

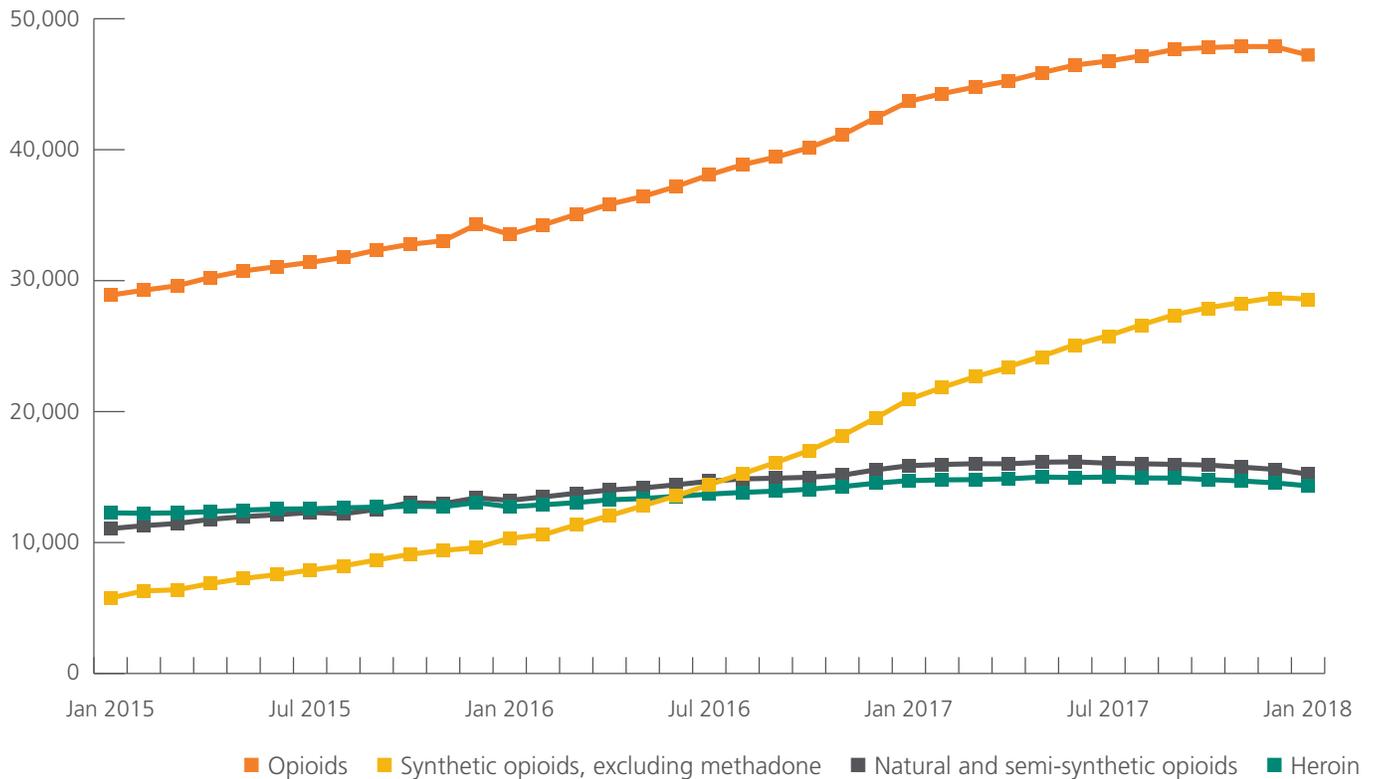


## Addressing opioid analgesic use in workers' comp and auto no-fault



# Challenges with opioid analgesics

Number of Drug Overdose Deaths by Drug or Drug Class



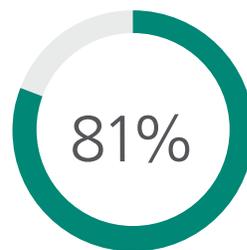
Preliminary report from the CDC 2018



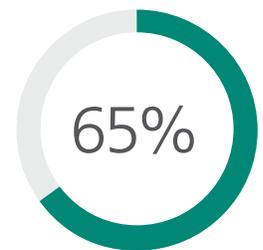
The U.S. consumes more than:



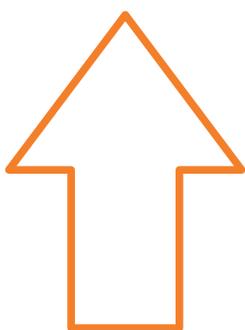
of the world's hydrocodone (Vicodin)



of the world's oxycodone (OxyContin, Percocet)



of the world's hydromorphone (Dilaudid)



Opioid overdoses increased **30%** from July 2016 through September 2017 in 52 areas in 45 states



**\$635 billion** in annual costs for medical treatment and lost productivity



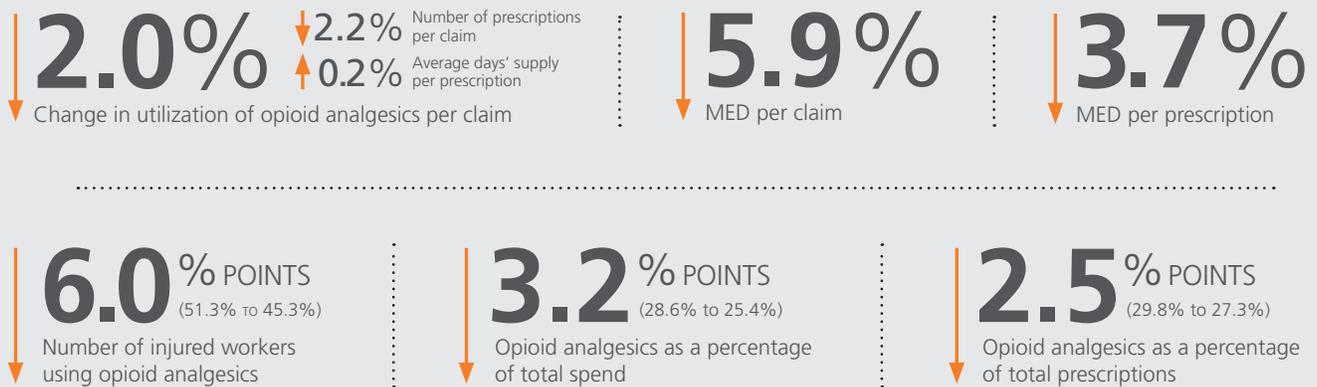
In 2016, **2 million Americans** had an addiction to prescription or illicit opioids

