

# Workers Compensation Outlook

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## Is the Sky Really Falling? — Getting to the Root of the Opioid Issue

*An alarming increase in deaths from prescription drug overdoses, as well as driving costs, has made opioids the bane of the workers compensation industry. Employers, insurers, and government agencies are demanding solutions — and rightfully so. However, the best outcomes won't come from witch hunts and knee-jerk reactions, but from solid data analysis and well-thought-out holistic strategies. Preliminary research indicates that what looks like a black cloud has many shades of gray. This issue of Workers Compensation Outlook looks at the trends driving increased opioid use, with a special focus on pain management in workers compensation, suggesting areas that organizations should analyze before attempting to develop their own solution. It also examines the role of each stakeholder group — from the network to the adjudicator, the prescriber, the employer, the case manager, the worker — in addressing the issue of opioid use and abuse. Finally, it suggests approaches for each stakeholder group that could contribute to controlling costs, improving outcomes, and supporting greater patient safety.*

### Prescription pain medications in the news

Hardly a day goes by when prescription pain medications don't make the headlines — and the news is rarely good. The Lexington Herald-Leader reported, "nearly a third of Kentuckians report that a relative or friend has had problems as a result of abusing prescription pain drugs." The Lewiston Sun Journal covered the reprimand of a Maine doctor who prescribed methadone for a pregnant patient. Citing a new report from the Centers for Disease Control and Prevention (CDC), US News & World Report noted that "More Americans now die from drug overdoses than in car accidents," and a group of Tennessee legislators issued a press release on the passage of a new law designed to regulate pain clinics.

All of those articles, and many more like them, were generated within a single 24-hour period in late December. Clearly, people are talking about prescription pain medications — and demanding solutions. Is the situation truly that bad, or is it hype? Is the media running around like a bunch of Chicken Littles? Finding an accurate answer to that question may not be as simple as it sounds, and organizations can't make good decisions based on headlines.

### National statistics are sobering

The CDC is keeping a close eye on trends related to prescription

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pain medications – specifically opioid pain relievers (OPRs) such as Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone), and methadone. Sales of OPRs to pharmacies, hospitals, and doctors offices increased by 400 percent between 1999 and 2010. In that same time period, deaths from prescription painkillers have increased at nearly the same rate, resulting in what the CDC calls “a public health epidemic.” Admission to substance abuse treatment programs has increased in parallel.

A November 2011 CDC Policy Impact brief on prescription painkiller overdoses points to a large and growing problem.

- Drug overdose death rates in the United States have more than tripled since 1990.
- In 2008, OPRs were involved in 14,800 overdose deaths – more than cocaine and heroin combined.
- OPRs were responsible for more than 475,000 emergency room visits in 2009 – more than twice as many as in 2004.
- U.S. physicians prescribed enough painkillers in 2010 to medicate every American adult around the clock for a month.

The CDC has called for workers compensation programs to monitor prescription claims information through prescription drug monitoring programs (PDMPs) for signs of inappropriate use. It also suggests regulatory action against providers who operate “outside the limits of accepted medical practice” and calls for states to enact and enforce new laws against doctor shopping and rogue pain clinics.

The American College of Occupational and Environmental Medicine (ACOEM) and the International Association of Industrial Accident Boards and Commissions (IAIABC) have expressed similar concerns. Last fall the two groups issued a joint comment about “the growing issue of prescription opioid abuse” and asked workers compensation jurisdictions to take steps to address the issue if they have not already done so.

## **Pendulum of pain management**

Thinking about pain medication has evolved and continues to change. Years ago, physicians were reluctant to prescribe narcotics for all but the most intractable pain. That reluctance eroded as physicians were taught that narcotic pain relievers were not addictive. Now, the pendulum has swung back and physicians understand that addiction is always possible. However, at the same time, they stress the importance of pain management.

Pain that is not managed successfully can have several negative consequences. It can limit activity and therefore impede timely return to work. Patients may repeatedly switch providers, trying to find relief. If the pain continues, becoming chronic, it could lead to further complications such as depression, which may increase the patient’s vulnerability to substance abuse issues.

