I. OVERVIEW

Prescription drug abuse is the nation’s fastest-growing drug issue; an epidemic affecting all of society and workers’ compensation in particular. Prescription opioids\(^A\) are presently the number one workers’ compensation problem in terms of controlling the ultimate cost of indemnity losses. 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. Nationally, an estimated 55 to 86 percent of all claimants are receiving opioids for chronic pain relief. However, the overwhelming consensus of evidenced-based medicine does not support its long-term treatment protocol outside of very specific cases, most of which involve end-stage cancer treatment.

The aggressive prescribing of opioids to treat chronic pain is a relatively new phenomenon in workers’ compensation’s 100-year history. Overdose deaths from prescribed painkillers have increased

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\(^A\) Traditionally drugs derived from the poppy plant were known as narcotics, and technically that term does denote a substance derived from the opium poppy. However, law enforcement adopted the phrase “narcotic” to refer to all controlled substances, which includes non-opiate drugs such as amphetamines, marijuana, benzodiazepines, etc. Therefore, to avoid confusion, the medical community adopted the term opiate to refer to all drugs derived from opium, and more specifically, opioids to refer to synthetic derivatives. The phrase ‘opioids’ will consistently be used in this paper.
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Pharmacy is growing disproportionately to total medical costs. Pharmacy only accounted for about 2 percent of medical in 1990, grew by 400 percent by year 2001 and almost another 90 percent by 2010. Today, on average, workers’ compensation prescription drugs account for 19 percent of total medical spend, which equates to slightly less than 11 percent of “ultimate developed” total incurred claim costs. Opioids themselves account for an average of 25 percent of that pharmacy spend, and 35 percent or greater for claims over three years old. But those are just the direct costs. The indirect impact on indemnity costs is equally dramatic. Claimants on long-term opioid care, greater than 90 days, are not typically going back to work, have become tolerant or

300 percent since 1999, when the nation experienced approximately 15,000 fatalities, more than cocaine and heroin combined, and they originate from prescriptions, not home labs (see Figure 1). The misuse and abuse of prescription painkillers was responsible for more than 475,000 ER visits in 2009, doubling in just five years. Employers’ workers’ compensation claims are caught right in the middle of the fray.
even dependent on the drugs, and suffer a multitude of associated illnesses and debilitating side effects secondary to the drugs’ use. The Medicare Set-Aside (MSA) calculations become heavily burdened by the chronic use of these drugs of nearly indefinite duration. These losses become exceptionally expensive and very difficult to settle.

Combining the direct and indirect costs of an under-managed pharmacy benefit program and its impact on indemnity losses caused by longer temporary total disability (TTD), greater permanency ratings, and the treatment of comorbidities, we are looking at total pharmacy representing somewhere in the neighborhood of 20-30 percent of workers’ compensation ultimate developed claims costs. Pharmacy is no longer of minor importance in the management of workers’ compensation claims.

II. WHAT DO PHARMACY BENEFIT MANAGEMENT (PBM) STEWARDSHIP REPORTS REALLY TELL YOU?

Most Employers Don’t Know What They Don’t Know

The crisis is made worse by the fact that most, if not nearly all, employers simply don’t know what they don’t know about workers’ compensation pharmacy and how seriously impactful this lack of knowledge is to their bottom line. Pharmacy Benefit Management (PBM) stewardship reports are typically not quantifying the severity of the problem when they do not represent both direct and indirect savings.

Ask most CFOs and corporate managers of risk how much influence prescription drugs have on their cost of claims and the answer will typically be “a very small percentage.” They will, however, state that they are saving large sums of money from discount pricing as communicated by their third-party administrator. Typical pharmacy stewardship reports are inadequate and not representative of the complete picture. They tell the favorable money-saving discount story that the employer is anxious to hear. In nearly all cases, there is an absence of factual data on pharmacy clinical utilization or absence thereof (the control of inappropriately prescribed medications, unreasonable dosage, duration of use, etc.). There is usually too much fluff and not enough substance for effective employer decision making. Remember, managed care reports represent only those prescriptions processed through the pharmacy benefit management provider, which may only be between 50-60 percent of the total pharmacy spend. We have yet to see a stewardship report include a slide on “Total Estimated Losses in Net Savings through PBM Leakage.” The cost of leakage will normally be greater than the PBM savings from network discounts, as leakage represents the absence of clinical utilization controls.

Without near-term clinical intervention into a claim involving both early and high-dose prescribing of opioids, the savings from drug repricing is but a fraction of the total potential savings in ultimately developed total claims costs.

B In nearly all cases, there is an absence of factual data on pharmacy clinical utilization (the control of inappropriately prescribed medications, unreasonable dosage, duration of use, etc.).
So What Is the Problem?

The problem is that the executive information provided to employers by their TPAs and Managed Care Organizations (MCOs) is falling short of telling the whole story. We have found that TPAs simply do not know what the employer is actually spending on pharmacy. The reason is that between 40 to 50 percent of pharmacy is dispensed and billed by physicians, or the claimant filled their prescriptions without a pharmacy card, and the pharmacy sold the script to a third-party, who subsequently bills the TPA. In these cases, the paper bills seldom go through the pharmacy benefit management company where formulary controls and clinical edits may be applied. There are some exceptions out there with TPAs having the sophistication to extract pharmacy from physician-embedded billings and out of network paper bills and consolidate that information into the claimant’s pharmacy file. They are, however, few in number.

When combined with consensus statistics, our marketplace data as a whole suggest a mere 60 percent of pharmacy is running through PBMs. CorVel Corporation, a TPA that integrates its bill review and pharmacy platform, in its exhibit below, “visibility” refers to the actual identification of all pharmacy, including paper bills. Penetration only refers to the percent of total pharmacy going directly through the PBM. Employers whose TPAs report penetration in the high 80s or greater should view that as a big red flag and ask for proof.

“Typical pharmacy stewardship reports are inadequate and not representative of the complete picture.

Figure 2. Courtesy CorVel
Let’s break this down for clarity, as we must impress upon employers the importance of this “leakage” from what most think is automatically running through their PBM. There are three general categories in which prescriptions are dispensed and paid outside of the employer’s pharmacy benefit management program:

- Physician-dispensed drugs
- Local pharmacies sales of Rx to 3rd party billers
- Non-PBM mail order pharmacies

1. **Physicians are dispensing drugs directly to their patients** for increased revenue. No pharmacy is involved. According to the NCCI (National Council on Compensation Insurance), this costs about 10-20 percent more per script than through a pharmacy. Or, physicians use repackaged drugs and dispense these drugs directly to their patient. Again, no pharmacy is involved. This is far more lucrative, and the NCCI states that repackaged drugs cost around 2-3 times that of a pharmacy.

