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Opioids in the MSA— How to Mitigate MSA Exposure and Maybe Even Save Lives

INTRODUCTION

Opioid use and abuse has been a hot topic in the news recently, and for good reason. From 2001 to 2013, US overdose deaths from prescription drugs increased 250%, with opioid deaths alone increasing 300% in that time.

The panelists will discuss the opioid epidemic; its impact on claims and Medicare Set-Asides; and how good claim handling early on can mitigate overall exposure. The panelists will use specific examples and give real-life tips on how to effectively handle these tough cases, assisting claims professionals in identifying problem cases early and providing tools to reduce overall claims costs in chronic pain cases.

THE PROBLEM

Pain management physicians struggle with treating chronic pain, particularly in workers' compensation situations.

Studies demonstrate there is only limited evidence for the use of opioid medication in addressing chronic non-cancer pain. Studies also reveal that chronic opioid use has an adverse impact on activity levels and self-efficacy, leading researchers to conclude that the use of pain medication impedes, rather than facilitates, an injured worker's recovery from occupational back injuries. Treating injured workers for back pain with opiates early on increases disability duration, medical costs, the prescription of subsequent surgery and later opioid use. Despite this, the United States still prescribes 80% pf the world's opioids. Opioid-related addiction and deaths continue to rise exponentially, yet over-prescription continues in the face of a patient population that reports no improvement in pain levels.

The World Health Organization designed an "analgesic ladder" in 1986 for palliative treatment of cancer pain. The ladder begins with aspirin and non-steroidal anti-inflammatories, moves up to Codeine if needed, and then ends with drugs such as Morphine. This analgesic ladder was never meant for escalating drug use with non-cancer pain, but has been used in the United States for chronic low back pain nonetheless. Retail sales of the third tier of medications increased, in fact, between 154% and 933% in a span of seven years while use of the second tier of medications actually decreased. There is also a direct parallel between the increase in opioid prescription and opioid-related deaths.

National focus is now shifting to the opioid epidemic. Leading practitioners and researchers are working to shift the focus from opioid prescription to opioid abuse, urging practitioners to focus on the rehabilitative use of opioids rather than the palliative use. Focus should be on function, not self-reported pain levels.

States have also been taking steps to curb opiate use and abuse, with Washington State leading the way. Most states now have formal Prescription Monitoring Programs, but monitoring does not ensure prevention.

Three out of four injured workers in the United States receive opioid medications for pain relief after workplace injuries. With that noted, workers rarely receive the services recommended to accompany chronic opiate usage. Claim professionals are in a unique position to monitor and, in effect, exert some control over the extent of a claimant's opiate abuse and misuse. When preventative steps are not taken, carriers and self-insureds pay the price for long-term opioid abuse, in the form of much larger indemnity payments and enormous Medicare Set-Asides (which each make up approximately 50% of the total settlement value). Accordingly, implementing early strategies to mitigate both medical and prescription drug utilization can drastically impact claim experiences.

POSSIBLE SOLUTIONS

By identifying problem claims in advance, early steps can be taken to lessen opiate usage and ultimately mitigate the loss. Strategies include the following:

- **Pharmacy utilization review:** Polypharmacy takes many forms. Often an injured worker obtains prescription drugs from more that one physician. Each physician may rely on the patient's self-report of medications prescribed by other providers when deciding to supplement with other prescription drugs. Pharmacy utilization review has an independent reviewer look at all prescribed medications together. The reviewer can then address warnings, counter-indications, and dangers of a patient's poly-pharmacy and patterns of abuse.

- **Direction of care:** The earlier opioid use occurs in the treatment of an injury, the more likely the patient is to be come addicted. By using a trustworthy and responsible panel of physicians (in states that allow this), opioid abuse prevention can be tackled right from the start of a claim.

- **Nurse case management:** Facilitating communication and watching for signs of opioid abuse or dependency are two key areas a nurse case manager can add enormous value. Nurse case managers help ensure treating physicians receive accurate information, not just self-reported and sometime self-serving histories from claimants, and give claims professionals a heads-up when opioid abuse looms on the horizon.

- **Prescription Drug Programs (including Prescription Benefit Management (PBR) programs):** Consolidating prescription fills goes a long way in ensuring that the drug interactions are well addressed and that the patient is made aware of the risks and warnings associated with using multiple drugs. Prescription drug programs will also warn claims management professionals when an injured worker is on a path to addiction. PBRs often also incorporate drug utilization review programs, which is an added bonus. PBRs also make claims handlers aware of early refills, a sign of drug abuse or illegal sale of the prescribed drug.

- **Utilization of State prescription drug monitoring information:** When an injured worker uses more than one pharmacy to fill medications, particularly where both opioids and non-opioids are being prescribed, obtaining data concerning an injured worker's actual medication usage and filling helps claims handlers, nurse case managers and physicians to identify and attack opioid abuse and misuse earlier.