## Working together achieves healthier outcomes

Despite the challenges, across the healthcare industry multi-faceted efforts to reduce opioid use are underway by many stakeholders. State-based formularies, national treatment guidelines, limits on morphine equivalent doses (MED), and opioid quantity limits are all influencing how we treat pain and these combined influences are improving outcomes.

The workers' compensation and auto no-fault division of Optum has also been working hand-in-hand with our clients and public policy makers to continue efforts to manage pain treatments and corresponding use of opioid analgesics. As a result of this effort, a multi-year trend of declining opioid utilization continues. Fewer claimants are using opioid analgesics and because of that the associated MEDs continue to follow a downward trajectory. In recent years, work by state regulators and legislators throughout the country has similarly brought about system change.

### Optum workers' compensation and auto no-fault data: January - June 2018



## Opioid analgesic use in workers' comp and auto no-fault

Use of opioid analgesics has been under scrutiny by stakeholders throughout the system due to thousands of overdoses and deaths stemming from opioid overuse, misuse and abuse. In 2016, the Centers for Disease Control and Prevention (CDC) released opioid use guidelines suggesting non-opioid alternative therapies as first-line treatment along with limited opioid analgesic use, typically less than seven days for initial therapy of most acute injuries. In addition, the CDC recommends opioid analgesic therapy not escalate above 90 morphine milligram equivalents (MME) if needed. Employing routine, random urine drug testing and reviewing prescription drug monitoring programs (PDMPs) to assist in managing opioid therapy are also encouraged.

Similar state-based guidelines have begun to take effect in some states and are in development in other jurisdictions. These state-based versions contain provisions designed to reduce the prescribing of opioid analgesics while increasing awareness among healthcare providers and patients about risks associated with opioid use. Other common themes include requirements such as reporting all prescriptions to state PDMPs, establishing treatment protocols or plans and requiring better medical documentation. Some provide clearer definitions of acute pain compared to chronic pain, thus better focusing opioid prescribing and dispensing to certain times in the claim lifecycle. Adherence to PDMP reporting protocols is also a best practice and mandated in nearly every state.

Often, adopted legislation in each state applies to the broader healthcare market and is not specific to the prescribing of opioids in the workers' compensation and auto no-fault systems. However, fully understanding the varying nuances of each state's requirements gives adjusters, claimants and physicians stronger tools and insight to better address the treatment of pain and to more effectively manage opioid analgesic utilization.

Evidence-based medical guidelines offer another level of assistance. Some assert the sole use of opioid analgesics for chronic pain should be avoided, especially in the case of chronic, non-cancer pain. According to the Official Disability Guidelines (ODG), opioid analgesics are not recommended as first-line treatment for chronic, non-cancer pain, neuropathic pain or in claimants at high risk for misuse, diversion or abuse. And while ODG states there is limited evidence supporting use of opioid analgesics for low back pain, it highlights use should be limited to treatment of acute pain. Long-term (greater than 16 weeks as defined by ODG) efficacy, however, is unclear. For treatment transparency and as a form

Opioid abusers generate, on average, annual **direct health care costs 8.7 times higher** than non-abusers

of informed consent, the use of a medication agreement between prescriber and claimant outlining the benefits, risks of opioid use, as well as the consequences for misuse or abuse of opioid analgesics or other medications is considered a best practice. Also, a claimant's failure to respond to a time-limited course of opioid analgesics suggests that reassessment and consideration of alternative therapy is appropriate. Behavioral therapy should also be evaluated, and potentially utilized, for chronic pain unrelieved by other treatment approaches.

Even with evidence that use of opioid analgesics in chronic, non-cancer pain may not have the benefits once believed, in our experience, opioid analgesics continue to have a place in treatment for pain. One such place is in managing moderate to severe acute pain, which is often attributed to accidental trauma, surgery, and occupational or other injury, much like what we manage in workers' compensation.

### What are opioid analgesics?

Opioid analgesics are a class of medications used to relieve pain. They are generally classified according to their chemical makeup, whether they are from natural, synthetic or semi-synthetic sources. They are also grouped according to the duration of action on the body, typically as short-acting (immediate-release) or long-acting (extended-release) opioid analgesics.

- A **short-acting opioid analgesic** is one with an onset of action in the body typically within 30 minutes and a duration of action from four to six hours, although these times are determined by, to a large extent, the individual person's make up. Short-acting opioids may be useful in the management of acute and breakthrough pain (an acute pain exacerbation often caused by some added stimuli or change in normal routine).
- **Long-acting opioid analgesics** are designed to provide baseline pain control through slow release in the body, typically over eight hours or longer and, in the case of topical patches, up to several days (review the specific package inserts for details on particular medications). By providing baseline pain control, long-acting opioid analgesics are typically used to provide continuous pain relief, reducing the claimant's need to take multiple doses of medication per day.

