

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: May 8, 2020

CLAIM NO. 199523317

KAREN NORRIS

PETITIONER

VS. APPEAL FROM HON. CHRISTINA D. HAJJAR,
ADMINISTRATIVE LAW JUDGE

FRANCISCAN HEALTH CARE CENTER/
FRANCISCAN ALLIANCE INC.
and HON. CHRISTINA D. HAJJAR,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
VACATING AND REMANDING

* * * * *

BEFORE: ALVEY, Chairman, STIVERS and BORDERS, Members.

STIVERS, Member. Karen Norris (“Norris”) appeals from the December 12, 2019, Opinion and Order of Hon. Christina Hajjar, Administrative Law Judge (“ALJ”) determining Franciscan Health Care Center/Franciscan Alliance, Inc. (“Franciscan”) is no longer liable for the medications Percocet and Avinza.

On appeal, Norris asserts Franciscan did not meet its burden of proving Percocet and Avinza were neither reasonable nor necessary for the treatment of her work-related injury.

BACKGROUND

The Form 101 alleged Norris sustained work-related injuries to her low back on May 25, 1995, in the following manner: “Claimant was lifting a patient when she had an onset of back pain.”

By Order dated November 18, 1996, Hon. J. Landon Overfield, Administrative Law Judge (“ALJ Overfield”) approved a settlement between the parties for a lump sum payment of \$2,846.01 based upon a 5% impairment rating. Norris’ entitlement to medical benefits was left open.¹

In a January 20, 2004, Opinion, Award, and Order, ALJ Overfield determined Norris’ condition had worsened and she is totally occupationally disabled.

In an order dated May 8, 2008, in response to a Medical Fee Dispute filed by Franciscan, Hon. James L. Kerr, Administrative Law Judge, determined, in part, that Franciscan shall remain liable for the medications Avinza and Hydrocodone but not Maxalt and Alprazolam.

On May 13, 2019, Franciscan filed a Motion to Reopen/Medical Fee Dispute expressing the nature of the dispute as follows: “Movant seeks relief from liability for all additional medical treatment. Alternatively, Movant seeks relief from future liability for prescription of Percocet, Avinza, Oxycodone, Zanaflex and all other opioid medications and relaxers.”

¹ We are unable to locate the Form 110 in the record.

Attached to the Medical Fee Dispute are several medical reports, including Dr. Leon Ensalada's October 5, 2017, Utilization Review report. After performing a medical records review, Dr. Ensalada answered, in relevant part, the following question regarding Norris' current medication regimen:

The current medication regimen is comprised of medicines prescribed for non-work-related conditions and medications prescribed for the May 25, 1995 injury of record related symptoms.

Medications prescribed for non-work-related conditions (and not covered under her Workers' Compensation coverage) include:

- 1) Bupropion (Wellbutrin): 100 mg twice per day.
- 2) Lorazepam (Xanax): 10 mg once per day as needed.
- 3) Rizatriptan (Maxalt): 0.5 mg three doses per day.

The following medications are predicated upon the work-related injury and are covered under her Workers' Compensation insurance:

- 1) Oxycodone 10 mg/acetaminophen 325 mg (Percocet), five doses per day which equates to a total oxycodone dose of 50 mg per day.
- 2) Morphine extended release (Avinza) 90 mg, two doses per day for a total daily morphine dose of 180 mg.
- 3) Tizanidine (Zanaflex) 4 mg, three doses per day.

The morphine equivalent dose (MED) resulting from the currently prescribed extended release morphine and oxycodone is 255 mg per day.

Chronic opioid therapy and chronic muscle relaxant therapy are neither medically necessary nor clinically appropriate for treatment of Ms. Norris' chronic pain syndrome and is not in accordance with updated evidence-based pain treatment guidelines, such as The Official Disability Guidelines (ODG) Pain Management

Guidelines. Of note, regarding chronic opioid therapy, there has been a change in the thinking regarding chronic opioid therapy for chronic non-cancer pain in the last 10 years.

Dr. Ensalada continued as follows:

Ms. Norris has no condition, based on objective diagnostic criteria, for which treatment with opioids is either reasonable or necessary.