- **Prescription card programs/Mail order programs:** Usage of a prescription drug or mail order programs allow monitoring of polypharmacy and facilitate pharmacist communication to an injured worker concerning drug warnings and possible interactions. Injured workers can be sent correspondence with opioid prescriptions concerning the possibility of abuse with "chronic" use, signs and symptoms of abuse and the like.

- **Independent Medical Evaluations (IMEs) (and their state-specific equivalents):** Usage of IMEs to address the reasonableness and necessity of opioid use, particularly early in the case, can bring opioid weaning to the forefront of the discussion before addiction occurs. Efforts should always be taken, even if later in to the cycle of addiction, to remove the addictive drugs from the treatment plan where medically appropriate. Independent medical evaluators can help attack the problem throughout the claim.

- **Fraud/SIU investigation:** Opioids have a high street value, even higher than heroin in most markets. In late-stage addiction, injured workers may even sell their opioids for a high price and turn to the street to purchase less expensive, and stronger, street heroin. Fraud investigation teams can also be used to monitor the state's prescription drug monitoring system's database and alert claims handlers of red flags. Particularly when urinary drug screens fail to show the prescribed medication in the injured worker's system, fraud and SIU teams can also be used to investigate whether the injured worker is selling his or her prescription drugs.

- **Litigation and attorney involvement:** Using the attorney to push weaning and tapering though the workers' compensation hearing system is often necessary in states that allow

such action. Sometimes the threat of litigation is enough, other times cases need to be tried in order to put an effective weaning process in place. Attorneys should have a good working knowledge of the science of addiction, and should vigorously cross examine the chronic opioid-prescribing physician on the evidence-based studies that demonstrate that chronic opioid use is counter-productive and deadly.

HealthSouth developed a program for automatic review of claim files involving Morphine Equivalent Dosages of 50 or more. This program utilizes many of the above claims management tools, and has them all work together, to achieve early successful outcomes.

CASE EXAMPLES/APPLICATION

The following are two, real-life examples of approved Medicare Set-Asides involving injured workers who used chronic opiate pain medications. These examples will be used to illustrate the problem, demonstrate the potential monetary impact of the problem and identify claims management techniques which could have been employed to yield a better result. To protect patient and client confidentiality, names have been omitted.

Case Example #1:

- Lumbar disc symptoms, Brachial neuritis, Left knee pain, Cervical disc symptoms, Depressive and mood disorder, PTSD
- Treatment recommendations: 2009 candidate for anterior cervical and lumbar fusions (refused); 2011; Lumbar medial branch blocks (unhelpful); physical and psychotherapy (continues to be recommended); Epidural steroid injections (ineffective); Spinal cord stimulator discussed (patient declined trial)
- Continued medication usage: Opana ER, 10 mg, 60 per month; Acetaminophen/ Hydrocodone Bitartrate, 5/325 mg, 60 per month; Ambien CR, 12.5 mg, 30 per month

Case example #1 involves a Morphine Equivalent Dose of 70, with additional use of Ambien. Concerns for this patient should be: high opioid dosages coupled with an allocation for a spinal cord stimulator, the likelihood that the opioid use will increase over time, and utilization of three nervous system-depressing drugs. This Medicare-approved Set-Aside gives the carrier few options with which to address the real problem, and makes it difficult to cost-effectively resolve the case. The approved MSA also sends a message to the patient that Medicare approves of this dangerous treatment plan.

Case Example #2:

- Right shoulder injury, then 2nd accident causing neck injury; Right shoulder surgery; Several cervical spine surgeries over 5 year period; Sent for pain management; No further surgery recommended; 29 year life expectancy

- Treatment recommendations: Pain management and blood work

- Continued medication usage: APAP/Hydrocodone bitartrate, 10/325 mg, 120 per month; Ibuprofen, 800 mg, 45 per month; Metaxalone (Skelaxin), 800 mg, 30 per month; Methadone Hydrochloride, 10 mg, 90 per month x 29 years

Case example #2 involves a Morphine Equivalent Dose of 280, but was relatively inexpensive. Concerns for this patient are: the extremely high opioid dosage, usage of Skelaxin in conjunction with high dosages of opioids, and death. Again, this Medicare-approved Set-Aside sends the message to the injured worker that the treatment plan is safe, when it is actually likely to cause death.

Concerns in both fact patterns raise are medical, legal and ethical. The second case presents a much more cost-effective claim resolution but will almost certainly lead to death. Managing the medical in the cases more aggressively and earlier may have led to more expensive treatment in the short-term, but the permanent partial (or permanent total) disability that stems from either medical outcome remains expensive. Applying one or all of the above tools, starting early in the case, could have led to different patient outcomes, lower permanency settlements and possibly lower MSAs.

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