medical necessity for the use of OxyContin, or gradually weaning claimant off the medication. (*Id.* at 12-13.)

(12) On May 28, 2004, the insurer and employer, Rogers Cable System, filed with the department a request for review of the appropriateness of medications prescribed by Dr. Kane to treat claimant's accepted conditions; specifically, the medications OxyContin; Soma/carisoprodol; Neurontin/Tegretol/carbamazepine; and Effexor. (Ex. 192.)

(13) On June 1, 2004, Dr. Kane began tapering claimant off Soma and substituted MS Contin for OxyContin. (Ex. 175 at 53.) Dr. Kane responded to the insurer's request for review by letter dated June 1, 2004. (Ex. 194.) Dr. Kane pointed out that pain is by definition subjective, and that many non-narcotic medications induce physical dependence, but this does not contraindicate their use when clinically appropriate. Dr. Kane noted that in the course of his treatment of claimant, the guidelines for prescribing and monitoring use of narcotics for intractable pain had been met, although not documented in writing. (*Id.* at 1.) Dr. Kane further noted that claimant's functional capacity has improved since using the prescribed analgesics, with respect to self-care, household care, and care of his schizophrenic son, as well as driving and participating in appropriate recreational activities, without any evidence of addictive behavior. (*Id.* at 2.) Dr. Kane pointed out that the use of serotonin agents, such as Effexor, has been endorsed by pain specialists, including the American Pain Society and pain management leaders in the Portland area, as one component of pain management. As a result of using Effexor, claimant's depression, clearly manifested when he began treating with Dr. Kane, has

been stable and in remission, with the added benefit of mitigation of pain symptoms. Dr. Kane noted that claimant's pain perception and processing benefited from use of a serotonin agent. (*Id.* at 3-4.) Dr. Kane pointed out that claimant has not used alcohol for many years, and that he has been painstakingly compliant with scheduled use of his medications. Furthermore, claimant has "repeatedly and enthusiastically reported meaningful gains in independence and activity tolerance" since taking the medications prescribed by Dr. Kane. (*Id.* at 4.)

(14) After Dr. Kane substituted MS Contin for OxyContin, Dr. Burton further reviewed the medications at the insurer's request. By letter dated August 18, 2004, Dr. Burton explained that MS Contin, like OxyContin, is a narcotic analgesic, indicated for severe, acute pain, that both drugs have a similar abuse profile, and that neither drug avoids the propensity for tolerance or abuse. Dr. Burton reiterated his opinion that MS Contin, like OxyContin, is not an appropriate medication for long-term use in treating chronic musculoskeletal pain. (Ex. 202 at 1.) Dr. Sherman agreed with Dr. Burton's report. (Ex. 205.) The insurer requested the department to also review the appropriateness of MS Contin (as well as some other medications) for treating claimant's accepted conditions. (Ex. 203.)

(15) By letter dated August 25, 2004, Dr. Kane responded to Dr. Burton's report. Dr. Kane explained that MS Contin has less abuse potential because it has less street value than OxyContin. Dr. Kane pointed out again that claimant is not suspected of abusing or diverting the narcotic medication. Dr. Kane also pointed out that as a pain management specialist, he is more likely to see the rare musculoskeletal pain condition for which it is appropriate to prescribe narcotic analgesics. Dr. Kane identified his initial evaluation of claimant on July 1, 1998 as providing the diagnoses that justify the medications he has prescribed. (Ex. 204.)

(16) At the Department's request, Roxanne Donovan, M.D., served as a physician reviewer. (Ex. 206.) Dr. Donovan examined claimant on October 15, 2004 and reviewed his medical records. She concluded that treatment of claimant's chronic pain with MS Contin, or a similar long-acting opiate, is appropriate. She noted that claimant has not demonstrated any drug-seeking behavior, has not required increasing dosage to achieve the same level of pain relief, and has not required short-acting narcotics for break-through pain. She observed that, in general, there is a large subjective component to pain response, but that claimant has physical pathology that contributes to his pain syndrome. She explained that there is no standard approach to treating chronic, non-malignant pain, but that, in general, if a short-acting opiate provides pain relief, it is appropriate to develop a plan using a long-acting opiate with a standing dosage and time so as to avoid the "hill and valley" effect of short-acting opiates. Dr. Donovan noted that claimant had apparently achieved functional improvement in that he has been able to perform activities of daily living (ADLs) independently since beginning chronic opiate use. She observed that chronic opiate use should be accompanied by a medication contract between the patient and the prescriber, informed consent with respect to possible side effects and complications, and information about the patient's risk of addiction. The patient should be required to use only one prescriber and one pharmacy, and the prescribing physician should closely monitor response to the medications, particularly with respect to functional improvement. Dr. Donovan did not comment on the medication Effexor, except to identify it as a medication for treating depression. Dr. Donovan did, however, suggest the use of the medication Amitriptyline, a tricyclic antidepressant, to help claimant sleep and to address any perceived neuropathic component of