2. **Local pharmacies sell their prescriptions to third-party billers.** These prescriptions are typically not run through the PBM formulary. Here is what is important about this category. Many claimants will show up at a pharmacy without a prescription card before their claim has even been set up by the TPA/carrier. The pharmacy does not have the time to figure out which PBM to bill, so they sell the script to a third-party biller at a discount and are paid immediately. The third-party biller will later identify the payer and charge a very hefty markup over the pharmacy contracted rate. What is worse, and quite typical, the pharmacy may continue to sell the same claimant’s refills to the third-party, who, in some cases, hides the name of the original pharmacy so the employer cannot call to convert future prescriptions to their PBM. What is interesting is that many TPAs and their PBMs make no effort to make the necessary communications to convert future fills. This high cost prescription cycle continues and the claimant’s prescription history is not centralized into a database against which to conduct continuous drug utilization reviews for safety, dosage, or medical efficacy.

3. **Then, there is the smaller category of alternate pharmacies providing mail order service directly to the claimant.** These also are not screened by the PBM. Furthermore, these alternative mail order operations may use repackaged drugs in a manner similar to dispensing physicians in order to inflate drug costs.

In summary, employers must consider that 40-60 percent of pharmacy without point of sale controls is very costly. Recommendations to reverse this leakage are addressed in Section VI, Best Practices and Recommend Program Guidelines.

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C Drugs have unique National Drug Codes (NDC) that are specific to both the drug strength and formulation, and in the case of physician-dispensed drugs, to the repackager. Thus, the repackager can set their own inflated average wholesale price (AWP) of the drug from which a percentage of that AWP is paid, according to usual and customary payment formulas. This artificially inflated AWP is substantially higher than the same drug through a pharmacy.
Generic vs. Brand Penetration Report

When evaluating the effectiveness of a PBM to increase savings through the use of generic substitution, there are three significant reports that a TPA/carrier (payors also include self-insured programs, state agencies, guaranty associations, excess carriers, and others responsible for the payment of workers’ compensation claims—for our purposes, we will label payors solely as “TPAs”) must evaluate: 1) generic substitution; 2) generic efficiency; and 3) upcoming patent expiration dates.

The first of these reports, generic substitution, is a measure of the percent of prescriptions that are dispensed as a generic out of a TPA’s entire book of business and provides a good baseline to compare one’s own book of business to industry reports. This number should be in the 80 percent range for most workers’ compensation payors. However, for those TPAs that are below this number, the generic substitution report does not delineate between poor performance on behalf of the PBM versus a patient population that may require the use of more drugs that are still considered “single-source” brands, meaning that only brand names are available for certain drugs because they are still covered under patent. Fortunately for workers’ compensation, most of the common drug categories are overwhelmingly available as generics. For example, in the nonsteroidal anti-inflammatory drug (NSAID) category, Celebrex is the last remaining single source brand. Ironically it is within the opioid category where the preponderance of single-source brands remains, e.g., OxyContin®, Exalgo®, Fentora®, and others.

In order to make this delineation between the prevalence of generic dispensing versus the opportunity for generic dispensing, a generic efficiency report is necessary. Generic efficiency is a measure of how often a generic drug is dispensed when a generic is available. In other words, single-source brands which have no generic substitute are kept out of the equation. Generic efficiency should approach 100 percent, and most payors should see efficiency ratings equal to or greater than 98 percent with the remaining 2 percent of brand dispensing being attributed to restrictions on generic dispensing either through regulatory limitations or market conditions.

A report on upcoming patent expiration dates is also critical in evaluating one’s drug spend because this gives some insight into potential savings through the introduction of new generic alternatives. Brand name drugs are protected by patent for 17 years, during which time no other company may produce that same drug. A significant portion of those 17 years is consumed by simply getting a drug through the FDA approval process. As a result, a new drug may only have a few years of patent protection remaining once it hits the market. Once the patent expires, the FDA then typically gives one generic company exclusive rights to market a generic version during the next six months, and only after that exclusion period has ended may other generic companies launch their generic version. As a result, the average wholesale price (AWP) of the new generic only drops about 10 percent during that exclusivity period, and only after multiple generic companies launch their version will the market see a significant decline in AWP. To further
complicate the process, the original brand name version will often see a corresponding rise in AWP just before patent expiration. However, knowing these generalities may help a company better define its reserves for the period just before market expiration, for the six months of generic exclusivity, and for the period past that six-month mark. In fact, being armed with such knowledge could directly influence the timing of conducting an MSA settlement. If the timing of an MSA may be postponed a short period of time in order to see if a generic is launched, then the payor may realize significant savings over the lifetime of the patient if that settlement may be based on a generic drug versus a single-source brand. The lesson here is to check each long-term drug used by a claimant at the time of an MSA analysis. Simply contact the PBM for information on patent expirations.

The PBM Penetration Report

PBM Penetration reports, also known as Retail Pharmacy Network Utilization reports, are crucial to evaluating the performance of a workers’ compensation PBM. Simply stated, if pharmacy is not running through the PBM, the employers simply will not realize the savings from its structured program.

PBMs have varying methods of encouraging this utilization, but it is only through a measure of network penetration that these methods can be proven to work. In order to perform this measurement, the payor typically must provide the PBM with copies of its out-of-network or paper bills so that the PBM may use these to calculate its degree of success at promoting network participation. Most TPAs are unable or fail to provide bills to PBMs.

Example: Payor With $10M in Annual Drug Spend at a Fee Schedule

<table>
<thead>
<tr>
<th></th>
<th>PBM 'A'</th>
<th>PBM 'B'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective discount rate</td>
<td>-15%</td>
<td>-10%</td>
</tr>
<tr>
<td>Calculated Savings off fee schedule</td>
<td>$1,500,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Actual penetration rate</td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td>Actual savings off fee schedule</td>
<td>$750,000</td>
<td>$900,000</td>
</tr>
</tbody>
</table>
In this example, it becomes readily apparent that a greater contracted discount rate will not equal greater actual savings if the PBM does not actively promote network utilization by both the injured worker and the network pharmacy.

Figure 3 below illustrates how a TPA may see network utilization increase over time with active network management:

It is also crucial that an TPA understands how competing PBMs define what is included in the measure of Network Penetration. Therefore, the following questions are offered as a guide to navigate through this process:

1. Are first-fill prescriptions included in the calculation?
2. Are prescriptions that are not actually processed online ever considered to be “network” transactions?
3. What prescriptions are excluded from the calculation, and under what circumstances?
As stated previously, it is crucial to understand how the PBM defines its reports. In the case of network utilization, be aware that some PBMs may include certain paper bills as “in-network” if those bills are repriced but never actually processed online. These should never be included as “in-network” penetration. Alternatively, a PBM may exclude certain bills, such as physician dispensing bills, because they are not dispensed from a pharmacy. If you provide your PBM with copies of these bills, be sure you understand how they factor into the calculation.

