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Improving Workers' Compensation Through News and Education

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State:
Weinmann: Opioid Prescribing and Panic: [2017-08-15]

The mechanism of opioid action is through a receptor mechanism that we all have, namely, mu, delta and kappa receptors.


Dr. Robert Weinmann

Human opioid receptors are endogenous and can be activated by endogenous peptides such as the enkephalins, dynorphins and endorphins. These substances are released by neurones and are thereby made available for pain modification. Endogenous opioid peptides comprise a class called endorphins.

This class of neurochemical stimulation is available to injured persons and can be mobilized into action without prescribing the likes of vicodin, oxycodone, OxyContin or similar controlled substances (or illegal non-controlled substances).

This level of neurochemical stimulation can be triggered to release endogenous substances in the human body that relieve pain. For instance, physical therapy, aquatic therapy or massage can have this favorable effect. When these methods don't work, analgesic medication, including opioids, may then be prescribed.

The trouble is that in the case of injured workers covered by workers' compensation, these alternative methods to opioid prescribing are often rejected by utilization review. Then that rejection by UR gets rubber-stamped by anonymous independent medical review doctors whose prejudices cannot be addressed, since their names are kept secret.

When the primary treating physician's attempt to prescribe an alternative to analgesic relief is denied authorization, the next step is pharmacological, often opioids. That's when the bureaucratic howling begins. What should happen instead is that the UR and IMR doctors who denied treatment by physical therapy or massage should be relieved from duty.

"Turn the Tide," a publication of the U.S. surgeon general, discloses resources for the proper prescribing of opioids for pain, chronic pain in particular. For instance, once opioids are prescribed, they should be continued only if "meaningful improvements in pain and function without significant risks or harm" can be documented. Interestingly, the brochure distributed by the surgeon general, states in red capital letters, "Start low and go

slow."

In fact, in The Weinmann Report entry "Opioid Denials and Obstruction of Alternative Treatments" (June 26, 2017), we discussed how The Washington Post in 2001 made a front-page headline about a doctor in California who was being sued for not prescribing enough pain medication.

We also cited a peer-reviewed reference from Headache that stated that opioids were useful in pain management but that their use had to be slow, slow, slow, this advice was 17 years ahead of "Turn the Tide" and 10 years before Joe Paduda's original article.

In Paduda's panic-ridden piece entitled "Narcotic use is rampant in workers compensation," we are told that "the problem is showing up in a doubling of emergency room admissions due to prescription drug abuse, driven primarily by oxycodone, methadone and hydrocodone." This particular article makes no reference to the UR denials for physical therapy, massage and alternative treatments that force patients into the pharmaceutical stream.

On the contrary, Dr. John Torres recommended massage therapy on MSNBC with moderator Craig Melvin on Aug. 1 this year. It isn't clear whether Dr. Torres knew he was recommending a treatment often rejected by workers' comp UR. Since we had the privilege of evaluating just this kind of patient recently, we'll see what happens if and when the PTP asks for overturn of the denial of massage therapy.

Readers should not be surprised. Since the emphasis now placed on evidence-based-medicine, the reliance on the winds of fashion and bureaucracy has only increased.

Dr. Robert Weinmann writes the Politics of Healthcare blog, from which this entry was taken with permission.

the weinmann report - politicsofhealthcare.com

POLITICS OF HEALTH CARE WITH EMPHASIS ON CALIFORNIA LEGISLATION INCLUDING WORKERS COMPENSATION AND UTILIZATION REVIEW AND FEDERAL LEGISLATION IN WASHINGTON, DC

monday, june 26, 2017

OPIOID DENIALS AND OBSTRUCTION OF ALTERNATIVE TREATMENTS

"Doctor's Duty to Ease Pain at Issue in Calif. Lawsuit" was headline news for The Washington Post on 7 May 2001. The story was about how a patient died in pain at age 85 after his doctor reportedly "discharged him from the hospital with what (his daughter) said was inadequate pain medication."