claimant's pain. She observed that Amitriptyline is sometimes helpful for pain management. (Ex. 210.)

(17) Dr. Kane commented on Dr. Donovan's report by a letter dated November 16, 2004. He agreed to provide a written informed consent and pain medication contract with claimant, as required by the Oregon Board of Medical Examiners, although he pointed out that these matters were addressed informally with claimant during the course of his treatment. He pointed out that Effexor is also used for pain management, particularly neuropathic pain. Dr. Kane asserted that claimant does have neuropathic pain, evidenced by his reporting of symptoms such as burning and hypersensitivity. (Ex. 211.)

(18) By a letter dated December 19, 2004, Dr. Burton commented on Dr. Donovan's report and Dr. Kane's letter, reiterating his previously stated position that narcotic analgesics are not justified by the medical documentation in this case. (Ex. 212.)

(19) The department issued an Administrative Order on December 28, 2004, finding that the medications MS Contin and Effexor are appropriate for claimant's compensable conditions, but that the other medications are not appropriate. (Ex. 214 at 11.) The insurer filed a Request for a Contested Case Hearing. (Ex. 216). Claimant did not appeal the administrative decision.

(20) Dr. Kane, a physical medicine, rehabilitation, and pain management specialist, explained that the medication Effexor, while often and primarily prescribed for mood disturbance and anxiety, modulates nerve transmissions throughout the body, thereby mitigating pain, reducing the "volume" of the pain transmission, and allowing an individual to be more animated and active. The narcotic medication and Effexor together provide sufficient analgesia to allow claimant to function independently. Dr. Kane agreed that dependence on the analgesic medication is a natural corollary, but that claimant is not addicted to the medication, which Dr. Kane defined as continued use of a drug despite decreased function. In Dr. Kane's opinion, if the analgesic medication is withdrawn, claimant would have to endure pain at a level of 6 to 8 on a 1 to 10 scale, with 10 the most severe degree of pain. With respect to Effexor, Dr. Kane pointed out that claimant uses a very low dose, which is sufficient for the medication to help reduce pain. If claimant were being treated for major depression, he would be prescribed a much higher dose of Effexor. (Test. of Kane.)

(21) Claimant returned to work with his at-injury employer doing modified, light duty work until 1993. Claimant worked for another year for two different employers, but was unable to work after 1994. He applied for and was granted Social Security Disability benefits, beginning in approximately 1998. When claimant started treating with Dr. Kane in 1998, he (claimant) was in severe pain and unable to function. At the time of the hearing, claimant was able to perform most normal functions, except that he was still unable to lift anything. Claimant has not used alcohol since 1992. The medication prescribed by Dr. Kane relieves pain so that claimant is able to do activities such as shopping, driving, sleeping better, and getting out of bed. (Test. of Claimant.)

## CONCLUSIONS OF LAW

The Administrative Order correctly determined that the medications MS Contin and Effexor are appropriate for claimant's compensable conditions, and that the insurer is liable to pay for the medications.

### OPINION

Jurisdiction over this medical services dispute lies with the director. ORS 656.245(6); OAR 436-010-0008(1). I review for substantial evidence and errors of law. OAR 436-001-0225(1). The burden of proving a fact or position rests with the proponent of that fact or position. ORS 184.450(2). As petitioner, the insurer bears the burden of proving by a preponderance of the evidence that the administrative order is incorrect. *See Cook v. Employment Div.*, 47 Or App 437 (1980) (In the absence of contrary legislation, the standard of proof in an administrative hearing is preponderance of evidence). Proof by a preponderance of evidence means that the factfinder is persuaded that the facts asserted are more likely true than false. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390 (1989).