Clinical Savings Report

It is a poorly kept secret that the more drugs that are processed, the more money a PBM makes. In fact, the business model for both pharmacies and PBMs is dependent upon the sale of drugs. Consequently, the PBM industry has been compared to the “fox watching the henhouse” when it comes to the curtailment of prescribing, especially with regard to opioids. Hence, this is truly a case of “buyer beware” when it comes to the evaluation of PBMs. If the expectation is to simply provide a discount off of fee schedule, then there are plenty of providers that can offer an efficient processing platform at a low-cost model (keeping in mind the statements in the previous section regarding network penetration). On the other hand, if the expectation is for the PBM to provide the payor with the tools necessary to curtail overutilization of prescription drugs and to identify potential fraud, waste and abuse via a clinical pharmacy program, then both the program and its measurement must be clearly defined and understood.

First of all, it must be acknowledged that clinically-based decisions regarding pharmacy treatment may not always involve the selection of a lower-priced drug. There will be valid situations in which a more expensive therapy is actually the best choice for the patient in terms of outcomes. With that said, the vast majority of clinical pharmacy recommendations do represent cost savings primarily because the majority of decisions represent either discontinuation of a drug or weaning from a drug. As a result, a clinical savings report is a valid measure of the success of such a program.

![Drug Regimen Review Outcomes](image)
These measurements may include many, if not all, of the following components:

1. **Savings from rejected transactions**: Prescription transactions that are rejected at the point of sale represent savings only if they stay rejected. In other words, if the rejection is overridden by a retail pharmacist, an adjuster, or an adjuster authorizes payment for a subsequent third-party billing, then no actual savings are realized. It is not unusual for a TPA’s adjusters to override rejections 50 percent of the time. Make sure your PBM does not include these transactions as savings. However, when a transaction is blocked for reasons such as nonformulary, unauthorized physician, coverage terminated, refill too soon, duplication of therapy, dangerous drug interactions and other drug utilization review edits, and that reason is not overridden, then those blocked transactions are a valid component of clinical savings.

2. **Savings from physician outreach programs**: Educational-based intervention programs will have an impact on the drug selection process. However, it is not valid to accept what a physician states that he or she will do. Instead, the PBM must measure and document a true change in prescribing patterns.

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**PROGRAM RESULTS—FENTORA**

- Total Script %
- Cost %

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**PROGRAM RESULTS—ACTIQ**

- Total Script %
- Cost %

Courtesy of myMatrixx
3. **Savings from pharmacist to physician** interventions: Teleconferences conducted by clinical pharmacists have an impact on guideline compliance from physicians. Oftentimes, physicians are not aware that they are practicing outside of guidelines or that they are placing their patients at risk by doing so. Inclusion of the nurse case manager in this equation also increases compliance.

4. **Savings from peer to peer interventions:** Similar to pharmacist to physician interventions, peer to peer interventions (physician to physician) can improve guideline compliance and may be a crucial step in those difficult cases that must be managed one on one.

Unfortunately, there is no magic bullet that will “fix” the prescription drug abuse epidemic. Each case is unique and must be treated as such. Even so, there is a downstream effect of these interventions, sometimes known as a “shotgun” effect, that is difficult to measure but is valid nonetheless, and that is the impact that one intervention has on a physician’s treatment of other patients in his or her practice. Once a physician adopts best practice guidelines, it is likely that those guidelines will be applied to all patients under his or her care.

**III. THERE IS A CRISIS IN OPIOID PRESCRIBING PROLIFERATION AND THE SUBSEQUENT MISUSE AND ABUSE OF THESE OPIOIDS**

**Opioids Influence on Impacting Both Pharmacy and Overall WC Costs**

The financial impact of pharmacy, especially opioids and opioid/acetaminophen combination analgesics, is becoming clearer as new research data is being published at an increasing rate. Previously, pharmacy was only looked at in terms of its percentage to total medical spend. As we have addressed thus far, that percentage has been communicated as artificially low due to substantial underreporting of total filled prescriptions through the PBM.

Its total impact on claims is just now being estimated from large population data. Potentially, the author believes savings from combining (1) the reduction in overexpenditure in total pharmacy, (2) the potential reduction in costs of treatment for addiction recovery and morbidities secondary to opioid use, and (3) the reduced number of disability days and permanency ratings from those claimants on long-term pain management, and (4) proactive management of Medicare Set-aside settlements, could potentially equate to 8 to 15 percent of total incurred costs. That’s a powerful incentive to gain control of pharmacy.

The recent Hopkins-Accident Research Fund Study (2012) found “workers prescribed even one opioid had average total claims costs four to eight times greater than claimants with similar claims who didn’t get opioids.”

Swedlow, et al., reported “Average claim costs of workers receiving seven or more opioid prescriptions were three times more expensive than those of workers who receive zero or one opioid prescription, and these workers were 2.7 times more likely to be off work and had 4.7 times as many days off work.”

Another study involving a large database indicated that
The NCCI, in its 2009 Research Brief on Opioids in Workers’ Compensation, simply stated that the longer a worker is on opioids, the longer he is off work. California’s MTUS Chronic Pain Medical Treatment Guidelines state that “The likelihood of return to work diminishes significantly after approximately three months of sick leave.”

There are a multitude of costs directly linked to prescribed opioids. Many can occur after only a short-term use following an injury and then increase in frequency and severity as the claim ages. These increased costs can be summarized into the following categories:

- Increased frequency of emergency room visits from overdose
- Death
- Addiction treatment
- Comorbidities (illness)
- Abuse and misuse of prescribed drugs

It is estimated that about 35 percent of patients receiving long-term treatment with opioids may be addicted. Addiction is individual in nature. It can affect some patients after only a few weeks and not others after many years of chronic use.

Medical research suggests opioids, as a pain management tool, can only reduce a patient’s pain by 30-40 percent. Therefore, it is common for opioids to be prescribed in combination with other, non-opioid, analgesics such as acetaminophen.