Providers often prescribe OPRs because they are powerful and effec-

tive at relieving severe pain. Although nonopioid medications are available for pain management, there are also legitimate reasons to prescribe OPRs. For example, if a patient is at risk of heart disease, OPRs may be a preferable alternative to COX-2 inhibitors. Additionally, OPRs may be preferable to nonsteroidal anti-inflammatories (NSAIDs) in patients with ulcers or when the potential for bleeding is a concern. Despite the media headlines, it's important to remember that just because a pain reliever is an opioid doesn't automatically mean its use is inappropriate.

Increasing opioid use is part of an overall increase in prescription drug utilization in society. Experts point to direct-to-consumer marketing, pharmaceutical company profits, and the Internet as potential influencers. A July 2010 article in The Christian Science Monitor cites the instant gratification culture and Americans' unwillingness to bear even mild pain. Regardless, the issues are real, and clarity is needed.

## Getting behind the headlines

It would be wonderful if the workers compensation industry could just say no to the use of opioids, but it's not that simple. To develop an appropriate strategy, an organization must get the real story – and that story is hidden deep in the data. Importantly, it's necessary to understand the drivers.

A national study of Schedule II opioid prescriptions, conducted by Coventry Workers Comp Services in August 2011, examined five years of prescription data, along with supporting bill review data, proprietary network provider data, and claims information from several large payor clients. The study design was similar to a March 2011 California Workers' Compensation Institute (CWCI) study and identified many of the same trends, with some notable differences.

Both studies found that a relatively small number of physicians were responsible for a large percentage of the Schedule II opioid prescriptions. The CWCI study found that the top percentile accounted for 33 percent of the prescriptions and 42 percent of the measured payments. The results of the Coventry study were less dramatic. The top percentile wrote only 31 percent of the OPR prescriptions for 28 percent of the measured dollars.

It is tempting to assume that this utilization equates to less-than-optimal outcomes, but it is important to dig deeper before jumping to conclusions. For example, Coventry's analysis of the data showed that half the providers in the top percentiles were pain specialists. Therefore, one would expect these providers to have more patients requiring pain medications, including OPRs.

To gain a better understanding, it's necessary to look at the kinds of injuries that the high-volume prescribers are treating with OPRs. An analysis of diagnosis codes is a start, but it may not provide enough detail.

For example, an analysis by diagnosis code shows that 54 percent of the Schedule II opioid claims were for diseases of

the musculoskeletal system, accounting for 59 percent of the prescriptions and 63 percent of the costs. Matching that information with bill review data provides more useful information. Back/spine injuries account for 33.6 percent of claims, 46.4 percent of Schedule II opioid prescriptions, and 55.7 percent of dollars. However, this analysis does not differentiate between milder and more serious back injuries, which may require the use of OPRs.

Further analysis can help to validate the appropriateness of the medications for the injury. Using advanced techniques, it is possible to mine medical billing data to uncover the severity of the patient's injury or potential comorbid conditions such as smoking, diabetes, depression, and obesity — some of which might contraindicate opioids. In this study, 35.1 percent of claimants had at least one diagnosis code for smoking, diabetes, depression, obesity, or hypertension. These claims accounted for 53.7 percent of the Schedule II opioid prescriptions and 61.2 percent of the payments in the subsample.

It is also possible to use diagnosis-based data analysis techniques to measure the severity of injury. Using a simple index ranging from 1 representing the mildest acuity to 10 representing the most severe, analysis of the bill review and claim injury data shows 87.5 percent of the prescriptions for OPRs were written for claims grouped as moderate to severe (acuity 5 through 10).

The analysis performed also evaluated severity with and without comorbidity. It is interesting to note that the less severe claims with the presence of a comorbidity had an average of 13.5 OPR prescriptions versus those without comorbidities, which averaged 5.1.

## **Areas for further exploration**

While not conclusive, the examination of diagnoses using bill review data and claim injury information does suggest that many of the claimants receiving Schedule II opioid drugs may be suffering from injuries that warrant at least some use of OPRs.