There is no documentation of a treatment effect from the opioids (such as can be documented by a decrease in sequential numerical pain scores).

There is no documentation of objective functional improvement in conjunction with the chronic opioid therapy; rather, Ms. Norris has established a life predicated upon disability. She has not worked since May 25, 1995, now 22 years, 4 months and 10 days ago.

Importantly, continuing the chronic opioid therapy places Ms. Norris at risk of prescription opioid overdose death, a risk that is greatly elevated as a consequence of morphine equivalent dose (MED) of mg 255 per day and concurrent psychiatric illness for which is maintained on an antidepressant medication (bupropion/Wellbutrin) and a benzodiazepine medication (lorazepam/Xanax). Additionally, concurrent treatment with a benzodiazepine independently increases her risk of overdose. (emphasis in original).

If Ms. Norris is using the opioid as prescribed, she is probably experiencing opioid induced hyperalgesia (OIH), which means that the opioids are increasing (rather than decreasing) her perception of pain.

If Ms. Norris is using the opioid as prescribed, she is probably experiencing opioid induced androgen deficiency (OIAD).

In Ms. Norris's case, she has no condition for which treatment with chronic opioid therapy is either reasonable or necessary and the risks of continuing the chronic opioid therapy outweigh any benefits, real or perceived.

Finally, although Ms. Norris may have reported variable levels of relief in conjunction with opioids, and although her prescribers characterize her as 'stable' on these medications, her subjective report does not mean that the treatment is effective. When the outcome of a treatment is a person's subjective report, there are many potential explanations for a subjective report of relief, including the placebo response and regression to the mean. Many patients have reported symptomatic relief in conjunction with treatments that were proven to be worthless, for example, hysterectomy for the treatment of mood disorders in women and internal mammary artery ligation for the treatment of angina. Many of these treatments were, in addition to being worthless, were dangerous. Because a patient's self-report of satisfaction, or subjective report of relief, does not mean that a treatment is either safe or effective, treatments are subjected to testing such as randomized controlled double-blind studies and other epidemiological studies. As discussed above, the weight of the evidence from such studies indicates that chronic opioid therapy for chronic non-cancer pain is, at best, not effective and, at worst, deadly.

The ODG offers the following evidence based guidance referable to the employment of muscle relaxant medication for the treatment of pain:

Recommended non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain.

Ms. Norris is not receiving tizanidine (Zanaflex) for the short-term treatment of acute pain nor is she receiving tizanidine (Zanaflex) for the short-term treatment of acute exacerbations of chronic pain. Based upon the evidence and this fact pattern, tizanidine (Zanaflex) is neither reasonable nor necessary.

As requested, Dr. Ensalada provided a weaning schedule. Concerning

Norris' entitlement to future medical treatment, and he stated, in part, as follows:

Ms. Norris, similar to any patient, should not receive medical care that is not medically necessary or clinically appropriate. She should not receive medical care that is not medically necessary or clinically appropriate. She should not receive unproven treatments, such as chronic opioid therapy, which in addition to being unproven for chronic non-cancer pain, markedly increase her risk of overdose death.

Ms. Norris's current opioids and muscle relaxant should be tapered to abstinence. Once this is accomplished, she should be reevaluated, following which a medically necessary and clinically appropriate treatment plan can be devised.

By Order dated June 19, 2019, the ALJ sustained Franciscan's motion to reopen.

Norris filed the July 13, 2019, report of Dr. Gary Reasor, her treating physician. Dr. Reasor's report, solicited by the ALJ during a July 1, 2019, telephonic conference, states, in full, as follows:

Per your request during the telephonic benefit conference held on July 1, 2019, I have prepared this report. As you know, Mrs. Norris was injured in 1995 while working as a nursing assistant. Per her history, obtained at her first visit to my office on July 6, 2006, she related a history of suffering a herniated L1-2 disc when she was preventing a patient from falling.

She did not undergo surgery until 2002. At that time, she had a fusion at L1-2 by Dr. Richard Holt. The surgery required a lateral approach with a 12th rib resection. During the surgery the lumbar sympathetic chain was accidentally cut. Unfortunately, the surgery did not help, and she developed chronic left flank pain.