Research from 1998 to 2000 showed acetaminophen was the leading cause of acute liver failure in the United States. Extra Strength Tylenol was reformulated just for this reason. Yet, it is not unusual to find numerous claims involving the long-term use of acetaminophen at or well exceeding maximum FDA recommended dosage. Combine the daily intake of acetaminophen at high levels with alcohol consumption, which would not be uncommon, and liver toxicity increases proportionally. Liver failure may result in the need for liver transplants for which the employer is responsible.
The list of comorbidities (illnesses) secondary to opioid therapy seems endless. The following are the most typical side effects and are frequently found with those on long-term therapy:\(^\text{12,13}\):

- Respiratory depression (very common)—slow, shallow breathing causing sleep apnea, which can result in heart attack and stroke.
- Hyperalgesia (the patient becomes more sensitive to pain)
- Serious fractures
- Depression
- Infertility
- Decreased libido
- Erectile dysfunction
- Bowel obstruction
- Chronic constipation
- Immunosuppression
- Myocardial infarction
- Tooth decay (from dry mouth)
- Testicular atrophy
- Chronic obstructive pulmonary disease

Each of the above disorders becomes secondary to the prescribing of drugs for pain relief and in and of themselves become compensable medical conditions, rapidly increasing the medical and indemnity cost of claims. These expenses are not necessary in the treatment of most workers’ compensation claimants.

If the employer and TPA understand and integrate countermeasures into their claims management program to address the following facts\(^\text{14}\), significant improvement can be experienced with claims outcomes:

- Evidence of long-term efficacy of chronic noncancer pain (≥ 16 weeks) is limited and of low quality. Opioids are effective for short-term pain management. But for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.
- With daily opioid use, physical dependence and tolerance can develop in days or weeks.
- Successfully tapering chronic pain patients from opioids can be difficult, even for patients who are motivated to discontinue opioid use.
- Estimates vary. Between 4 percent and 26 percent of patients receiving chronic opioid therapy have an opioid use disorder.
- Opioids have significant risks besides addiction and misuse. These risks include respiratory depression and unintentional overdose death.
- No randomized trials show long-term effectiveness of high opioid doses for chronic, noncancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.
- When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but can increase risk.

**The Impact of Opioids on Pharmacy Spend on Claims Open Greater Than 2-3 Years**

A study by the NCCI in 2009 determined that although opioid use declined over time, its use could continue for many years. A more recent study\(^\text{15}\) found that high
use of opioids in the first quarter following an injury is related to that injured patient continuing to receive opioids in subsequent quarters. One conclusion that may be drawn from this study is that early intervention to ensure evidence-based guideline compliance may also lead to a decrease in use in subsequent years.

The Impact of Pharmacy, and Opioids in Particular, on Medicare Set-Aside Calculations and Settlements

The 80:20 “Paretto’s Rule” applies to many things, including workers’ compensation. Approximately 20 percent of a claim’s medical cost is for pharmacy, while the claim is open, and 80 percent for medical expenses. When the claim moves to the closure stage and a Medicare Set-Aside (MSA) is required, this percentage is inverse; 80 percent of the MSA cost is pharmacy, and the numbers can be staggering, so staggering that many self-insured companies want to leave the medicals, or at least the pharmacy, “open” and settle the indemnity.

CMS regulations coupled with the increased use of opioids in older claims (up to 40 percent of medical cost according to the NCCI’s 2011 data) are the major cost drivers. An effective PBM program will apply clinical protocols to get ahead of the claim and ensure that therapy is within guidelines and cost-effective measures are in place well before time for an MSA.

IV. UNDERSTANDING THE KEY FINANCIAL COMPONENTS OF A PHARMACY BENEFIT MANAGEMENT PROGRAM

How Does Prescription Pricing Work and What Is Its Impact on Total Savings From an Effective PBM Program?

When it comes to pharmacy spend, the majority of attention is always focused on the “cost per pill”. This is an obvious choice to look at when purchasing any item – however, its significance should be placed in perspective: the “cost per pill” approach is based on a contracted rate for the purchase of brand and generic drugs, and is typically a discount off of AWP plus a dispensing fee:

- AWP per unit, times quantity, plus dispensing fee = contracted price

Since most states have a fee schedule based on similar formulas, the savings model is simply:

- Contract price minus fee schedule = Savings

Unfortunately, this approach does not account for the significance of savings that may be realized from an effective PBM program that ensures the following: 1) maximize the network pharmacy utilization—
remember, one will not realize contracted savings on out-of-network prescriptions that likely go through a third-party biller; 2) maximize generic utilization—generic substitution represents one of the single greatest cost savings strategies, but it also diminishes a PBM's top-line revenue—therefore, look for generic efficiency rates in the high 90th percentile to ensure that the PBM has your interests in mind and not their own; 3) ask for your refunds—many prescriptions are never picked up by the patient, but the pharmacy bills for prescriptions at the time of dispensing. If the prescription is not picked up, then the pharmacy “reverses” the transaction through the PBM, generating a credit. When was the last time you or your TPA received a credit? Do you know? Does your PBM measure and record these refunds? And, 4) clinical savings—discussed in detail below—there is no greater savings than cost avoidance.

What Is Clinical Utilization Management and What Is Its Impact on Total Savings From An Effective PBM Program

Most PBMs are very efficient at processing prescription transactions, though those that follow best practices will also provide clinical pharmacy oversight, such as:

- Formulary management
- Guidelines compliance
- Identification of potential fraud, waste and abuse
- Identification of risk factors
- Identification of medication therapy alerts
- Physician and patient intervention programs

Although there may be situations where clinical guidelines indicate that one drug is therapeutically superior to another, and that drug also happens to be more expensive, the vast majority of clinical interventions involve less expensive alternatives or discontinuation of a drug altogether. An effective PBM program will measure those efforts and provide measurable savings tied to these activities. Caution: make sure that clinical savings are “real” savings—the transaction was reversed or the prescription cancelled—and not “soft” savings—this is what might happen.

V. HOW SHOULD CHRONIC PAIN PATIENT CLAIMS BE MANAGED?

First, Make Sure All Is As It Appears

The hydrocodones, oxycodones, and morphine sulfates seen time and again with long-term claims may not always be actually taken by the patient, may be taken in higher dosages than prescribed or even taken along side illicit substances. The Workers’ Compensation Research Institute, in a study involving 17 states, found that fewer than 7 percent of treating doctors conduct baseline and periodic urine drug screens. That number has apparently doubled in recent years but is still a very low percentage given the following concurrent research facts:

- 71 percent of workers’ compensation claimants on chronic opioid therapy greater than three months are not taking their pain medication as prescribed due to misuse or abuse.\(^{16}\)
- 38 percent of patients were found to have no detectable level of prescribed medication; 29 percent had nonprescribed medication; 27 percent had drug levels higher than expected; 11 percent had illicit drugs.\(^{17}\) (Based on a sample of 939,000 drug screens)
Does your PBM/TPA ensure all opioid-prescribed claimants are being routinely drug tested?