Roughly

21 to 29%

of claimants prescribed  
opioids for chronic pain  
misuse them

## Our perspective

- While certain workers' comp and auto no-fault injuries such as muscle injury or joint pain due to overuse are generally best treated using non-opioid analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs) and acetaminophen, opioid analgesics are considered a medication choice in claimants experiencing pain not adequately relieved by these and other first-line, non-pharmacological treatments.
- In situations where opioid analgesics are necessary to treat chronic, non-cancer pain, clinical guidelines further suggest utilization of one long-acting opioid analgesic for around-the-clock pain control. Some claimants may require use of one short-acting opioid analgesic for breakthrough pain; however, appropriate selection and dosing of long-acting opioids should result in the minimal use of short-acting opioids.
- Taking short-acting opioid analgesics often result in higher peak blood concentration levels causing more cognitive-type side effects such as drowsiness or euphoria. Since the effects of short-acting opioids only last a few hours, multiple doses per day may be needed for pain relief. This constant fluctuation of blood levels may cause further pain facilitation, erratic development of tolerance, hyperalgesia and a greater risk of addiction. Long-acting opioid analgesics, on the other hand, typically provide steady concentrations in the body, reducing fluctuations and thereby providing more continual and constant pain control at lower doses.

In all situations, the key is making certain opioid analgesics are not only the right medication for the claimant and their injury, but also prescribed at the right time, in the right dose and for the right duration with ongoing management and monitoring to ensure clinical safety and efficacy of care. As with most medication therapy regimens, using the lowest possible dose for the shortest duration of time is a best practice in opioid therapy management. Use of non-medication therapy, including physical or occupational therapy and home exercise programs may also be an appropriate first-line therapy approach to acute injuries. Furthermore, the benefits of therapy must outweigh the risks.

**Throughout the claim, the PBM provides payers with pharmacy care services which allow them to experience even greater value from their program from first fill to claim resolution and/or settlement.**

### MANAGING PHARMACY BENEFITS STARTS WITH THE NETWORK

The importance of driving transactions in network remains paramount as pharmacy costs approach 20 percent of overall medical spend. The workers' comp and auto no-fault pharmacy network helps payers to:

- Lower pharmacy costs with network discounts applied to in-network transactions
- Reduce bill processing fees and other administrative inefficiencies
- Increase access to pharmacy data

### ONCE A PRESCRIPTION IS IN-NETWORK, YOU CAN ADDRESS UTILIZATION

Beyond the lower costs, increased network penetration allows payers to

- Become better equipped to holistically manage the claim
- Improve the safety and efficacy of the claimant's medication therapy
- Provide better clinical management throughout a claimant's care

This combined with network enforcement capabilities, electronic adjudication, program business rules, drug utilization review criteria and injury-based formularies, payers can begin to see how better pharmacy management can influence overall medical spend, a claimant's functional restoration and/ or return to work and their overall health status.

To this goal, we have designed our products and services to mitigate the risks associated with opioid analgesic use. Our comprehensive utilization management strategies include:

- Emphasis on prevention from the first fill, because it is always more difficult to change behavior or therapy regimens after-the-fact.
- Limit utilization of long-acting opioid analgesics to 90-days post injury, helping to reduce escalating doses and long-term use.
- Utilize clinical alerts to inform claims professionals of escalating opioid utilization and MEDs as well as other medication regimens not consistent with the injury.
- Meld data with clinical expertise to provide insight into prescription use and prescribing practices, and guiding intervention efforts.
- Educate prescribers and claims professionals on the risks and benefits of using opioid analgesics through clinical letter programs, continuing education, and other tools and resources.
- Stress the importance of collaborative, goal-oriented, multidisciplinary care plans.
- Recognize the utility of PDMPs.
- Recommend the use of medication agreements, especially when a prescriber is treating chronic, non-cancer pain.
- Leverage technology to facilitate timely, secure communication for claim management.

For more information email us at [expectmore@optum.com](mailto:expectmore@optum.com).

## MANAGING PHARMACY UTILIZATION OFTEN REQUIRES CHANGE

The ability to measure pharmacy activity allows PBMs and payers to act when the medication therapy regimen presents a concern. To recommend and help implement these changes as early in the claim lifecycle as possible, PBMs employ a variety of outreach tools to facilitate multi-disciplined care coordination and information sharing including:

- Pharmacist reviews
- Specialty-matched peer-to-peer evaluations
- Drug testing and monitoring

When done correctly, this collaborative effort can have a dramatic effect: claimants receive the right medication at the right time, in the right dose and for the right duration.