The Medical Review Unit determined that the medications MS Contin and Effexor are appropriate for treating claimant's compensable conditions. MRU relied on Dr. Donovan's opinion, rather than Dr. Burton's and Dr. Sherman's opinions, to find that the long-acting narcotic medication MS Contin was appropriate. With respect to Effexor, MRU relied on Dr. Kane's opinion to conclude that the medication is appropriate. Claimant contends that the administrative order is correct and should be affirmed, while the insurer contends that the medications MS Contin and Effexor are not appropriate for claimant's compensable conditions.

Pursuant to ORS 656.245(1)(a), an insurer is obligated to provide medical services that are materially related to a compensable condition for so long as the nature of the injury or the process of recovery requires. This obligation continues over the worker's lifetime. ORS 656.245(1)(b). Prescription medications are compensable after the worker's condition becomes medically stationary. ORS 656.245(1)(c)(B).

Dr. Kane began treating claimant July 1, 1998, 11 years after claimant's work injuries occurred on August 11, 1987. Claimant fell some 20 feet and fractured his left wrist and right elbow. Later, the insurer accepted left shoulder rotator cuff tear and left biceps tendon tear, in addition to the conditions flowing from the original accident. Claimant was in severe pain and had been unable to work for four years when he started treating with Dr. Kane for pain management. Dr. Kane prescribed a long-acting, narcotic medication (at the time of hearing, MS Contin), as well as the anti-depressant medication Effexor, to relieve claimant's pain. As a result of the treatment, the intensity of claimant's pain decreased and he has been able to function better.

MRU found that the analgesic medication MS Contin was appropriate for treatment of claimant's compensable conditions, and substantial evidence supports that conclusion. In addition to the treating physician's opinion that the analgesic medication is effective in managing claimant's pain caused by his compensable conditions, claimant testified that he functions better with pain relief, and Dr. Donovan, the reviewing physician, agreed that under certain circumstances, long-acting, narcotic analgesic medication is appropriate to treat non-malignant

pain. In response to Dr. Burton's opinion that MS Contin is not an appropriate medication, Dr. Donovan pointed out that there is a large, subjective component to pain, but that claimant also has physical pathology that contributes to his pain. Responding to Dr. Burton, both Dr. Kane and Dr. Donovan pointed out that, after seven years of treatment with narcotic analgesics, claimant demonstrates no drug-seeking behavior, has not required increasing dosage, has not required short-acting analgesics for break-through pain, and has achieved functional improvement. MRU did not err by relying on the opinion of Dr. Donovan, over the opinions of Drs. Burton and Sherman, to conclude that the medication MS Contin is appropriate for claimant's compensable conditions.

Insurer argued that under Dr. Kane's treatment claimant has actually become more disabled, but the evidence does not support this position. Claimant was unable to work due to disability for four years before starting treatment with Dr. Kane, and Claimant credibly testified that he has improved functionally since obtaining better pain relief.

MRU's conclusion that Effexor is an appropriate medication to treat claimant's compensable conditions is also supported by substantial evidence. Dr. Kane and all the medical professionals who evaluated the record agree that the approved and primary use of Effexor is to treat depression and anxiety. However, Dr. Kane persuasively explained the benefit of the medication in relieving pain – by modulating nerve transmissions throughout the body, including the transmission of pain – and that the use of serotonin agents, such as Effexor, is endorsed by pain specialists, the American Pain Society, and pain management leaders in the Portland area as an effective component of pain management. Furthermore, Dr. Kane pointed out that claimant is using a small dose of Effexor, which is sufficient to relieve pain, but that the dosage would be much higher if the medication were used to treat major depression. Thus, Dr. Kane's medical opinions and testimony support the conclusion that the use of the medication Effexor is materially related to claimant's compensable conditions and is appropriate treatment for those conditions.

Insurer argued that Effexor is used to treat depression, which is not an accepted condition. However, as discussed above, Dr. Kane's opinion constitutes substantial evidence that the medication is at least materially related to the management of pain caused by claimant's compensable conditions. Therefore, MRU's conclusion is supported by substantial evidence and is not contrary to law, and it should be affirmed.

#### ATTORNEY FEES

Claimant has prevailed in a contested case hearing and is entitled to a reasonable attorney fee. ORS 656.385(1). However, because claimant's attorney has not submitted a statement of services, no attorney fee is awarded.

#### ORDER

IT IS HEREBY ORDERED that:

The Director's Administrative Order dated December 28, 2004, is affirmed.