**Responsible Treatment Protocols**

There is no short supply of evidence-based medical treatment guidelines for the long-term treatment of chronic pain. There are numerous references cited here that are closely aligned with the Centers for Disease Control and Prevention (CDC) recommendations. These guidelines have been published in response to the increasing morbidity and mortality associated with the increasing use of opioids.18

Adjusters are responsible for ensuring, to the extent permitted by state laws, that treating doctors follow medical treatment guidelines or seek appropriate remedies through consultants’ support or the workers’ compensation statutory process. In brief, the following are some of those key evidence-based medical guidelines:

1. Use opioid medications for acute or chronic pain only after determining that alternative therapies do not deliver adequate pain relief. The lowest effective dose of opioids should be used.

2. In addition to behavioral screening and use of patient agreements, treating doctors must consider random, periodic, targeted urine testing for opioids and other drugs for any patient under 65 years old, with noncancer pain, who has been treated with opioids for more than six weeks.

3. Do not prescribe long-acting or controlled-release opioids (e.g. OxyContin®, fentanyl patches, and methadone) for acute pain.

4. The total daily dose of opioids should not be increased above 120 mg oral MED (morphine equivalent dosage) without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a practitioner qualified in chronic pain management (emphasis added).

5. Risks substantially increase at doses at or above 100 mg, so early attention to the 120 mg MED benchmark dose is worthwhile.

6. Chronic opioid therapy (more than 90 days) should only be initiated on the basis of an explicit decision and agreement between prescriber and patient.

Patients prescribed greater than the morphine equivalent dose (MED) of 100 mg opioids daily had a ninefold increase in overdose risk; most medically serious and 12 percent were fatal.
Who Is a Qualified Pain Management Specialist?

Any physician can hang out a shingle as a pain management specialist. All too frequently, the pain specialists are no better in their improper prescribing patterns than the inadequately trained treating doctor. TPA claims handling instructions should specifically require that adjuster approval of a pain management specialist be contingent on the physician having either completed a fellowship in pain management or hold a board certification by the American Board of Anesthesiology or a psychiatrist or neurologist with pain management expertise (fellowship preferred). Other pain management board certifications are self-serving, and most are not recognized by the American Board of Medical Specialties (ABMS). It is easy for an adjuster to verify fellowships and board certification by simply visiting the American Board of Anesthesiology and looking up the physician. The extra five minutes of research may be worth thousands in claim costs savings.

What Is the PBM’s Role?

Ideally a PBM will have access to all data involving pharmaceuticals, which includes not only those prescriptions processed online via the PBM provider, but also those prescriptions processed through a third-party biller, processed via a group healthcare PBM (and available through the states’ PDMP databases), dispensed by a physician or delivered via an implantable drug delivery device, such as an intrathecal morphine pump. Each PBM may have different methodologies to obtain this data, but the end result should be to provide you with a complete picture of what your claimants are receiving in terms of number of opioids, number of physicians, total dosage, duration, etc. Only with this kind of 360-degree view can your PBM evaluate guideline compliance.

A note about PDMPs: because of concerns over privacy, access to PDMPs is typically restricted to law enforcement and physicians and pharmacists licensed in that state. Furthermore, any information discovered in accessing that database cannot be shared with anyone else. However, a pharmacist may use what he or she discovers from the PDMP in a treatment discussion with the treating physician.

What Is the Adjuster’s Role?

The adjuster’s primary role is to stay on top of claims with prescribed opioids either within the first 10 days of an acute injury or where these opioids are being prescribed beyond 45 days.
What this translates to is:

- Not overriding formulary denials without specific justification and seeking medical guidance from internal professional staff to assist in making override decisions.
- Engage the PBM as often as necessary if medical reports show the onset of illnesses not normally associated with workers’ compensation claims and are typically side effects from prolonged opioid use.
- Follow PBM recommendations for engaging the treating doctor in modifying prescribing patterns.
- Ensure physician-patient agreements are in place where opioid use extends beyond 30 days.
- Encourage the treating doctor to make use of tools for assessing the risk of opioid addiction in advance of prescribing opioids.
- Ensure the opioid prescribing doctor conducts a baseline urine drug test, where opioids are being prescribed beyond 30 days, and for patients under age 65, periodic, unannounced random urine drug tests are conducted.
- Only approve referrals to qualified pain specialists.
- Above all else, engage and challenge the treating doctor as to the validity of continuing opioid prescribing where periodic medical reports do not indicate progress in work and life skills functions and reduction in pain.
VI. BEST PRACTICES AND RECOMMENDED PROGRAM GUIDELINES

Consensus

TPA claims handling instructions should be modified to require adjusters to follow the consensus guidelines established by the Centers for Disease Control and Prevention, American College of Occupational and Environmental Medicine, the Washington State Department of Labor and Industries AMDG Guidelines, the California MTUS, and many others that are uniform in their standards.

The TPA/carrier and its managed care PBM have joint responsibility for the effective management of pharmacy. The PBM, through its formulary edits and point-of-purchase controls, may restrict the dispensing of nonformulary drugs, early refills, or inactive claimants. Pharmacies can circumvent the formulary denials by filling the prescriptions and selling the scripts to a third-party biller. The PBM should also be reviewing individual claimant prescription trending and alert the TPA when a claimant's prescribing history raises red flags. Adjusters can and do override the PBM formulary denials. With some exceptions, this option should be removed and centered with a designated TPA triage nurse, who acts in compliance with the employer's claims handling instructions.

This suggests a whole new paradigm in claims management, but it is driven out of necessity.

Pharmacy First Fills

Getting early control of a claimant's clinical utilization of pharmacy is of course critical. Without directing as much of total prescribing through the PBM with its point-of-sale controls, utilization management is severely hindered. There is no more effective and efficient approach to this control than capturing that injured worker and the treating doctor at the point of initial treatment with an immediate authorization to fill the first prescription (Rx First Fill) at a participating PBM pharmacy. While no system is perfect, there is a tool combined with an outsourced vendor solution to gain very early control combined with numerous attendant co-advantages.

While this paper is focused on pharmacy, it is necessary to expand the employer's understanding of the greater process in which pharmacy is a vital component. By early soft (recommended) or hard (mandatory) direction of an injured worker to a designated PPO medical provider, there is a greater opportunity to control pharmacy.

There are two further considerations for employers with respect to gaining early control of the claim. The first involves 24/7 nurse triage. This very simple, low cost remedy to reduce the frequency of workers' compensation claims and to direct care is greatly underutilized. The second is the use of an inexpensive, real time, controlling document called a health ticket by VIIAD Systems. While VIIAD's products can be used separately with impressive results, these two resources, when used in concert, can yield extraordinary outcomes.