## THE MORE YOU KNOW, THE GREATER YOUR INFLUENCE

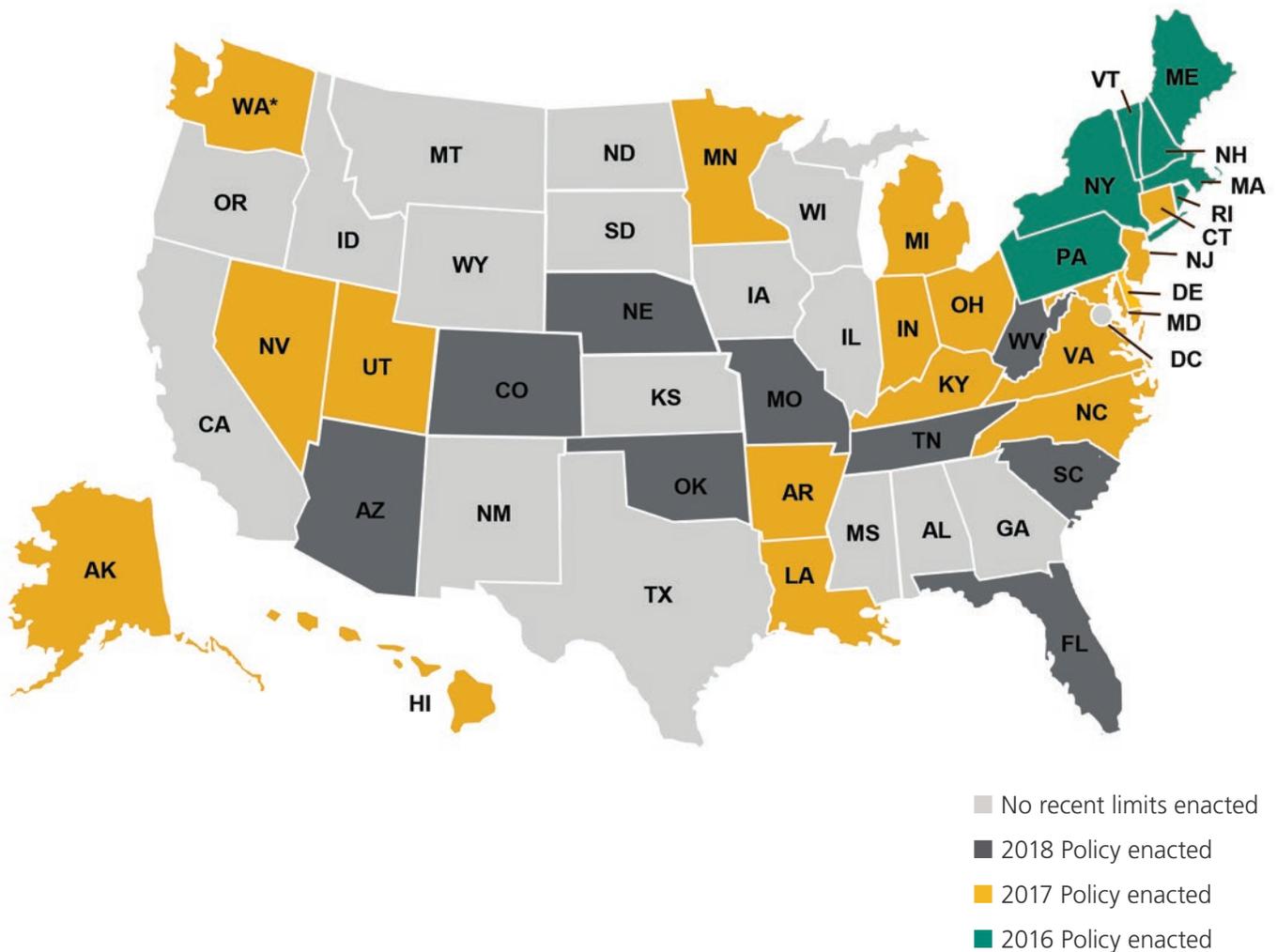
With cost and utilization management tools in place, the PBM continues to encourage and empower claims management professionals to take more proactive approach with their claims resources including:

- Continuing education programs
- Interactive resource guides, white papers and other educational tools
- Statistical analysis of claimant data

All of these help payers dissect and better understand pharmacy and its influence on claim outcomes. Plus, as data and analytics pair with clinical expertise, payers intervene earlier in the claim lifecycle leading to lower costs, increased administrative efficiency, shorter claim duration, and safer, more appropriate care.

# Legislative updates impacting opioid analgesic utilization and control

In the past five years, there has been increased legislative and regulatory activity to help curb opioid utilization. Whether direct changes to the medical/pharmacy practice acts to further restrict opioid prescribing to state specific workers' compensation efforts such as formularies and treatment guidelines, the efforts continue in hopes of slowing the opioid epidemic. The following pages highlight the most recent opioid policy activities by state. The following map identifies states which have implemented initial opioid prescribing limits.



Data – Reflects Legislation/Regulation enacting initial opioid prescribing limits.  
Note – Initial days supply limits can vary across jurisdictions and treatment facilities.  
Current as of July 2018.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Alaska [HB 159](#)

Effective July 25, 2017

- Prohibits licensed prescribers from issuing any initial prescription for an opioid analgesic exceeding a seven-day supply to an adult patient for usage, with exceptions.
- Prescribers permitted to issue an opioid analgesic exceeding a seven-day supply for management of chronic pain (and other conditions) as long as condition triggering the prescription is well documented in patient's medical record.
- Reduces state PDMP reporting time frame from weekly reporting to a daily reporting requirement.

### Arizona [Regulation](#)

Effective October 1, 2016

- Industrial Commission adopts ODG Chronic Pain and Opioid Treatment Guidelines.
- Urges prescribers to follow recommended ODG treatment guidelines.
- Payers to consider guidelines before denying care.
- Applies only to medical treatment or services occurring on or after effective date.

### Arizona [SB 1001](#)

Effective April 26, 2018

- Limits initial prescriptions for a Schedule II opioid to not more than a five-day supply, except for an initial prescription following a surgical procedure which is limited to not more than a 14-day supply and other end-of-life conditions.
- Prescribers issuing a new prescription for a Schedule II opioid shall not exceed 90 MMEs per day except for continuation of a prior prescription order issued within the previous 60 days and other end-of-life conditions.
- If a prescriber believes treatment requires a daily dosage in excess of 90 MME they must first consult with a physician who is licensed in pain treatment, and the provider shall also prescribe an opioid antagonist if opioid treatment exceeds 90 MMEs.
- Requires pharmacists to register with the State Board of Pharmacy and secure access to the state PDMP program and prior to dispensing any CII must obtain a PDMP report.

