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

Multi-faceted efforts to reduce opioid use are underway. Formularies, treatment guidelines, limits on morphine equivalent doses (MED), and opioid quantity limits are all influencing outcomes. In recent years, the work by state regulators and legislatures throughout the country has similarly brought about change to the system.

Working together achieves healthier outcomes. The workers’ comp and auto no-fault division of Optum has also been working hand-in-hand with our clients to manage pain and the 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 the associated MEDs continue to follow a downward trajectory.
The number of prescriptions for opioid analgesics has escalated from around **76 million in 1991** to nearly **207 million in 2013**

| **80%** | Of all opioid analgesics dispensed in the world are dispensed in the U.S. |
| **99%** | Of all hydrocodone dispensed in the world is dispensed in the U.S. |
| **5.8 million** | People have used prescription pain relievers non-medically per year |
| **2.1 million** | People aged 12 and older began using opioid analgesics for the first time in 2015 |
| **25%** | Of all workers' compensation costs are related to opioid analgesics |
| **91%** | Of patients who survive opioid overdose are prescribed more opioids |
| **41** | Americans die each day from prescription opioid overdoses |
| **Almost 2 deaths an hour** | |
| **15,000** | Annually |

For the first time, 2016 saw a **12% decline** in opioid analgesic prescriptions, after a peak in 2012.
Opioid analgesic use in workers’ comp and auto no-fault

Opioid analgesics 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, 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 stimul 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 baseline pain relief to reduce the claimant’s need to take multiple doses of medication per day.

The use of opioid analgesics has been under scrutiny by stakeholders throughout the system due to the thousands of overdoses and deaths stemming from opioid misuse, misuse and abuse. The Centers for Disease Control and Prevention (CDC) has released opioid use guidelines suggesting non-opioid alternative therapies as the first-line treatment along with limited opioid analgesic use, typically less than seven days of initial therapy, for most acute injuries. In addition, the CDC recommends the opioid analgesic therapy not escalate above 90 morphine milligram equivalents or greater or carefully justify a decision to titrate (adjust the dose based on claimant response) above 90 morphine milligram equivalents to achieve the desired clinical effect. Employing routine, random urine drug testing and reviewing prescription drug monitoring programs (PDMPs) to assist in managing the opioid therapy are also encouraged. Similar state-based guidelines are under review and/or in development throughout the country.

The various state versions of the legislation contain similar provisions designed to reduce the prescribing of opioid analgesics and increase awareness among healthcare providers and their patients about the risks associated with using an opioid. The common provisions include new requirements for accessing and reporting to the state PDMP, establishing treatment and documentation protocols for using opioids, providing clearer definitions for acute pain compared to chronic pain, and limiting opioid prescribing and dispensing.

The adopted legislation in each state applies to the broader healthcare market and is not specific to the prescribing of opioid analgesics or their use in managing low back pain or other injuries. The ODG recognizes many of the common provisions and is in development to include new requirements for opioid therapy for all claimants, regardless of injury.”

Most treatment guidelines assert the sole use of opioid analgesics for chronic pain should be avoided, especially in the case of non-cancer chronic 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. While the ODG states there is some evidence for efficacy supporting the use of opioid analgesics for low back pain, their opioid analgesic use should be limited to the treatment of short-term pain. Long-term (>16 weeks) efficacy, however, is unclear and there is limited evidence supporting the use of opioid analgesics for chronic low back pain. A claimant’s failure to respond to a time-limited course of opioid analgesics has led the ODG to suggest reassessment and consideration of alternative therapy. Behavioral therapy should also be evaluated, and potentially utilized, for chronic pain unrelieved by first or second-line approaches. For treatment transparency and as a form of informed consent, the use of a medication agreement between the prescriber and the claimant outlining the benefits, risks, use of opioid medications, as well as the consequences for misuse or abuse of opioid analgesics or other medications is considered a best practice. So too is adherence to prescription drug monitoring program (PDMP) protocols.

For more information email us at expectmore@optum.com.

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A recap of regulatory and legislative activity addressing opioid analgesics

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.
- Does not mandate preauthorization to ensure payment for reasonably required medical treatment or services.
- Prohibits paying from denying preauthorization solely because treatments are not addressed by the guidelines.

California Regulation
Effective July 28, 2016
- Adopts revised existing MTUS [medical treatment utilization schedules (treatment guidelines)] for chronic pain.
- Adopts new opioid MTUS for the utilization of opioids, which sets the recommended maximum levels of 80 MED and requires prescribers to conduct semi-annual attempts to wean patients who exceed the 80 MED dosage.

Connecticut HB 5053
Effective January 1, 2017
- Restricts the issuing of an initial prescription for an opioid analgesic to more than a seven-day supply.
- Provides exemptions for cancer treatment and at the professional judgment of the physician, however, this must be documented in the 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 the utilization of naloxone, in case of an overdose, and provides protection for first responders from civil penalties.