24/7 Nurse Triage. There are a number of qualified vendors (Medcor, CorVel, Coventry NT24, Bunch & Associates’ Care Solutions) who provide around-the-clock registered nurses as the initial claims intake and
medical triaging of a worker’s injuries. On average across all industry classifications, these services will divert more than 30 percent of injured worker calls to self-care, eliminating the need to file claims. Some industry classifications, such as manufacturing, grocery, retail, and hospitality, will see upward of 50 percent self-care. The injured worker is directed to a toll free number to report his injury, which commences what can be a very specific initial claims process with incredible results. Besides the sizeable direction to self-care, the nurse will pull up a client-specific list of predesignated PPO providers by geographic location. The injured worker can then be either soft channeled, with high success ratios, where states prohibit direction of care, or hard channeled to a mandatory panel provider. Many insureds will have company profiles on file with these respective providers addressing return to work, prescription formulary controls, etc. Now, add to the triage process a health ticket, and the results continue to improve.

VIIAD Health Ticket. (VIIAD Systems LLC (www.viiaid.com), offers among other services, a Health Ticket that is customized to each customer’s specific needs and state-specific content. Following the nurse triage intake, the client’s intake report is picked up by VIIAD within minutes and immediately directed by fax to the designated medical provider to which the injured worker has been referred. The ticket includes a client-specific pharmacy prescription first-fill I.D. card, notes to the pharmacist about the client’s formulary controls, identification of specialty PPO networks, where to direct billing and who to call with the TPA/carrier for questions. CorVel also has a treatment authorization and first-fill form that their triage will send to providers in advance of care (www.corvel.com). While we prefer to avoid vendor endorsements, these products are too good not to suggest.

Both the nurse triage and health ticket are completed within roughly 25 minutes of the injured worker’s initial call to triage, and the health ticket is usually in the hands of the medical provider before the injured worker arrives for treatment. The combined process is well orchestrated, maintaining very low costs while hopefully yielding sizeable returns.

Summary of Best Practices

The following is a consolidation of minimum best practices guidelines for an effective pharmacy benefit management program

TPA Responsibilities (Adjuster)
- Drug Regimen Reviews. In lieu of leaving the discretion of ordering DRRs to adjusters, service instructions should reflect orders to the PBM to commence these reviews when very specific flags are first raised.
- Adjuster Performance Standards. Have objective opioid reduction goals as a substantial part of adjuster performance standards for insured.
Adjuster Intervention. Adjuster to obtain and review monthly narcotics reports on insured’s claimants combined with review of latest physician notes to ensure regular intervention to challenge physician’s ongoing use of opioids if claimant is not showing positive signs of continuous improvement in function and reduction in pain.

Adjuster Validation of Patient Screening. Adjuster to ensure that physician has engaged in both initial patient behavioral screening for the potential of opioid abuse and addiction as well as physician-patient signed agreements (contracts) in all cases where claimants are receiving prolonged opioid therapy (>60 days).

Patient Drug Screens. Adjuster to monitor file for physician reports of baseline and periodic (at least quarterly unannounced) urine drug screening for all patients under age 65 following the short acute stage of an injury or post-operatively where opioids are continuing in use.

Pain Management Consult. Adjuster to require/request (depending on state rules for directed care) a pain management consult where opioids therapy has not shown a reduction in pain or improvement in function after 30 days or where the prescribed opioids following the acute stage of treatment equal or exceed 120 mg. of morphine equivalent dosage daily. Consults should only be authorized for board certified rehabilitation/anesthesiologist pain specialists.

Conditioned Rx Prior Approval Authority. Limit adjuster prior approval authorization only after following patient Rx history review and nurse consult.

Mail Order Pharmacy. Monitor all claims for actual or expected Rx greater than 90 days to ensure claimants are enrolled in mail order pharmacy.

Adjuster Prior Approval Reviews. TPA and employer jointly hold quarterly reviews of all adjuster approvals of “Rx Prior Approvals” to monitor adjuster compliance with service instructions.

TPA Designated Nurse Responsibilities (Optional but highly recommended)

Designated Nurse. TPA should designate (dedicate for large clients) an RN triage nurse to first handle all of the insured’s TCM claims as well as manage the pharmacy oversight on all claims where opioids are prescribed.

Nurse Opioid Reduction Goals. Have objective opioid reduction goals as a substantial part of the nurse’s performance standards.

Centralize Prior Approvals. Centralize all Rx prior approvals with the designated/dedicated triage nurse.

Review Open Claims. Review 100% of open claims for all years with current opioid use greater than 30 days. Order DRR’s as needed.

Engage Physicians. Engage in direct communication with treating doctors. Manage timely intervention in all claims involving opioids, including initial physician communications and coordination with adjusters. Interventions should not be left to adjuster discretion.

Routine Narcotics Reports. Run at least monthly PBM narcotics reports by claimant to evaluate acetaminophen and morphine equivalent dosages.

Monitor Physician Compliance with Evidenced Based Medical Guidelines. Identify physician requirements associated with prescribing opioid pain therapy, i.e., initial behavioral assessment, non-opioid therapy, opioid trial, initial and routine urine screening, pain management consult after 30-45 days of opioids pain therapy. Communicate with all treating doctors upon initial treatment when opioids are first used.

Pharmacy Benefit Management (PBM) Provider

Automatic DRRs. Initiate automatic drug regimen review (DRR) after 60 days if prescribing patterns have been unaltered by earlier interventions (TPA or PBM). Notification of employer and adjuster when activated. This process should not be adjuster-centric. PBM to use automatic flags to trigger DRR.

P2P Communications. Include physician to physician (P2P) communications with each DRR.

DURs. Ensure drug utilization reviews (DURs), performed with each new prescription, carefully monitor acetaminophen dosage and duration.

PBM Daily System Sweeps. PBM to ensure client that daily, not monthly or quarterly, sweeps of incoming prescriptions are engaged in an alert process whereby the designated nurse, adjuster, employer, and physician are automatically notified of prescribing patterns with red flags, i.e., multiple opioids within 21 days of injury, opioid treatment beyond 45 days, 120 MED or greater daily, prescribed drugs with interactions, etc.

Managed Care Bill Review Vendor

Separation of 3rd Party and Physician-dispensed Billing. Bill review vendor guarantee that all third party pharmacy billers and physician dispense pharmacy in physician billing is broken out and immediately forwarded to the PBM for repricing and attempted conversion to future PBM fills.