### Arizona [SB 1111](#)

Effective July 21, 2018

- Applies prescribing restrictions of Senate Bill 1001 to workers' compensation claims. Adds additional reporting requirements to providers who are treating and prescribing opioids to injured workers – including but not limited to – justifying use of the controlled substance, performing a physical examination of the injured employee, conducting a substance abuse risk assessment and securing informed consent from the injured employee for opioid treatment.
- Prescribers must also produce a treatment plan which includes – among other provisions – a medication treatment agreement, the frequency of face to face visits to re-evaluate continued opioid usage, criteria and procedures for tapering or discontinuing opioid treatment and procedures for offering or referring employee for treatment for dependence on or addiction to opioids.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Arkansas [SB 339](#)

Effective April 4, 2017

- Authorizes various boards of medicine and other prescriber licensing boards to promulgate rules limiting the amount of schedule II narcotics that can be prescribed and dispensed by licensees of the board. Includes ability to establish an initial prescribing limitation for acute pain.
- Requires prescribers to check the state PDMP when prescribing (every time) an opioid from Schedule II or Schedule III and a when prescribing a benzodiazepine medication for the first time to a patient.

### Arkansas [Regulation](#)

Effective July 1, 2018

- Implements workers' compensation specific opioid prescribing restrictions and MED levels for all claimants with a date of injury on or after July 1, 2018.
- Restricts initial prescription for opioids to a five-day supply and shall not exceed 50 MED per day without prior authorization. Restricts subsequent opioid prescriptions to a maximum 90-day supply and not to exceed 50 MED per day without prior authorization.
- For continued opioid usage beyond 90 days, prescriptions shall not exceed 50 MED without prior authorization but cannot exceed 90 MED and shall not exceed a 90-day supply.

### California [Regulation](#)

Effective July 28, 2016

- Adopts revised existing MTUS [medical treatment utilization schedules (treatment guidelines)] for chronic pain.
- Adopts new opioid MTUS for utilization of opioids, which sets recommended maximum levels of 80 MED and requires prescribers to conduct semi-annual attempts to wean claimants who exceed the 80 MED dosage.

### Colorado [SB 22](#)

Effective May 21, 2018

- Limits prescribing of an opioid to treat pain to no more than a seven-day supply when prescribed to a claimant who has not had an opioid prescription in the last 12 months by current prescriber. The prescribing limits do not apply if in professional judgment of prescriber patient:
  - Experience chronic pain which typically lasts more than 90 days past normal time of healing
  - Has been diagnosed with cancer and is experiencing cancer related pain
  - Is experience post-surgical pain that, because of the nature of procedure, is expected to last more than 14 days
  - Is undergoing palliative care or hospice care focused on relief of pain from a serious illness
- Requires providers, prior to prescribing second fill of any opioid prescription, to comply with elements of state PDMP program for reviewing and reporting information. The bill also enhances data requirements for the state PDMP program and permits properly licensed providers to prescribe opioids electronically.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Connecticut [HB 5053](#)

Effective January 1, 2017

- Restricts issuing of an initial prescription for an opioid analgesic to more than a seven-day supply.
- Provides exemptions for cancer treatment and professional judgment of physician; however, this must be documented in patient's file.
- Any provider who prescribes more than 72 hours of a controlled substance, other than a Schedule V non-narcotic controlled substance, shall review the state PDMP.
- Enhances reporting requirements for pharmacies to the state PDMP program from 24 hours to the "next business day".
- Requires training for municipal first responders in utilization of naloxone, in case of an overdose, and provides protection for first responders from civil penalties.

### Delaware [Regulation](#)

Effective April 1, 2017

- Limits first time prescriptions of an opioid analgesic to treat acute pain to no more than a seven-day supply unless in prescriber's professional judgment the medical condition requires additional treatment. Prescriber shall query the state PDMP program and document reasoning in patient's medical record.
- For subsequent prescriptions of an opioid analgesic to treat acute pain after the first time seven-day supply, prescribers are required to first perform an appropriate evaluation of patients' medical condition, query the state PDMP, administer a drug test (at prescribers discretion), conduct a physical examination and obtain a signed Informed Consent Form from patient.
- When treating a patient for chronic pain using an opioid analgesic, prescriber shall complete all requirements indicated for using opioid analgesics to treat acute pain and shall query the PDMP at least every six months, administer a drug test at least once every six months, obtain a signed Treatment Agreement and conduct a risk assessment.
- The regulation provides certain exemptions from the acute and chronic pain treatment protocols for end-of-life, cancer and palliative care.

### Florida [HB 21](#)

Effective July 1, 2018

- Limits prescriptions for Schedule II opioids to treat acute pain to a three-day supply with certain exceptions for up to a seven-day supply. Limits dispensing providers to the same acute pain treatment requirements.
- Defines acute pain and chronic pain, for treatment purposes, and includes requirements for prescribers who exceed three-day supply to treat acute pain to indicate on the prescription "Acute Pain Exception", and requires prescribers treating pain other than acute pain to indicate on the prescription "Non Acute Pain."
- Requires co-prescribing of an opioid antagonist for treatment of pain related to a traumatic injury with a Severity Score greater than nine.
- Enhances existing PDMP reporting requirements for both prescribers and pharmacies.

### Hawaii [SB 505](#)

Effective July 1, 2017

- Initial concurrent prescriptions for opioid analgesics and benzodiazepines shall not be longer than seven consecutive days unless under a special exemption with supporting documentation. Prescribers authorizing subsequent prescriptions shall consult patient in person at least once every ninety days during subsequent treatment.
- Providers authorized to prescribe opioid analgesics (effective July 1, 2018) shall adopt and maintain a written policy to include execution of a written agreement and informed consent for treatment process between prescriber and patient. This agreement is required if patient requires opioid analgesics for greater than three months, is being prescribed benzodiazepines and opioid analgesics together, or is being prescribed opioid analgesics exceeding 90 morphine equivalent doses (MED).