One year later it was discovered that she had a tethered spinal cord. She underwent conservative and injection therapy which was not successful in controlling her pain. In 2005 she had a tethered cord release by Dr. Greg Nazar. This did not resolve her pain either. She was then referred to my office for treatment.

Since then she has complained of significant pain around the hips and down the left leg. She developed left leg weakness requiring the use of a cane to aid in ambulation. Her pain distribution, which has been consistent throughout her treatment, is in the back, down the left leg to the foot and involves the left vaginal area as well. She described the pain at her first visit as burning and squeezing. This has not significantly changed and is representative of a nerve-injury generated pain.

At her first evaluation she reported that she had been placed on Avinza, a time release morphine preparation, and hydrocodone for breakthrough pain. In reviewing her paper charts, it shows that has been on the time release morphine since the 2006 visit. She has also been on Xanax since that time as well. She was on hydrocodone which was changed to Percocet in November 2006.

Unfortunately, the chronic pain that Mrs. Norris has suffered since at least 2002 has caused both anxiety and depression. She has remained, and, in my medical opinion, will remain disabled and unable to work in either a full or part time position. This would include sedentary positions as she reports exacerbation of pain with sitting, standing and walking.

The morphine dose remained stable until March of this year. At that time, I was able to reduce the dose from 90 mg twice a day to 60 mg twice a day. She was able to tolerate the decrease. Currently she is taking: (emphasis added).

1. Time release morphine 60 mg twice a day.
2. Percocet 10/325 every 4-6 hours
3. Xanax 0.5 mg three times per day
4. Wellbutrin SR 100 mg twice a day

At her last routine follow up, she reported 80% reduction in pain using the morphine and Percocet. This allows her to carry out her activities of daily living. The Xanax and Wellbutrin have been successful in treating the anxiety and depression that is caused by her chronic pain. (emphasis added).

Mrs. Norris and I have discussed other interventional therapy such a spinal cord stimulation. In fact, a trial of spinal cord stimulation was requested by me in 2008. It was, of course, denied at that time. My appeal of that denial fell on deaf ears.

My fear is that Mrs. Norris' workers' compensation carrier will continue in their attempts to have her medication denied. This is not the first time her medication has been challenged and always by the same method. Her records are reviewed by a physician who has neither seen nor treated her. This physician will recommend stopping all mediations as this treatment falls outside the ODG guideline. A legal challenge is then mounted to either stop or significantly reduce Mrs. Norris' care ignoring her physical and emotional condition.

I would hope that my 13 years of caring for Mrs. Norris would trump these attacks. If you have any additional questions or concerns, please contact me at your convenience.

The August 29, 2019 Benefit Review Conference Order and Memorandum lists the following contested issues: "The issues to be determined is the reasonableness and necessity of prescription medications: Percocet, Avinza, Oxycodone, Zanaflex, and all opioid medications and muscle relaxers."

Norris testified at the October 15, 2019, hearing. At the time of her work injury, Norris was working as a certified nursing assistant. Norris had to delay treatment of her injury because she was pregnant. She testified as follows:

A: Yes. I was injured in May '95, and my daughter was born January 7, '96, and we could not do the MRI until, like, mid January.

Q: What were the ultimate findings of the MRI?

A: I have a ruptured disc at L1 and 2, and then it's ran [sic] into arthritis and things later.

Q: There's also mention of a tethered spinal cord?

A: Yes. And I later found out that I have a tethered spinal cord.

Q: Now, how many surgeries have you had on your back?

A: Two.

Q: And those were by whom or when?

A: 2002 I had one by Dr. Richard Holt, I had a discectomy and fusion, L1 and 2, they took out my rib, made me a disc, and that was a very difficult surgery as well. In 2003, I had a tethered cord release from Dr. Gregory Nazar in Louisville, both surgeries were in Louisville. Both surgeries was [sic] pretty invasive.

Norris discussed the pain medications she was taking at the time of the hearing:

Q: Now, let's talk about your medications and the opioids and other prescriptions that are being given to you. And what pain medication do you take now?

A: I take Avinza, 60 milligrams twice a day, I take Percocet, ten milligrams every four to six hours as I need it, I also take Xanax, muscle relaxers, and – what else was it. I think that was it.

