Opioids and the Injured Worker
Is there an opioid epidemic?
The answer seems to be a resounding yes. Across the country, addiction and excessive use of prescription opioids are wreaking havoc.

The Centers for Disease Control and Prevention (CDC) recently reported that

16,651 people died of opioid overdoses in the United States in 2010 alone.

A similar report from 2012 states that for every one opioid-related death, more than 150 people are abusing or dependent on these powerful narcotics.

The workers’ compensation community has not been spared with opioids ranking among the most commonly prescribed pain medications for injured workers. According to the Workers Compensation Research Institute (WCRI), for roughly

80% of injured workers who are prescribed pain medications, that prescription is for an opioid

– and when patients start on opioids, a significant number of them continue to take opioids six to 12 months later.

Aside from the toll on an individual’s health, why is there such great concern among states to mitigate opioid abuse and misuse among injured workers? In the workers’ compensation universe, significant proof exists that long-term opioid use leads to longer claim duration and longer-term disability, thus raising costs and medical expenses.

A 2012 report by Lockton and Associates captures the scope and severity of the problem, stating

“ There has never been a more damaging impact on the cost of workers’ compensation claims from a single issue than the abuse of opioid prescriptions for the management of chronic pain. ”

It is no question, then, why states nationwide have adopted their own strategies to mitigate the opioid epidemic within their borders.

In this issue, we will compare the strategies adopted by Florida, Massachusetts, Pennsylvania and Texas and the successes and shortcomings of each of their programs. Texas and Massachusetts are known for being particularly proactive in addressing and regulating opioid abuse in the workers’ compensation system. Florida has seen success as a leader among states with strong anti “pill mill” legislation on their books. Pennsylvania, on the other hand, records some of the highest rates in the nation of long-term opioid use by injured workers. The state hopes to combat this statistic with several bills currently pending in the legislature.
Significant changes followed the September 2011 introduction of a closed formulary on prescription drugs in the Texas workers’ compensation system. The Texas formulary designates an extensive list of drugs which, prior to dispensing, must receive prior approval by a claims payer. Implementation of this formulary appears to have impacted the prescription of opioids as much as, if not more than, any other initiative. According to the “Healthcare Cost and Utilization, 2012” report issued by the Texas Department of Insurance-Division of Workers’ Compensation (TDI-DWC), the success has been easily measurable: the total cost of opioid use began decreasing in 2007 for both lost-time claims and medical-only claims; the use of opioids and other “not-recommended” drugs has been significantly reduced – specifically, the frequency of opioid prescriptions dispensed to injured workers decreased by 10 percent; and the cost associated with dispensing these prescriptions decreased by nearly 17 percent.

Texas’ most recent efforts to battle opioid abuse include new legislation to eliminate pain management clinics that dispense narcotics to patients without an exam. Texas has become one of nine states to implement such legislation (including Florida, but not including Massachusetts or Pennsylvania).

**Regulation & Education**

Recognizing the strong correlation between opioid use and physician discretion in the workers’ compensation arena, Massachusetts has enacted some of the broadest physician-related regulatory reforms in the nation. As of February 2012, physicians in Massachusetts are legally obligated to take a continuing-education course on pain physiology and the effects of opioids before obtaining or renewing medication licenses (*this requirement applies to all physicians who prescribe controlled substances*). As part of these courses, physicians are provided treatment guidelines to deal with chronic pain, focusing outside of prescription pain management. The state’s guidelines also call for a written agreement between patient and doctor, random drug screenings for concentration of painkillers in the body, and a second opinion when total opioid doses exceed 120 mg per day of morphine equivalents.

Similar to 46 other states, Massachusetts also runs an active prescription drug monitoring program (PDMP), which has collected information on a weekly basis since its establishment in 1992.

In 2010, the state enhanced its PDMP by moving the system online. Through a secure website, licensed prescribers or pharmacists may obtain authorization to view the prescription history of a patient for the past year – enabling them to be aware of potential abuse or long-term opioid dependence – before issuing that patient another potentially dangerous prescription. Even prior to these reforms, the state had closely regulated doctors’ prescribing activities – notably, Massachusetts has never allowed physician-dispensing of prescription drugs.

During a time when the prevalence of long-term opioid use in most states increased or remained the same, a WCRI study shows long-term opioid use decreased by 4 percent in Massachusetts. This decrease in use has been credited to the implementation of the state’s wide-ranging opioid reforms.
**PDMPs and then what?**

Despite having among the highest percentages of injured workers who become long-term users of opioids in any state, Pennsylvania has yet to see substantial reforms make it through the legislative process. The state’s medical society recently characterized Pennsylvania’s current PDMP as “limited and outdated,” noting that “physicians still struggle to determine whether a patient sitting in their exam room could be abusing prescription drugs or doctor shopping.” However, this current legislative session could produce changes, as several reforms have been proposed and are pending before the House and Senate.

Among these proposed reforms is House Bill 1694, which would establish a Pharmaceutical Accountability Monitoring System to establish and maintain an electronic system for monitoring all scheduled drugs. The bill seeks to reduce opioid abuse by ensuring that practitioners who make prescribing decisions have complete information about what, if any, other drugs have recently been prescribed to their patients. The bill also recommends reporting mechanisms with full confidentiality protections in which dispensers report prescription information to a central repository, thus enabling the state to identify questionable behaviors by patients and practitioners that may suggest inappropriate opioid prescribing or usage.

Similar legislation has been proposed in prior years, but has never gained enough support to be signed into law. Despite recognition of the opioid issue in Pennsylvania, House Bill 1694 has already seen opposition from the ACLU and other groups (chiefly citing privacy concerns) and will have several hurdles to overcome if it is to become law.

**What’s Next?**

As THE Patient Advocate Pharmacy, IWP has a long history of advocating for and protecting the interests of the injured worker. The company has been consistently aware of the risks involving opioid misuse and abuse, and has implemented various programs to ensure that patients are at the least possible risk of developing a dependency, or misusing prescription drugs. To learn more about what IWP has done to combat this epidemic, and for further analysis of state-by-state opioid management, please visit www.IWPharmacy.com.

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Although 49 states have implemented PDMPs – the only exception being Missouri – several states have yet to fund the program.


Arizona, Florida, Georgia, Kentucky, Louisiana, Ohio, Tennessee, Texas, and West Virginia have specific “pill mill” regulations (as of June 2013). Florida was once notorious for its “pill mills” – pain clinics and doctor’s offices in which patients are dispensed a month’s supply of any number of prescriptions, including opioids. Despite having a PDMP since 1999, the state was still seeing excessive rates of opioid use among injured workers. In response to this problem, the Florida legislature enacted broad legislation targeted at physician dispensing of opioids. This legislation, enacted in 2011, has shown measurable results in curbing opioid use in injured workers.

As part of the 2011 reforms, physicians who practice medicine in Florida are prohibited from onsite dispensing of Schedule II and Schedule III controlled substances, which include “strong opioids,” such as oxycodone and hydrocodone. (*The very narrow exceptions include providing free samples and prescribing a single two-week supply of those drugs to ease surgery-related pain.*) Florida law considers violating the prohibition a third-degree felony that can result in at least a six-month suspension of a license to practice medicine. Since the law went into effect two years ago, the WCRI reports that the percentage of physician-dispensed opioids has dropped to 0.5 percent, almost all of which represent exceptions to the law.

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**Shutting Down the “Pill Mills”**

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