Future Rejection of 3rd Party Bills. Create mechanism to reject future invoices for third party billing in states with directed care where the third party biller has been repeatedly informed of required processing through the PBM on specific claims.
References


7 Joe Paduda, Proceedings of the National Rx Drug Abuse Summit, April 11, 2012: Compliance with Opioids Guidelines, April 11, 2012, Orlando, FL.

8 ibid


APPENDICES

Sample Employer

Dear Employee: This Health Ticket is your I.D. card for your work-related injury. In many cases, it has already been sent to the medical provider to whom you have been referred for treatment. We are committed to ensure you receive the best medical care available to facilitate your safe return to work. Please sign this document on page 2. The medical provider will do the rest. If at any time you have questions, please contact your TPA claims professional at 800-XXXX-XXXX ext. XXXX.

Patient Name: John Smith
Employer: Sample Employer
Date of Injury: 05/30/2012
Claim #: 123456789
Body Park: Left Arm
State of Jurisdiction: SD

Send bills to:
2 East Main Street, Towne Centre Building, Suite 208,
Danville, IL 61832-5852
Ph. 800-XXX-XXX / Fax 800-XXX-XXX

TPA Fax: 800-XXX-XXX

Email: jdoc@tpa.com

Authorizations and treatment questions: 800-XXX-XXX ext. XXXX

THIS CARD DOES NOT CERTIFY COMPENSABILITY OR GUARANTEE PAYMENT

PreAuthorization Requirements

Contact an TPA claims adjuster at 800-XXX-XXX for information regarding state-specific regulations or for the following treatment requests:

- Non-emergency hospitalizations, surgeries, outpatient surgery and transfers
- Psychiatric or psychological therapy
- Chiropractic treatment
- Physical therapy greater than six visits
- Work hardening or work conditioning programs
- Pain, chemical dependency, or weight loss clinics
- Nursing home or convalescent home admissions/transfers
- Home health
- Non-emergency dental services
- Myelogram/discagram
- Bedrest
- Imaging procedures
- Face, trigger point, or epidural steroid injections
- Bone growth stimulators
- Durable Medical Equipment (DME)
- Experimental/investigational procedures
- Request for unusual procedures
- Repeated diagnostic studies
- Radiation therapy or chemo.
- Second surgical opinions
- Inpatient rehabilitation
- Acupuncture

Pharmacy Information:

Use this Care Ticket for any prescriptions that you need to get filled.

Participating Pharmacies:
- Walgreens
- ACME

Provider: John Smith
BIN: 014211
PCN: myMatrix

Safeway
Rx Helpdesk: 1-877-804-4900 x2

The pharmacy benefit card is only to be used for medications prescribed for your work-related injury. By using this card, you acknowledge and accept financial responsibility for any prescriptions billed under this card that are later found to be unrelated to your injury.

Preferred Drug List: generics should always be considered as the first line agents for prescribing. The following therapeutic categories and the drugs listed are not all inclusive but instead represent cost-effective first-line agents that should be tried before second-line agents.

- Skeletal Muscle Relaxants: cyclobenzaprine, baclofen. Carisoprodol should not be considered because of its abuse potential
- Non-Steroidal Anti-inflammatory Agents (NSAIDs): naproxen, ibuprofen
- Neuropathic Pain Agents: amitriptyline, venlafaxine, gabapentin
- Opioid Analgesics for chronic pain: morphine sulfate immediate release, morphine sulfate extended release. Hydrocodone with acetaminophen may be appropriate in short term situations. Opioid analgesics should only be considered after non-opioid products have been tried.

Trans-mucosal fentanyl citrate (TRF) products should not be used except for end-stage cancer patients.

Medical Provider:
Due to concern for our employees, our PBM has removed certain prescription drugs from our formulary that prove to be harmful if used in excess. Please contact myMatrix at 1-800-804-4900 for details.

Scheduling Services

If the patient requires any of the following services/treatments, Scheduling should be provided by calling the following:

DME – myMatrix
877-804-9400 x4

Diagnostic Imaging – One Call Medical
1-800-872-2375

PT – Network Synergy Group
1-888-533-0727

Transportation - Optional
1-866-672-5797

To be completed by Treating Physician
We have a return to work program designed to return injured employees to productive work as soon as possible. If John Test is unable to return to work at full duty, please return this form to our office. This information will be used in identifying other transitional employment opportunities. Injured employees are aware of our desire to have them return to productive employment as soon as they are physically capable. If necessary, we will consider rearranging work schedules around medical appointments to facilitate an early return to work. Thank you for your participation in our efforts to return employees to a safe and productive workplace.

Upon completion, please fax the entire form to 800-XXX-XXX

We would appreciate your cooperation in completing the following items on this form. It is important to our efforts in determining this person’s work potential. Any item that you do not believe you can answer should be marked N/A. Thank you.

1) Total Hours Able to Perform Tasks:
Sit
Stand
Walk

2) Person Can Lift

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3) Person Can Carry

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4) Person Can Push/Pull

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5) Person Can Do Repetitive Movements As in Operating Controls

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Doctor’s Signature __________________________ Date ____________
Cautious, Evidence-Based Opioid Prescribing

Despite low-quality evidence supporting practice change,¹⁻⁶ use of chronic opioid therapy (COT) for chronic non-cancer pain increased dramatically over the past two decades.³⁴⁻³⁶ Concurrently, opioid analgesic overdose deaths, addiction, misuse and diversion have increased markedly.²⁰,³⁷ COT may provide modest, variable short-term pain relief for some patients with chronic pain. Long-term benefits of COT for chronic pain have not been established. Potential medical and behavioral harms of opioids are an important concern, particularly at higher dosage levels and in higher risk or medically complex patients. While COT at lower doses may be a useful treatment for some patients, it should only be considered for carefully evaluated, closely monitored patients when a cautious, structured and selective approach is employed, and clear benefits for pain and function are documented. COT always entails risks for patients, their families and the community, so vigilance and caution are essential.
Myths and Facts about Chronic Opioid Therapy (COT)

**Myth:** COT for chronic pain is supported by strong evidence.

**Fact:** Evidence of long-term efficacy for chronic non-cancer pain (≥16 weeks) is limited, and of low quality. Opioids are effective for short-term pain management. But, for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.

**Myth:** Physical dependence only happens with high doses over long periods of time.

**Fact:** With daily opioid use, physical dependence and tolerance can develop in days or weeks.

**Myth:** Patients who develop physical dependence on opioids can easily be tapered off.

**FACT:** Successfully tapering chronic pain patients from opioids can be difficult—even for patients who are motivated to discontinue opioid use.