## **Hawaii [SB 2244](#)**

Effective July 9, 2018

- Requires – as of July 1, 2019 – providers who prescribe opioids for WC claimants to include documentation of a written treatment agreement when utilizing opioids to treat pain.
- Limits initial concurrent prescriptions for opioids and benzodiazepines for no longer than a seven-day supply for qualifying injured employee(s).

## **Indiana [SB 226](#)**

Effective July 1, 2017

- Limits initial opioid prescriptions – for first time by prescriber – to not exceed a seven-day supply.
- Provides exemptions to the days-supply limitation for treatment of cancer, palliative care and medication assisted treatment for substance abuse disorder.
- Permits prescriber to exceed the seven-day supply if prescriber believes in their professional judgment the treatment is necessary which shall be documented.
- Permits a dispensing pharmacist to provide a partial fill of an opioid upon request of patient and requires pharmacist to document that patient was given a partial fill of the prescription upon request.

## **Kentucky [HB 333](#)**

Effective July 1, 2017

- Prohibits prescriptions for Schedule II drugs intended to treat pain as an acute medical condition to exceed a three-day supply (with certain exceptions such as chronic pain and end-of-life care).
- Requires the state's Office of Drug Control policy and each licensing (prescriber) board(s) to adopt rules addressing prescribing of Schedule II opioids when treating both chronic and acute pain.
- For the purposes of pharmacy dispensing, medical necessity for a Schedule II controlled substance as documented by practitioner in patient's medical record and the prescription for more than a three-day supply of that controlled substance are presumed to be valid.

## **Louisiana [HB 192](#)**

Effective August 1, 2017

- Limits initial prescriptions for an opioid analgesic for treating acute pain to a seven-day supply. Permits physician to prescribe more than a seven-day supply if in the professional medical judgment, more than a seven-day supply of an opioid is required to treat the adult or minor patient's acute medical condition. Requires prescriber to document, in patient's medical record, the condition triggering need for more than a seven-day supply.
- Requires prescriber to consult with patient regarding quantity of opioid being prescribed and patient's option to fill at a lesser quantity and practitioner must inform patient of risks associated with using opioids. Pharmacists are also authorized to fill opioid prescriptions at lesser amounts if requested by patient.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Maine [LD 1646](#)

Effective July 28, 2016

- Imposes a seven-day prescribing limit on opioid analgesics when used to treat acute pain and a 30-day prescribing limit on opioid analgesics when used to treat chronic pain while recognizing certain medical condition and end-of-life treatment exemptions.
- Requires prescribers to check the state PDMP every 90 days when prescribing opioid analgesics and for the initial prescription of any opioid analgesic or benzodiazepine.
- Requires dispensing pharmacies to check the PDMP if person presenting a prescription for an opioid analgesic is not a resident of Maine, is paying cash for the prescription, or has not filled a prescription for an opioid analgesic or benzodiazepine in the last 12 months.

### Maryland [HB 1432](#)

Effective May 27, 2017

- Requires providers who are treating a patient to prescribe lowest effective dose of an opioid and a quantity that is no greater than quantity needed for expected duration of pain severe enough to require an opioid that is a controlled substance.
- Allows exemptions for opioids prescribed for substance-related disorder, cancer, palliative and end-of-life care.
- When treating chronic pain, dosage of opioids prescribed should be of a duration that is based upon evidence-based clinical guideline(s) for prescribing a controlled substance that is appropriate for the delivery setting, the type of care being provided and age and health status of patient.

### Massachusetts [HB 4056](#)

Effective December 1, 2016

- Limits prescribing time frame for an initial prescription of any opioid analgesic to seven days and provides exemptions for prescribers' professional judgment, cancer related care and palliative care. Exceptions should be documented in patient's medical record.
- Requires prescribers in certain circumstances to engage in addiction risk assessment of the patient and have patient sign an opioid treatment agreement prior to prescribing of an opioid analgesic.

### Michigan [SB 274](#)

Effective July 1, 2018

- Limits opioid prescriptions to treat acute pain to a seven-day supply within a seven-day period.
- Defines both acute and chronic pain for application of prescribing requirements.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Minnesota [SB 2](#)

Effective July 1, 2017

- When used for treatment of acute dental pain or acute pain associated with refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II through IV shall not exceed a four-day supply.
- Quantity prescribed shall be consistent with dosage listed in the professional labeling for the drug that has been approved by the United States Food and Drug Administration.
- "Acute pain", defined as pain resulting from disease, accidental or intentional trauma, surgery, or another cause reasonably expected to last only a short period of time. Acute pain does not include chronic pain or pain being treated as part of cancer care, palliative care, or hospice or other end-of-life care.
- Prescriber, in their professional clinical judgment, may provide more than a four-day supply of restricted medications and may issue a prescription for quantity needed to treat such acute pain.

### Missouri [SB 826](#)

Effective August 28, 2018

- Limits initial prescription(s) of opioid controlled substances upon initial consultation with patient for treatment of acute pain to a seven-day supply.
- Subsequent consultations and prescriptions for same pain are governed by existing state law (CII allowed 30 day supply).
- Provides a definition of acute pain.

### Nevada [AB 474](#)

Effective January 1, 2018

- Limits initial prescriptions for a controlled substance (Schedule II – Schedule IV) for treatment of pain to more than a 14-day supply and limits to no more than both the days-supply and a 90 MME daily dosage if medication is an opioid. Prescribers can exceed quantities if it is documented in medical record of patient including reasons for prescribing quantity provided.
- Imparts additional requirements for providers who treat chronic pain, including before prescribing a Schedule II – Schedule IV for treatment of pain to a patient who has utilized a Controlled Substance for more than 90 days, prescriber must perform a risk assessment test, conduct an investigation into source of pain and meet patient in person. If the patient has been prescribed opioids in excess of 90 MME daily dosage prescriber must develop and document a treatment plan and consider referral to a pain specialist.
- Requires that prescribers issuing an initial prescription for a Schedule II – Schedule IV controlled substance shall obtain a report from the state PDMP.