Meanwhile, HEADACHE, Vol. 11, #2, summer 2000, in a series entitled "Controversies in Headache Medicine," published a column on "Long-Acting Opioids as Preventive Medicine for Severe Headaches." The report recognized the risks of opioid medication but opined nonetheless that "when they are not overused, the opioids are safe medication" and that "the doses must be kept low" since "occasionally, the body develops tolerance to the narcotic and the patient needs increasing doses to achieve the same result." The HEADACHE article discussed methods of management.

Pain management physicians understand these complications while also facing the needs of patients who suffer from chronic pain. That is why physicians try alternative methods to achieve pain relief, for instance,

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physical therapy, aqua therapy, and other methods not dependent on medications (these alternative methods are felt to induce secretion of endogenous substances that enhance pain relief). The trouble is that injured workers offered treatment under these techniques are likely to have these recommendations denied or delayed by Utilization Review (UR) and Independent Medical Review (IMR). DWC is ultimately responsible for care to injured workers and for the frequent denials and inadequate authorizations of treatment by UR and IMR. These denials then help throw these patients into opioid regimens because alternative treatment has been denied. The usual ruse is to call these treatments "experimental" or "unproved."

That's when the primary treating physicians (PTPs) and their consultants inherit the blame. Now that the political winds are against opioid use and physicians try to avoid their use, the ultimate sufferer is the injured worker and chronic pain patient. There is no winner in this sad game.

References

HEADACHE, V. 11, #2, Summer, 2000, by Lawrence Robbins, MD ("Long-acting opioids as preventive medicine for severe headaches")

The Washington Post, May 7, 2001, by Susan Okie ("Doctor's duty to ease pain at issue in Calif. lawsuit")

Workcompcentral, 2016-07-26, by Robert Weinmann, MD ("SB 863 benefits employers, harms injured workers")

Workcompcentral, 2017-01-04, by Robert Weinmann, MD ("Malpractice reform reaches California Supreme Court")

posted by robert weinmann at 12:28:00 pm

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2 comments:

Thursday, July 14, 2016

Comp Should Sue Purdue

by David DePaolo · 773 views · 0 shares

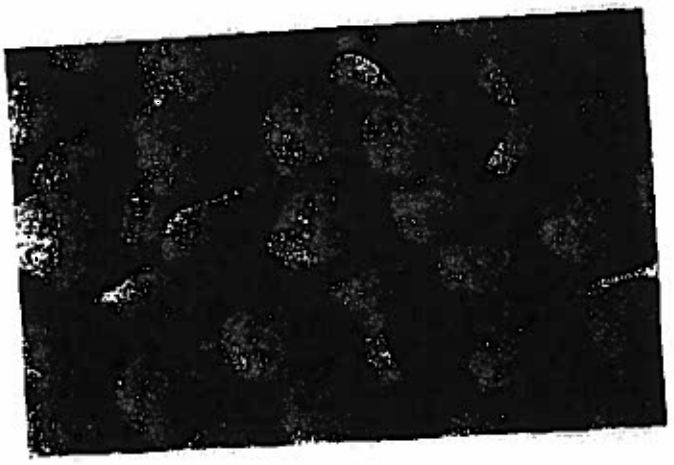
Over the past weekend the Los Angeles Times published a startling investigative story on Purdue Pharma, the maker of Oxycontin, and everything they knew about illegal distribution of the drug, their investigations, their suspicions ... and the company's complete lack of communication with anyone that could put a stop to the company's $31 billion revenue stream from the nation's best selling opioid.

How much did Purdue know?

And how much did they keep to themselves ... until pressured by law enforcement and the government?

According to the story, since 1999 more than 194,000 people have died from opioid overdoses, and more than 4,000 per day become addicted.

Four thousand a day...



Yet, even after three of Purdue's executives pleaded guilty to federal charges of misbranding Oxycontin and the company paid $635 million in fines and fees, the company turned a blind eye to clinics they knew were overprescribing, and even fronting criminal enterprises, all after touting increased security and controls over their drugs.

One year after the settlement, a Los Angeles pain clinic, Lake Medical, opened its doors on the license of Dr. Eleanor Santiago, a physician who had fallen on hard times and whom the operators of Lake Medical recruited to write prescriptions.

Santiago wrote 1,500 prescriptions for the pills in a single week - more than most pharmacies sell in an entire month; and according to the story, in October of 2008 she prescribed more than 11,000 pills.