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 the patient presenting a prescription for an opioid analgesic is not a resident of Maine, is paying cash for the prescription, or the patient has not filed a prescription for an opioid analgesic or benzodiazepine in the last 12 months.
- Mandates prescribers of opioid analgesics complete at least three hours of continuing education on the subject over a two-year period.

Massachusetts HB 4056
Effective December 1, 2016
- Limits the 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 the patient sign an opioid treatment agreement prior to the prescribing of an opioid analgesic.
- Requires the development of multi-leveled educational programs for prescribers, dispensers, first responders and educational institutions to inform impacted individuals on the dangers, risks and ways to handle opioid addiction and overdose situations.

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 the patient, complete a board approved risk assessment tool, provide a written rationale for opioid usage and utilize a written consent form acknowledged by the 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 the lowest effective dose for a limited duration. Certain terminal illnesses are excluded from these treatment provisions.
- Prescribers must now register with the state PDMP and prior to the initial prescribing of any Schedule II, III or IV opioid(s) must query the system. When managing chronic pain, prescribers are required to query the system no less than twice a year.
A recap of regulatory and legislative activity addressing opioid analgesics

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. The materials must meet minimum requirements which inform the patient of the 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, SB 175, Strengthen Opioid Misuse Prevention (STOP) Act
Pending gubernatorial approval

- Requires a physician’s assistant or nurse practitioner to consult with the supervising physician before starting a patient on a Schedule II-V drug for a time frame that is expected to exceed 30 days. It also requires on-going consultation every 90 days until the medication is no longer needed.
- Requires electronic prescribing of Schedule II-V drugs, with some limited exceptions.
- Limits an initial opioid prescription to a one-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 the initial prescription, if the prescribing physician deems it necessary and the 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 the database prior to prescribing a Schedule II-V drug and to monitor the database every 90 days for patients on long-term use of a Schedule II-V drug.
- Allows third-parties, such as pharmacy benefit managers (PBM), to access the database for purposes of client case management.
- Creates a Controlled Substances Reporting System Fund to finance the on-going operation and analysis related to the reporting system.
- Exempts in-patient and in-facility care, hospice care and palliative care from many of the restrictions in the legislation.

Pennsylvania HB 1699, SB 1202, SB 1368
Effective January 1, 2017

- HB 1699 limits the 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. The bill also requires the physician to indicate that a non-opioid analgesic medication was inappropriate for the patient before prescribing an opioid analgesic.
- SB 1202 requires all dispensers and prescribers to be registered with the state PDMP. Additionally, all prescribers must query the PDMP prior to prescribing an opioid analgesic or buprenorphine. The bill also reduces the reporting time for dispensing pharmacies from 72 hours to close of the 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.
- Requires providers to query the state PDMP prior to writing a prescription for a Schedule II or III opioid for the first time.

Utah HB 50
Pending approval

- Provides a full and clear definition of acute and chronic pain, including treatment protocols and daily morphine milligram equivalent dosage (MME) levels for both acute and chronic pain.
- Defines chronic pain as pain lasting greater than 90 days and requires the prescriber to complete a medical examination of the patient. Establishes a ceiling of 90 MME/day for treatment of chronic pain and when this level is exceeded, imposes new requirements for the possible co-prescribing of naloxone.
- Requires providers to follow universal precautions, discuss and document the risks with the 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.

Tennessee Regulation
Effective August 28, 2016

- Adopts the first phase of their formulary treatment guidelines effective as of August 28.
- Includes the Official Disability Guidelines (ODG) Drug Appendix A, any drug excluded from the formulary would require prospective approval.
- Includes ODG treatment guidelines (opioids and chronic pain) for treating doctors.
A timeline of activity addressing opioid use in workers’ comp and auto no-fault

Medication releases and regulatory and legislative activity

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<thead>
<tr>
<th>Year</th>
<th>Medication</th>
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<tbody>
<tr>
<td>1947</td>
<td>Fiorinal with codeine</td>
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<tr>
<td>1950</td>
<td>MS Contin</td>
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<td>1950</td>
<td>Subutex</td>
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<tr>
<td>1960</td>
<td>Demerol</td>
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<td>1961</td>
<td>Ultracet</td>
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<td>1963</td>
<td>Vicodin</td>
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<td>1964</td>
<td>Embeda ER</td>
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<td>1966</td>
<td>Embeda</td>
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<tr>
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<td>1983</td>
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<td>1986</td>
<td>Buprenex</td>
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<tr>
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<td>1987</td>
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<tr>
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<td>OxyContin</td>
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<td>1990</td>
<td>Suboxone</td>
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As a pioneer in opioid management, Optum continues to collaborate with stakeholders throughout the system, leading the way towards healthier outcomes.
Opioid analgesic statistics sources

Front cover


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