Q: The Percocet, can you tell us how long you've been taking it?

A: Well, Dr. Reasor put me on that after I started seeing him. I had been taking Hydrocodone, and he switched it because I was having so much pain.

Q: Now, when you say you were having so much pain, please describe where your pain was and the nature and frequency of it.

A: Low back, and it goes down my hips around to my vaginal area and mostly down my left leg and sometimes down my right. It just feels like I'm being squeezed.

That's the only way I know how to explain it. It's a lot of pressure.

Q: In your opinion, how did the effect of the Percocet compare to the effect of the Hydrocodone on your pain?

A: It helped.

Q: Now, how long have you been on the Avinza, the time released morphine?

A: It was after the fusion in 2002, it was after that, right after that.

Q: Have you remained on it since?

A: I have.

Q: Have you had discussions with Dr. Reasor about weaning yourself down or off of these medications?

A: Well, yeah, we talked about it, and we recently did that.

Q: What did you do as far as reducing dosage?

A: We went from Avinza 90 milligrams twice a day to 60 milligrams twice a day. It was very rough for the first week or two.

Q: Explain, please.

A: I was in bed quite a bit, I had to use my TENS unit a lot more, I have spasms, so it took an adjustment period for that.

Q: Has there been any reduction in your Percocet?

A: No.

Concerning her current level of pain, Norris testified:

A: The pain is constant. The pain medication does help in a sense that if I didn't have it, I would be in bed all the time. There's no question. But I do have it, you know, low back and into my hips, I have a lot of pelvic pain, I

have a lot of bladder issues due to the spinal cord. I have to go to the restroom anywhere from five to six times, sometimes more at night, so I don't even know what it feels like to sleep all night. It's been so long since that.

Q: Is the pain aching or stabbing; how would you describe it?

A: It's like a burning, squeezing. It just feels like if someone put something around your wrist, and they just pulled it as tight as they can, and then it runs down my legs and into my hips.

Q: If you still have this pain, why have you not asked the doctor to increase your medication level?

A: Well, I wished I didn't have to take it at all, so I just try to do the best on what I have. Really I haven't thought about asking for increasing.

Norris recounted her concerns regarding terminating the prescription medications in question:

A: Well, that would not be good. I would just have to be in bed because there's no other way I would be able to do that.

Q: If your prescription is continued but is not paid for by the insurance company, what effect would have on you?

A: That would be huge because I don't have any other insurance, I do have Medicare, don't have any other prescription plan, so there's no way I can afford that medication.

The ALJ's findings of fact and conclusions of law are set forth *verbatim*, in relevant part:

...

Norris was injured in 1995, while transferring a patient from a shower chair to a wheelchair. Treatment was initially delayed due to her pregnancy. She had surgery on her back in 2002 and 2003 with subsequent spinal injections. Norris has not worked since 1995, and now

receives Social Security Disability benefits. Norris takes Avinza twice per day, Percocet every 4-6 hours as needed, and Xanax. Prior to treating with Dr. Reasor, she was taking Hydrocodone for her pain, but Dr. Reasor switched it to Percocet. Norris has been taking the Avinza, time released morphine, since her surgery in 2002 and recently reduced the milligrams from 90 milligrams twice a day to 60 milligrams twice a day. It was rough for the first week or two. She had to use her TENS unit more, and she had spasms.

Norris has constant pain in her low back and hips with pelvic pain and bladder issues due to her spinal cord and issues sleeping at night. Following her injury, she developed anxiety and depression and has been on medication for those conditions off and on since her surgeries. She stated she takes the muscle relaxers off and on.

She presented with a cane to the hearing, which was prescribed by Dr. Reasor. She uses it more often than not. She stated if her prescriptions are not approved she will be in bed. She described she cannot work, as she cannot lift anything more than a gallon of milk. She described difficulty with bending, twisting, "anything physical," and even with her medication, her range of motion is pretty bad. Her inability to do these things has been consistent since the injury.

She stated that her husband hunts, and she goes once in a while, but it is difficult and she cannot stay very long. In the last three to four years she has gone very little if any. Her husband will take her all the way up the edge of the woods so she does not have to walk very far. She described sitting in a chair while squirrel hunting. Norris was presented with Facebook photos from 2008-2017. She admitted that the photos depicted her at deer hunting season, but stated that does not mean she is sitting in the woods 24 hours a day, seven days a week.