Purdue investigated and concluded Lake Medical was part of a criminal enterprise working with a pharmacy in Huntington Park.

"Shouldn't the DEA be contacted about this?" the sales manager, Michele Ringler, told company officials in a 2009 email, according to the story. She opined certainty it was an organized drug ring.

Still, Purdue didn't take any action against Lake Medical, and didn't tell anyone about what they knew until the clinic went out of business and its leaders indicted.

According to the LA Times, Purdue had collected exhaustive evidence suggesting criminal distribution of the drug, and not only did not share that information with law enforcement, but kept selling the drug to those being investigated.

"Purdue knew about many suspicious doctors and pharmacies from prescribing records, pharmacy orders, field reports from sales representatives and, in some instances, its own surveillance operations, according to court and law enforcement records, which include internal Purdue documents, and interviews with current and former employees," the Times says.

Since 2002 Purdue had been keeping a list of suspicious doctors, and the Times investigation revealed there were 1,800 names on that list.

Only 8% of them were reported to law enforcement.

Rather than risk its interfering with the obscene profits Oxycontin was delivering by releasing its information, Purdue instead came out with a tamper-resistant formulation. It was only after many arrests had been made that Purdue supplied its "suspicious" list to the DEA - by that time it was old news; many on the list had already been arrested.

The Times investigation and the resulting story are hugely incriminating. Big business making big money off of ... big business, when put into the context of the workers' compensation system.

The issues with opioids in workers' compensation are well known, the accounts well documented.

The harm to lives, families, business is huge.

The financial damage to workers' compensation payers is monumental, especially when tallying up the costs of unnecessary disability indemnity, drug rehab, lost production, medical bills, etc.

Suffice to say, the industry has probably supported, to its detriment, Purdue to the tune of billions of dollars, directly and indirectly.

Many states have sued and settled with Purdue, but those suits were based on the company's labeling misrepresentation.

Actively concealing damaging information for the sake of profits against the workers' compensation industry is another matter, however. (To be clear, there isn't evidence that workers' compensation was targeted, but certainly work comp was a huge victim.)

It seems to me, that the workers' compensation insurance industry (and self-insured employers along with them) have some leverage in the form of a class action lawsuit to recoup much of the damage Purdue caused by its fraudulent activity.

And it IS fraud! Knowingly concealing information that causes harm and damage to others is just as bad as misrepresentation.

Jack Crowley, who held the title of executive director of Controlled Substances Act compliance at Purdue and had spent decades at the DEA, told the Times, "Well, once we start to learn about it, we've got to report it. That's for sure."

Purdue didn't.

Pretty much a slam dunk to my jaundiced work comp "no fault" legal mind.

If any carrier wants a referral for a class action law firm, contact me..

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Opinion

Damned if you do . . .

THE Union of American Physicians and Dentists is outraged that a brainless bureaucratic boondoggle is again in the making, this time a federal proposal that physicians and pharmacists pay for the medical abuse of others.

The Drug Enforcement Administration, already deservedly under fire for making physicians fearful of prescribing legitimate medications to relieve pain, now also wants to prosecute doctors for *over-prescribing* painkillers. In California, meanwhile, the Medical Board of California wants to prosecute doctors for *under-prescribing* painkillers.

The current plan is to fund this dubious program by doubling the licensing fees for physicians, pharmacies, and manufacturers. The plan is attributed to the Bush administration. If that is so, then President Bush should scrap the plan and fire the bureaucrats and administrators who dreamed it up.

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Oakland

Reprinted from

JUNE 1983

on call

Valley West General Hospital

Robert Weinmann, M.D., 1983 president of the American Medical EEG Association and associate editor of its journal, *Clinical EEG*.

Neurodiagnostic Testing Primer

by Robert L. Weinmann, M.D.

A 40 year old patient states that he hasn't had a full night of sleep in over ten years and that he is always fatigued during the day. He insists that his situation is unique because he hasn't slept at all during this time. In short, he alleges dyssomnia (difficulty sleeping) with nocturnal insomnia (can't sleep at night) and diurnal somnolence (feels sleepy during the day). Is the patient to be dismissed as a "sleep hypochondriac" or can he be studied and treated? Typical disorders of sleep include excessive daytime sleepiness, enuresis, insomnia, narcolepsy, night terrors, somnambulism, and sleep apnea, which can be evaluated by polysomnography. A multichannel EEG machine is used along with nasal thermister, chest pneumograph, and ear-oximeter to measure O_2 saturation (Hewlett-Packard, $15,000).