**Myth:** Addiction is rare in patients receiving medically prescribed COT.

**Fact:** Addiction is rare in patients without an opioid use disorder. Among patients without an opioid use disorder, more than one in ten misuse opioids by: intentional over-sedation; concurrently using alcohol for pain relief; hoarding medications; increasing dose on their own; and borrowing opioids from friends.

**Myth:** Addiction is the main risk to be concerned about when prescribing opioids.

**Fact:** Opioids have significant risks besides addiction and misuse. These risks include respiratory depression and unintentional overdose death; serious fractures from falls; hypogonadism and other endocrine effects that can cause a spectrum of adverse effects; increased pain sensitivity; sleep-disordered breathing, chronic constipation and serious fecal impaction; and chronic dry mouth which can lead to tooth decay.

**Myth:** Extended-release opioids are better than short-acting opioids for managing chronic pain.

**Fact:** Extended-release opioids have not been proven to be safer or more effective than short-acting opioids for managing chronic pain.

**Myth:** Prescribing high-dose opioid therapy (≥120 mg morphine equivalents/day) is supported by strong evidence that benefits outweigh risks.

**Fact:** No randomized trials show long-term effectiveness of high opioid doses for chronic non-cancer pain. Many patients on high doses continue to have substantial pain and related dysfunction. Higher doses come with increased risks for adverse events and side effects including overdose, fractures, hormonal changes, and increased pain sensitivity.

**Myth:** Opioid overdoses only occur among drug abusers and patients who attempt suicide.

**Fact:** Patients using prescription opioids are at risk of unintentional overdose and death. This risk increases with dose and when opioids are combined with other CNS depressants like benzodiazepines and alcohol.

**Myth:** Dose escalation is the best response when patients experience decreased pain control.

**Fact:** When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but it can increase risks.

Do’s & Don’ts for Acute Pain Management

**DO** explain that opioids are for time-limited use. With the first opioid prescription, set expectations that opioids should be discontinued when the pain problem is no longer acute.

**DON’T** stock your patients’ medicine cabinets with unused opioids. Limit all initial and refill prescriptions for acute pain. A 30-day supply is often excessive—many patients only take a pill or two then leave the rest in their medicine cabinet. This increases the risk of diversion, which in turn increases the risk of addiction and fatal overdose in families and communities. For those patients who use the medicine daily for several weeks, physiologic dependence develops within days or weeks. Due to risks of accidental poisoning, it is important to store opioids in a medication lock box and flush unused opioids down a sink or toilet.

**DON’T** start long-term use of opioids by accident. Long-term opioid prescribing should only occur after careful patient evaluation, discussion of risks and realistic expectations of benefits, and clear explanation of rules for safe use. Routine authorization of refills may cause patients to expect the prescription to continue indefinitely.

**DON’T** prescribe extended-release opioids for acute pain or to opioid-naïve patients. Extended-release opioids are not appropriate for managing acute pain and should never be prescribed to an opioid-naïve patient.
Do's & Don’ts for Chronic Pain Management

**DON’T** initiate chronic opioid therapy (COT) before considering safer alternatives such as primary disease management, cognitive-behavioral therapy (CBT), participating in pleasant and rewarding life activities, physical therapy, non-opioid analgesics and exercise.

**DO** screen patients for depression and other psychiatric disorders before initiating COT. Patients with depression and other mental health problems often present with pain problems. They may not know that mental health problems can contribute to chronic pain. These patients are at higher risk of opioid addiction. They may be better served by mental health treatment.

**DO** talk with patients about therapeutic goals, opioid risks, realistic benefits, and prescribing ground rules. Therapeutic goals should include increased activity and improved quality of life, not just pain relief. Patients should understand the full range of opioid risks and the limited benefits they can reasonably expect. The rules for safe and appropriate use of opioids need to be explicit, preferably documented in a written treatment agreement.

**DO** realize that patients are reluctant to disclose a history of substance abuse. A history of substance abuse indicates greater risk of opioid addiction, but getting an accurate picture of past and current drug use can be difficult. If a patient denies past or current substance abuse, recognize that they may be afraid to tell you the truth. Consult the medical record, a prescription drug monitoring database, and third parties as needed.

**DO** perform a thorough medical evaluation and a urine drug screen before initiating COT. Starting chronic opioid therapy should be an affirmative decision based on adequate assessment of risk, urine drug screening, and use of a treatment agreement. Because it can be difficult to know if a patient is seeking opioids for addiction or diversion purposes, COT should only be considered by a physician who has an ongoing relationship with the patient. The prescribing physician should be willing to continue working with the patient if problems arise.

**DO** explain to patients that discontinuing opioids may be difficult. Some patients find it difficult to taper off of opioids, particularly from higher dose regimens, even when they are eager to do so. Patients can experience increased pain, insomnia, or anxiety when tapering from opioids. These unpleasant withdrawal symptoms can last for several weeks. Do not abandon chronic pain patients after discontinuing opioids.

**DO** perform random urine drug screens on patients receiving COT. Urine drug screening helps identify patients using illicit drugs or not taking the medicine as prescribed.

**DON’T** continue COT with patients who show no progress toward treatment goals defined by increased function and reduced pain.

**DON’T** assume patients know how to use opioids safely. Opioids are powerful drugs that patients sometimes use in unsafe ways. Risks of unsafe use increase with prescribed dose and are greater for extended-release medications with long half-life. Patients often do not understand that it can be unsafe to take extended-release opioids “as-needed for pain.” Take time to talk with patients about how they are using opioids. Ask patients about their problems and concerns.

**DON’T** assume patients use opioids as you intend. Many patients vary their dose and use combinations of other CNS depressant drugs or alcohol in ways that you may not know about. Patients may also sell their medications or share them with others. Opioid misuse often occurs among patients who do not have an opioid use disorder. Vigilance for unsafe use is essential.

**DON’T** start a treatment that you are not prepared to stop. Don’t initiate COT without benchmarks for stopping, a procedure for tapering that you are willing and able to use, and an approach to managing physical and psychological withdrawal symptoms. If substance abuse is identified, taper opioids and make arrangements for substance abuse treatment.

**DON’T** assume patients are doing well with COT without careful evaluation. Careful and compassionate interviewing about opioid use and misuse, questions about your patients’ problems and concerns, screening questionnaires, urine drug screening, and information from prescription drug monitoring databases often reveal problems with prescription opioids that would otherwise be missed.

**DON’T** abandon patients with a prescription drug problem. For patients who are misusing or addicted to prescription opioids, offer help or referral to someone who can treat substance abuse.
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References

Our Mission
To be the worldwide value and service leader in insurance brokerage, employee benefits, and risk management

Our Goal
To be the best place to do business and to work