### New Hampshire [Regulation](#)

Effective January 1, 2017

- Prior to prescribing an opioid analgesic for treatment of acute pain a prescriber must conduct a physical examination of patient, complete a board approved risk assessment tool, provide a written rationale for opioid usage and utilize a written consent form acknowledged by patient. Prescribers are not to exceed a seven-day supply of opioid analgesics.
- Prior to prescribing an opioid analgesic for treatment of chronic pain, prescribers shall also complete the same requirements for treating acute pain and shall prescribe lowest effective dose for a limited duration. Certain terminal illnesses are excluded from these treatment provisions.
- Prescribers must register with state PDMP and prior to initial prescribing of any Schedule II, III or IV opioid(s) must query system. When managing chronic pain, prescribers are required to query system no less than twice a year.

## A recap of regulatory and legislative activity addressing opioid analgesics

### New Jersey [SB 3604](#)

Effective January 16, 2018

- Makes changes to opioid prescribing restrictions put in place by SB 3 in 2017.
- Creates a definition of chronic pain and requires prescribers to discuss risks of opioid usage with patients and engage in pain management agreements where deemed necessary.
- Requires providers to access state PDMP program for a patient report when prescribing the first Schedule II opioid or any Schedule III – Schedule IV benzodiazepine or when prescribing an opioid or benzodiazepine for any new patient.

### New Jersey [SB 3](#)

Effective May 16, 2017

- Limits an initial prescription of opioids for acute pain to a five-day supply.
- Requires use of lowest effective dose possible.
- Prior to prescribing a Schedule II medication, practitioner should document patients' non-opioid pain therapy history, including non-pharmacological treatments.
- Practitioner should document any past substance abuse history and check the Prescription Monitoring Program for opioid use history.
- For opioid use beyond five days, practitioner should create a treatment agreement and inform patient of potential risks associated with long-term opioid use.

### New York [SB 8139](#)

Effective July 22, 2016

- For initial treatment of acute pain, practitioners may not prescribe more than a seven-day supply of any Schedule II, III or IV opioid. Subsequent refills are subject to current prescribing limitations under law.
- Requires pharmacists to provide approved educational materials to a patient when dispensing a controlled substance. Materials must meet minimum requirements which inform the patient of risks of using a controlled substance.
- Implements new educational training requirements for medical professionals, including physicians and pharmacists, on the practice of pain management, palliative care and addiction.

### North Carolina [HB 243](#) and [SB 175](#),

Effective June 29, 2017

- Limits an initial opioid prescription to a five-day supply for acute pain.
- Limits an initial opioid prescription for post-operative pain to seven days.
- Allows for refills of up to 30 days following initial prescription, if prescribing physician deems it necessary and prescriptions are consistent with current law.
- Requires dispensers to submit data on dispensed controlled substances to the Controlled Substance Reporting System and imposes a civil penalty for failure to report.
- Requires practitioners to review database prior to prescribing a Schedule II-V drug and to monitor database every 90 days for patients on long-term use of a Schedule II-V drug.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Ohio [Regulation](#)

Effective August 31, 2017

- Rules limit first opioid prescription for treatment of acute pain to not exceed a seven-day supply, with no refills. For continued treatment of acute pain, the total MED for an opioid prescription shall not exceed an average of 30 MED daily dosage, with exceptions.
- Prescribers shall consider other therapy treatment options before prescribing opioids. If opioids are deemed an appropriate treatment, provider shall prescribe the minimum quantity and potency needed to treat expected duration of pain. Additionally, extended-release or long-acting opioids shall not be prescribed for treatment of acute pain.
- Adopted revisions also address treatment of chronic pain, stressing usage of non-opioid therapies first and establishing a trigger level of 80 MEDs daily dosage as a level beyond which prescribing of opioids requires various activity by the prescriber to justify treatment.

### Oklahoma [SB 1466](#)

Effective November 1, 2018

- Limits initial prescriptions of opioids to treat acute pain to a seven-day supply at lowest possible dosage to treat the pain. Also limits the second prescription to a seven-day supply.
- Prescribers, before issuing an initial Schedule II prescription shall take steps to conduct a physical examination, document their assessment and check the state PDMP database.
- Prior to issuance of a third prescription prescriber must discuss with patient risks of opioid utilization. When a Schedule II opioid is continuously prescribed for three months or more, prescriber shall re-asses patient every three months, make efforts to engage in weaning as well as to develop and monitor progress with a pain management agreement.
- Treatment of chronic pain shall require execution of a Patient-Provider Agreement prior to issuance of any opioid.

### Pennsylvania [HB 1699](#), [SB 1202](#), [SB 1368](#)

Effective January 1, 2017

- HB 1699 limits prescribing of opioid analgesics to seven days for patients in a hospital emergency room, urgent care facility or under observation status in a hospital. Patients being treated for cancer-related pain are exempt.
- SB 1202 requires all dispensers and prescribers to be registered with the state PDMP. Additionally, all prescribers must query the PMDP prior to prescribing an opioid analgesic or benzodiazepine. The bill also reduces the reporting time for dispensing pharmacies from 72 hours to close of subsequent business day.
- SB 1368 requires development of safe opioid analgesic prescribing curriculum in Pennsylvania medical schools and continuing education programs for prescribers.