In central or diaphragmatic sleep apnea, respiratory excursions of the diaphragm cease briefly and repeatedly during the night. In obstructive apnea chest wall movement continues but airflow at the nose and mouth ceases. Profound oxygen desaturation may occur. Commonly, patients with sleep apnea have both forms, mixed sleep apnea. These patients sleep poorly, have diurnal somnolence, and run increased cardiopulmonary risk during prolonged apneic spells.

Fig. 1 demonstrates obstructive apnea because chest movement (diaphragm) continues while airflow at the nose and mouth stops. Note the drop in Oxygen saturtion which may predispose the patient to cardiac arrhythmias.

Narcolepsy is characterized by the precipitous onset of sleep which may occur in awkward situations. In the EEG or sleep lab, monitoring of the patient reveals the unusually swift appearance of rapid eye movements (REM) along with absent chin electromyographic activity (EMG). Increased autonomic activity occurs. This stage of sleep is therefore called paradoxical. Figure 2 demonstrates REM sleep and displays REMs (arrow), absent EMG (double arrow), and EEG activity resembling drowsiness or early sleep (stage 1, rest of fig.).

More commonly employed studies are routine and sleep-deprived EEG. Sleep-deprivation is useful in preparing patients for EEG who are suspected of having complex partial seizures. Other activation techniques include hyperventilation, photic stimulation, and other procedures. EKG monitoring is often revealing where the differential is "seizure vs. syncope." Figure 4 shows complete asystole in a child with breath-holding spells. Compare figure 4 with fig. 3 which shows the same child, seconds before, with normal EEG and normal EKG.

Electromyography (EMG) helps delineate myopathies, neuropathies, radiculopathies, dystrophies, motor neuron disease, is especially useful in root irritation, myasthenia gravis, and in entrapment neuropathies such as carpal tunnel syndrome. Both nerve conduction velocity (NCV) and EMG may be neded in some clinical situations, e.g., the "double crush" syndrome where there is both entrapment and root irritation. Figure 5 shows a delayed conduction of the motor impulse in the median nerve (top trace) versus a normal conduction wave (bottom trace). This patient has a carpal tunnel entrapment neuropathy.

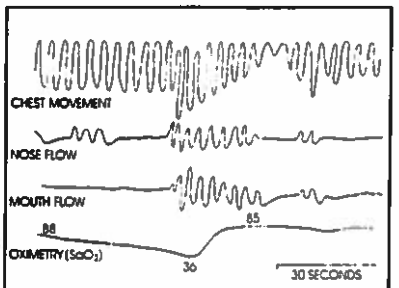

Figure 1 **Obstructive Apnea.** *Polygraphic tracing demonstrating continued chest wall movement cessation of airflow at the nose and mouth and profound oxygen desaturation.*

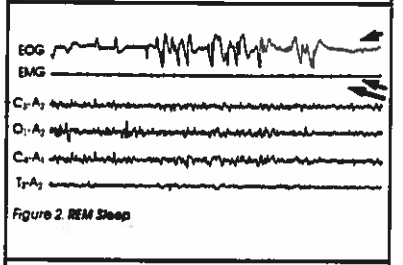

Figure 2. **REM Sleep**

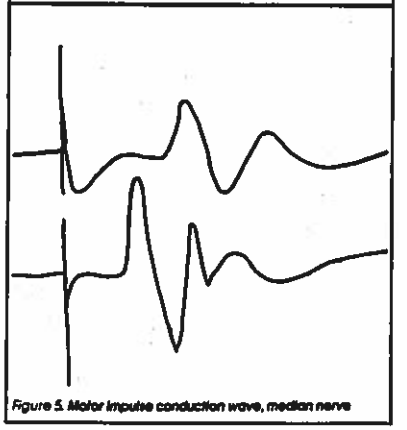

Figure 5. **Motor impulse conduction wave, median nerve**