Additional analysis could be beneficial. It might be helpful to look at the quantities of drugs over time to evaluate dispensing patterns. It could be useful to measure medication per month and medication rates relative to the age of the claim. Reviewing other prescriptions, including nonopioid medications, within these claims, as well as reviewing other nonpharmacological treatment, might also provide additional context. For instance, opioids may be an adjunct therapy to increased physical medicine treatments.

Examining claimants' use of the health-care system, including the number of providers involved in their care, may provide insight into OPR utilization. Preliminary analysis shows that claimants in the top 10 percent of opioid prescription volume had approximately twice as many prescribers as the average claimant — 4.2 versus 2.0. Further analysis is necessary to uncover any patterns of drug-seeking behavior or to clarify other complicating health conditions. For example, the Coventry study drilled down on claimants receiving

Fentanyl, a powerful drug used for breakthrough cancer pain. Data mining showed that a measurable number of claimants did have cancer diagnoses; therefore, Fentanyl use was more likely to be appropriate (questions of compensability aside).

To achieve this kind of insight, it makes sense to partner with organizations that already have the data and the analytical skills to understand it, as well as the business acumen to apply the knowledge.

## **Strategies for all stakeholders**

In their joint comment, ACOEM and IAIABC acknowledge that a solution isn't as simple as "passing a law against some easy target of abuse." Minimizing the potential for abuse or diversion while ensuring that injured workers get appropriate care – including appropriate pain medications – requires cooperation from multiple players. Working together, it is possible to achieve a positive outcome.

The CDC recommends monitoring prescribers for deviation from accepted medical practice in prescribing painkillers. Those using, or planning to use, an outcomes-based network should take this into account. A good outcomes-based network monitors its own providers to ensure that they are treating within accepted guidelines, including guidelines for OPRs. Even better, organizations should analyze prescribing patterns when selecting providers for outcomes-based network participation, given that pharmacy expenses continue to represent a substantial portion of the medical spend for indemnity claims.

Providers should follow evidence-based guidelines regarding pain management. The ACOEM and Official Disability Guidelines suggest limiting the use of opioids to cases of traumatic injury, fractures, severe pain, or post-operative pain. Based on national guidelines, prescription opioids are usually limited to two weeks from initial injury. Limiting the initial use of OPRs decreases the likelihood that use will become chronic and also limits the potential for diversion or theft of unused medication.

Providers also have a responsibility to educate the patient. A detailed consent form before initiating narcotic therapy provides an opportunity to do this. Providers should be aware of the connection between narcotic abuse and comorbid mental illness or other conditions when taking a patient's history. Monitoring or drug screening is a consideration for patients who use OPRs for an extended time.

## **Pharmacy benefit managers**

Clearly, pharmacy benefit managers (PBMs) play a role. Currently 37 states have operational prescription drug monitoring programs (PDMPs) that can track prescribing and dispensing of OPRs. PDMPs are designed to help prescribers and pharmacists monitor for suspected abuse or diversion. Additionally, the pharmacist has a role in educating the patient about appropriate dosing and refill schedules to avoid potential abuse.

It is interesting that jurisdictional law does not afford PBMs access to PDMPs. PBMs do, however, collect valuable utilization data that can identify patients whose medication regimen may need review. PBM access to the claimant's complete utilization history for the claim enhances this capability. The spectrum of utilization data makes it possible to identify inappropriate prescribing or utilization activities. PBMs also incorporate both nationally recognized clinical guidelines for point-of-sale edits as well as data analytic algorithms, and they are included in a variety of outreach programs. For example, the PBM pharmacist could alert the dispensing pharmacist to a potential drug interaction or could provide the prescriber with guidelines for the appropriate use of narcotics as they relate to workplace injuries.

At the adjuster level, there should be a positive complement between clinical decision support and claim adjudication. Here, PBM pharmacists can provide claims examiners with valuable information to help the examiners make complex decisions about OPRs. Support should include alerts to the adjuster regarding interventions, such as case management when necessary, to support improved patient safety and outcomes.