Work-relatedness

Although work-relatedness was not raised as an issue at the BRC, Defendant raised the issue in its Motion to Reopen, and asked for the BRC order to be amended to include the issue, citing a mistake. The ALJ disallowed the motion to amend, and thus, work-relatedness is not at

issue. Regardless, this ALJ finds Norris' condition to be res judicata. Norris underwent surgery, and later was found to have a worsening of condition, in part based upon the fact that her low back condition for which she underwent surgery was found to be due to the work injury.

Reasonableness and Necessity of Opioids

Dr. Reasor stated he has treated Norris for 13 years for her work injury. He recently reduced the dose of Morphine from 90 mg twice per day to 60 mg twice per day. She was able to tolerate the decrease. Her medications now include time-release morphine, Percocet, Xanax and Wellbutrin with Norris reporting 80% pain reduction with the use of Morphine and Percocet. The Xanax and Wellbutrin were successful in treating Norris's anxiety and depression caused by her chronic pain. Dr. Reasor recommended a trial of a spinal cord stimulator in 2008, which was denied both initially and on appeal.

This ALJ reviewed Dr. Best's and Dr. Ballard's reports, but finds them unpersuasive to the extent that they opined the medication were for conditions not related to the injury. However, this ALJ found Dr. Ensalada's report convincing. He opined that opioids are unproven for chronic non-cancer pain. Continuing the chronic opioid therapy of oxycodone(Percocet), morphine (Avinza) and tizanidine (Zanaflex) placed Ms. Norris at risk of prescription opioid overdose death, a risk that is greatly elevated as a consequence of a morphine equivalent dose (MED) of mg 255 per day. The concurrent treatment with a benzodiazepine independently increases her risk of overdose.

Dr. Ensalada also noted no documentation of objective functional improvement in conjunction with chronic opioid therapy. He thought she may be experiencing opioid induced hyperalgesia, which means the opioids are increasing rather than decreasing her perception of pain. He concluded the risks outweigh the benefits of continuing the opioids. Dr. Ballard agreed, noting that her narcotic medications are excessive, and that combining benzodiazepines with opioids was considered problematic and potentially could lead to fatal interactions. Dr. Best noted there was no objective

pathology that would justify the Percocet/Avinza, which he stated was highly addictive.

Although Dr. Reasor reported an 80% pain reduction with the use of Morphine and Percocet, he did not address the risks associated with continuing the medications, or the concerns raised by Dr. Ensalada and Dr. Ballard. Further, his report indicates that her dosage of Morphine was successfully reduced. She noted having spasms and needing to use the TENS unit more for two weeks, but the reduction was otherwise successful. This indicates to the ALJ that further efforts in reducing her medication could be successful. This ALJ is convinced that the continuation of the opioids is not reasonable and necessary, or compensable.

Reasonableness and Necessity of Zanaflex

Dr. Ensalada opined Zanaflex was not reasonable or necessary. It is recommended as a second-line therapy for short-term treatment of acute pain, but she is not receiving it for short-term treatment. Norris testified she uses it off and on to relieve spasms. This ALJ is not convinced that Dr. Ensalada's opinion rises to the level of proving the treatment is unreasonable or unnecessary. She testified she does not constantly use the medication, suggesting she may use it for acute pain rather than long-term treatment. Further, the ALJ is not convinced the medication is not generally accepted by the medical community or is unproductive. Thus, this ALJ finds Defendant has not met its burden, and the medication remains compensable.

Weaning

Dr. Ensalada recommended Norris taper off the opioid medication. He recommended a rapid tapering in a supervised inpatient setting for 3-5 days, followed by a six-week abstinence program with one visit per week with a medical doctor and psychologist with expertise in chronic pain syndromes and addictions psychology. Dr. Ballard agreed with Dr. Ensalada's recommendations for weaning. Dr. Reasor has not provided a weaning plan, but it was not raised specifically as an issue. The ALJ finds that the medication remains compensable for 90 days to allow for weaning pursuant to Dr. Ensalada's treatment plan, or pursuant to a schedule recommended

by Dr. Reasor within the 90-day period. Thereafter, the Percocet, Avinza, oxycodone, or other opioids are not compensable.