### Rhode Island [HB 8224](#)

Effective June 28, 2016

- Limits initial prescriptions of opioid analgesics for acute pain to not exceed 30 morphine milligram equivalent (MME) total daily dose per day for a maximum of 20 days, with exemptions for management of chronic pain under various medical conditions.
- Mandates registration with state PDMP program upon initial and/or renewal of a prescriber's license for prescribing controlled substances.
- Requires prescribers to review the state PDMP before starting any opioid analgesic therapy and at least once every three months for ongoing therapy. Pharmacies shall also report the dispensing of any opioid analgesic within one business day.

## A recap of regulatory and legislative activity addressing opioid analgesics

### South Carolina **SB 918**

Effective May 15, 2018

- Limits initial opioid prescriptions for acute or postoperative pain management to a seven-day supply, with exceptions. Upon any subsequent consultation for the same pain, a practitioner may issue an appropriate renewal, refill or new opioid prescription.
- Additionally, and effective November 15, 2018, the Department of Health and Environment Control shall develop and maintain, as part of the state prescription monitoring program, a system to provide prescription report cards to practitioners informing them of prescribing trends, including comparisons of their prescribing trends with peer averages.

### Utah **HB 50**

Effective May 9, 2017

- Limits initial prescriptions of opioid analgesics for acute pain not to exceed seven days.
- Requires providers to query the state PDMP prior to writing a prescription for a Schedule II or III opioid for the first time.

### Tennessee **HB 1831**

Effective July 1, 2018

- Unless specifically exempted, a healthcare practitioner shall not treat a patient with more than a three-day supply of an opioid and shall not treat a patient with an opioid dosage that exceeds 180 MME dose. A practitioner may treat a patient with more than a three-day supply of an opioid if practitioner treats patient with no more than one prescription for an opioid per encounter, and:
  - Personally conducts a thorough evaluation of patient
  - Documents consideration of non-opioid and non-pharmacological pain management strategies and why strategies failed
  - Includes the ICD-10 code for the primary disease in the medical chart and on prescription
  - Obtains informed consent and documents the reason for treating with an opioid in medical record
- If a practitioner treats a patient with more than a three-day supply of an opioid, the practitioner may treat patient with no more than a 10-day supply and with a dosage that does not exceed a total of a 500 MME dose.
- Additionally, the bill outlines various requirements and MME dose levels for the continued treatment of a patient with opioids beyond the 10-day supply limitation(s) as well as a listing of treatments and conditions which are exempted from the prescribing restrictions such as end-of-life and palliative care.
- The bill also outlines enhanced requirements for both prescribers and dispensers to engage with and review data available from the state PDMP program.

## A recap of regulatory and legislative activity addressing opioid analgesics

### Vermont [Regulation](#)

Effective July 1, 2017

- Provides a full and clear definition of acute and chronic pain, including treatment protocols and daily MME dosage levels for both acute and chronic pain.
- Defines chronic pain as pain lasting greater than 90 days and requires prescriber to complete a medical examination of the claimant. Establishes a ceiling of 90 MME/day for treatment of chronic pain and when this level is exceeded, imparts new requirements for possible co-prescribing of naloxone.
- Requires providers to follow universal precautions, discuss and document risks with patient and query the state PDMP prior to writing a prescription for a Schedule II, III or IV opioid for the first time.
- Categorizes acute pain into four specific levels of pain and establishes a ceiling of 50 MME/day for a seven-day supply of opioid analgesics.

### Virginia [Regulation](#)

Effective September 14, 2017

- Treatment of both acute and chronic pain under adopted rules is very complex with many treatment, examination and evaluation processes for both initial stage and ongoing/continuing stages. Information contained here is a short outline of key requirements
- Treatment of acute pain with opioids shall be with short acting opioids and shall not exceed a seven-day supply when prescribing a controlled substance containing an opioid.
- Treatment with opioids for acute pain related to a surgical procedure shall be for no more than 14 consecutive days and shall be documented in medical record.
- Prescribers shall carefully consider and document reasons to exceed 50 MME daily dosage and prior to exceeding 120 MME daily dosage shall document reasonable justification or refer/consult a pain specialist.
- Naloxone shall be prescribed for a patient with risk factors for overdose or when daily dose exceeds 120 MME.
- Prior to initiating opioid treatment for chronic pain, practitioner shall discuss risks and benefits of opioid therapy and responsibilities during treatment as well as an exit strategy for discontinuation if treatment is not effective.
- Before initiating treatment of chronic pain, non-pharmacological and non-opioid treatment for pain shall be given consideration and practitioner shall carefully consider and document reasons to exceed 50 MME daily dosage.
- Prescribers shall regularly evaluate for opioid use disorder and initiate treatment for opioid use disorder, consult with an appropriate health care provider, or refer patient for evaluation and treatment if indicated.

### Washington [HB 1427](#)

Effective January 1, 2019

Requires various medical and prescriber licensing board(s) to develop and adopt rules for the prescribing of opioid drugs not later than January 1, 2019.

### West Virginia [SB 273](#)

Effective June 7, 2018

- Limits initial opioid prescriptions to a seven-day supply at lowest effective dosage.
- Also limits initial prescriptions from issued by an Emergency room to a four-day supply, and limits initial opioid prescriptions issued by a dentist to a three-day supply.
- Additionally for chronic pain requires additional activity and justification by treating doctor/prescriber for subsequent prescriptions which exceed the initial 90-days of treatment.

## Opioid analgesic statistics sources

Optum workers' comp and auto no-fault book of business, 2015-2016

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### About Optum for Workers' Compensation and Auto No-Fault

The workers' comp and auto no-fault division of Optum collaborates with our clients to deliver value beyond transactional savings while helping ensure claimants receive safe and effective clinical care. Our innovative and comprehensive medical cost management programs include pharmacy, ancillary and managed care services from first report of injury to settlement.

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