### **Nurse case managers**

The nurse case manager plays a pivotal role in supporting positive outcomes when narcotics are involved. A nurse case manager should oversee and support appropriate management of narcotic medication use. The nurse case manager reinforces the education from the pharmacist to the patient about side effects and potential drug interactions. A trained field nurse case manager can holistically evaluate all treatment modalities, taking into account environmental and psychosocial factors that might put the patient at risk for narcotic overutilization.

A properly trained nurse case manager acts as a coach, helping keep the patient motivated and moving toward the goal. This approach can break the cycle of pain-depression-inactivity that can impede progress and make the patient particularly vulnerable to the mood-altering properties of OPRs. The nurse case manager should also serve as a patient advocate, keeping the lines of communication open between the injured worker, the employer, and the health-care provider. If the treatment plan goals are not being met, the nurse case manager should provide patient education to enable the injured worker to make appropriate and informed decisions.

Ultimately, of course, the patient's actions determine the outcome. The patient will comply with the medication regimen and other modalities, such as physical therapy or a walking program. Or not. The provider, the pharmacist, and the nurse case manager can all provide critical information that can direct the patient to make decisions in his or her best interests.

### **High risk populations**

Researchers are finding that certain populations are at higher risk of abusing OPRs. Several studies indicate that recreational drug use is higher among low-income Caucasian populations. Young adults

may also be more susceptible. A study by addiction researchers at the University of Pennsylvania reported that one in four 18- to 25-year-olds will abuse prescription painkillers in their lifetime. Teens and young adults with anxiety disorders, depression, or other mental illness are at higher risk, according to a University of Washington study presented at last year's annual meeting of the American Academy of Pain Medicine.

These high-risk populations, as well as those patients with comorbid health conditions and those who are also taking sedatives, would benefit from early intervention. Employing best practices allows an organization to leverage the most appropriate clinical resource for the situation. With claimants who take sedatives or have comorbid conditions, the dispensing pharmacist is positioned to educate the patient and physician at the earliest opportunity. If such education does not result in reasonable outcomes, data analytics could identify claimant risk. The PBM or case manager could leverage such information to work with the prescriber to mitigate health and safety issues for the claimant.

## Holding up the sky

Opioid pain relievers – and their potential for abuse – are a legitimate cause for concern. It's important to remember, however, that short-acting and long-acting narcotics, including opioids, are the two top therapeutic drug classes in workers compensation – so wishing won't make them go away. In fact, according to a Workers Compensation Research Institute (WCRI) study of some 75,000 non-surgical workers compensation injuries, 55 percent to 85 percent of injured workers with more than seven days' lost time, and at least one workers compensation prescription paid, received narcotics.

In a study on interstate variations on the use of narcotics, WCRI notes that "more frequent use of stronger, Schedule II narcotics does not necessarily lead to a problem if the regimen of Schedule II narcotics is used for relieving more severe pain to produce better outcomes. Without outcome data, we cannot tell if this is the case" in states where providers are more likely to prescribe the stronger medications.

While the industry works to develop a clearer picture of the drivers, stakeholders have many opportunities to make a positive impact and improve patient safety. Education is key to achieving this potential.

It is critical for PBMs to stay up to date on recommended prescribing trends through continuing education and to participate in Risk Evaluation and Mitigation Strategies (REMS), such as the Food and Drug Administration's program for long-acting opioids. Similarly, it is important for adjusters and claims managers to review accepted conditions prior to medication overrides. Using established protocols for clinical intervention programs can also help ensure proper use and help reduce the potential for misuse, abuse, overdose, and diversion of OPRs.

As appropriate to their role, physicians, nurse case managers, pharmacists, and other clinical workers compensation providers

have a responsibility to stay up to date with current treatment guidelines and industry best practices for pain management and prescription pain medication. In turn, they serve the patient best by sharing their knowledge regarding the risks and benefits of opioid pain relievers, dosage regimens, weaning schedules, and other information that can help increase the patient's understanding and enhance patient safety.

The sky may not be falling, but the clouds are threatening. The soundest approach seems to use common sense and work with a network whose members follow clinical guidelines, utilize leading edge pharmacy programs and technology, employ case management best practices, and base their strategy on insightful data analytics on an ongoing basis.

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