No petition for reconsideration was filed.

In contending Franciscan failed to meet its burden of proving Percocet and Avinza were neither reasonable nor necessary, Norris emphasizes that Dr. Reasor, who has been treating her for thirteen years, opined she has experienced an 80% reduction in pain with the use of her medications and reported no incidents of abuse. We vacate the ALJ's determination Percocet and Avinza are neither reasonable nor necessary and remand for additional findings. We point out Norris has not appealed the ALJ's determination regarding any other medications besides Percocet and Avinza.

ANALYSIS

The ALJ's analysis regarding the reasonableness and necessity of Percocet and Avinza evinces an incomplete understanding of the medical evidence. As an initial matter, the ALJ failed to incorporate into her analysis a key point made by Dr. Reasor in his July 13, 2019, a report she solicited. We acknowledge the ALJ noted certain key information provided by Dr. Reasor such as his reduction of Avinza from 90 mg twice a day to 60 mg twice a day, which Norris tolerated, and she reported an 80% reduction in pain with the use of Avinza and Percocet. However, the ALJ failed to incorporate into her analysis the critical fact that the 80% reduction in Norris's pain from Percocet and Avinza allows her to carry out her activities of daily living. This is consistent with Norris's hearing testimony indicating she would be in bed "all the time" but for the pain medication. This medical finding by Dr. Reasor is

particularly critical in light of the ALJ's reliance upon Dr. Ensalada's opinion that, there is no documentation of objective functional improvement in conjunction with Norris's opioid therapy, a conclusion that directly contradicts Dr. Reasor's finding that Norris' use of Percocet and Avinza allows her to carry out her activities of daily living.

We would be remiss if we did not point out that Dr. Reasor's report was written on July 13, 2019, two months after Franciscan filed its Medical Fee Dispute. Further, Dr. Reasor has acted as Norris's treating physician for thirteen years. In contrast, Dr. Ensalada's report, dated October 5, 2017, was generated nineteen months before the Medical Fee Dispute was filed, twenty-one months before Dr. Reasor's report, and after only performing a medical records review.

Finally, assuming, *arguendo*, Dr. Ensalada's opinion regarding a lack of objective functional improvement in conjunction with chronic opioid therapy was accurate, we believe the ALJ's reliance upon this statement would still be misguided. In Conley v. Super Services, LLC, 557 S.W.3d 917 (Ky. App. 2018), the Kentucky Court of Appeals emphasized that KRS 342.020(1) mandates that the employer shall pay for the cure **and relief** from the effects of the work-related injury. Citing National Pizza Co. V. Curry, 802 S.W.2d 949 (Ky. App. 1991), the Conley court recounted as follows:

[T]he words in KRS 342.020(1) "cure and relief" should be construed as "cure and/or relief." See KRS 446.080 and Firestone Textile Company Division, Firestone Tire and Rubber Company v. Meadows, Ky., 666 S.W.2d 730 (1984), which states that "[a]ll presumptions will be indulged in favor of those for whose protection the enactment [the Workers' Compensation Act] was made." *Id.* at 732. **Thus KRS 342.020(1) requires the employer of one determined to have incurred a work-related disability to pay for any reasonable and necessary medical treatment for relief**

whether or not the treatment has any curative effect.
(emphasis added).

Id. at 921.

Much like in the case *sub judice*, in Conley, the ALJ determined certain injections were “not reasonable nor necessary based upon Dr. Lewis’s opinion that there was no evidence of improved functioning and no documentation that the injections resulted in any decrease in pain medication for any period.” Id. The court determined the ALJ did not apply the proper standard in denying the injection, vacated that decision, holding as follows:

However, KRS 342.020(1) requires neither of these conclusions. “It is clear that KRS 342.020(1) places responsibility on the employer for payment of medical and nursing services that promote **cure and relief** from the effects of a work-related injury.... All that is required is that the services be for **cure and relief** of the effects of injury.” See *Bevins Coal Co. v. Ramey*, 947 S.W.2d 55, 56 (Ky. 1997) (emphases added).

Dr. Lewis’s UR report indicates that he reviewed Dr. Gutti’s April 7, 2017, progress note, which “highlights [that Conley] received greater than 50% relief of pain from the caudal epidural steroid injection in March. [He] reported good relief with the radicular component of pain and the residual pains were tolerable on medications.” Prior to the injection, Conley had suffered intractable back pain despite his many medications according to Dr. Gutti’s office notes, which Conley filed as evidence. We cannot consider or imagine any evidence more compelling that a procedure is reasonable and necessary for the “cure and relief from the effects of an injury” than one which actually affords relief from the devastating misery of intractable pain. We agree with Conley that the ALJ did not use the proper standard in denying the epidural injection, and to that extent, we vacate the Board’s opinion.

Id. at 921-922.

We question whether medications that provide an 80% reduction in Norris's pain, despite one of these medications (i.e. Avinza) being reduced by one third, fails to meet the "relief" criteria of KRS 342.020(1). Nevertheless, we are remanding the claim to the ALJ for a renewed analysis of this issue. On remand, the ALJ cannot attach any weight to Dr. Ensalada's incorrect statement regarding a lack of documentation of objective functional improvement in conjunction with the use of chronic opioid medication, as this statement was directly contradicted by Dr. Reasor. In her renewed analysis, the ALJ must also demonstrate an understanding of the tenets articulated in Conley - i.e. contested medical care need not have a curative effect in order to be compensable under KRS 342.020(1); rather, relief from the effects of the injury is sufficient.

We are cognizant that Norris did not file a petition for reconsideration. However, as articulated by the Court of Appeals in All Professional Tree Service v. Richard Pennington, 2009-CA-002092-WC (Not to be Published, 2010), a claimant is entitled to have his or her claim decided with a correct understanding of the record. A claimant need not file a petition for reconsideration in order to have the ALJ's incorrect understanding of the record remedied. Further, as in the case *sub judice*, where there is a mixed question of law and fact, this Board's standard of review is *de novo*. See Bowerman v. Black Equipment Co., 297 S.W.3d 858 (Ky. App. 2009). "When considering questions of law, or mixed questions of law and fact, the reviewing court has greater latitude to determine whether the findings below were sustained by evidence of probative value." Uninsured Employers' Fund v. Garland, 805 S.W.2d 116

(Ky. 1991). Therefore, a petition for reconsideration in this specific case was unnecessary.

We also acknowledge the ALJ's rejection of Drs. Best and Ballard as being "unpersuasive to the extent that they opined the medication were for conditions not related to the injury" and find this determination by the ALJ to be sound.

Finally, this Board notes that Franciscan's Medical Fee Dispute contested Percocet, Avinza, Oxycodone, Zanaflex and all other opioid medications **and relaxers**. The ALJ recognized this on page 2 of her decision. The ALJ determined Percocet, Avinza, oxycodone, and "other opioids" are non-compensable. She determined the muscle relaxer Zanaflex is compensable, but she did not address the other muscle relaxers. This omission was not contested by either party in a petition for reconsideration or on appeal. Therefore, Franciscan remains liable for all other work-related muscle relaxers.

In sum, on remand, the ALJ must engage in a new analysis of the reasonableness and necessity of Percocet and Avinza. In doing so, while the ALJ may once again rely upon Dr. Ensalada, the ALJ cannot rely upon his erroneous statement that there is no documentation of objective functional improvement in conjunction with the use of opioid medication. This statement is factually incorrect in light of Dr. Reasor's July 13, 2019, report. Further, in her renewed analysis on remand, the ALJ must consider the principles set forth in Conley as recited herein, particularly in light of the timing of Dr. Ensalada's report not only with respect to the date the Medical Fee Dispute was filed but also with respect to when Dr. Reasor issued his report.

Accordingly, the ALJ's determination Percocet and Avinza are neither reasonable nor necessary for the treatment of Norris's work-related injury as set forth in the December 12, 2019, Opinion, Order, and Award is **VACATED**. This claim is **REMANDED** to the ALJ for additional findings in accordance with the views set forth herein. Further, in an amended order and award, the ALJ shall find all other work-related muscle relaxers to be compensable.

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