THE LIFE OF A CLAIM: Strategies for Opioid Weaning

Presented by:
Renée E. Heitger
Hamberger & Weiss
& Jeanne Battaglia
Managed Care Network
NYSIA Seminar
January 13, 2017
Injured worker

- [Link](https://youtu.be/wGZEvXNqzkM)

- A look into the impact on the Injured Worker (IW) who is addicted to pain medication
Overdoses from RX painkillers like Hydrocodone (Vicodin), Methadone, Oxycodone (OxyContin) and Oxymorphine (Opana) kill more people than Heroin and Cocaine combined, per the CDC.*

*Dr. Richard Victor; Executive Director of WCRI, at 2014 RIMS Conference
Opioid prescription generally means one or more additional prescription medications:

- RX for opioid induced constipation
- Amphetamines due to sedation
- Sleep aid
- Anti-depressant
Case Study:

Dollar Costs of Long Term narcotic use:

Life Expectancy 35 years
D/A: 11/10/2005
ANCR: back, right hip, right shoulder, right elbow and right knee

CMS calculated MSA Rx costs of:
Oxycodone 15 mg, 120 per month x $0.73 each x 35 years = $36,792.00
OxyContin 40 mg, 90 per month x $8.68 each x 35 years = $328,104.00

• Precluded Section 32 settlement.
The cost to make a new drug averages about $4 to $5 Billion for research and development
A new study suggests there was a drop in the use of opioids in non-surgical Workers’ Compensation cases over a 2 year period from March 2012 to March 2014, including a slight decrease in New York. *

However, New York’s average amount of opioids prescribed to injured workers was still among the highest, along with Louisiana and Pennsylvania. *

*6/9/16 Insurance Journal referencing recent WCRI study.
Government

- https://youtu.be/QEzSJRBQ9RU

- Government recognizing the need to become involved in what is being called a Public Health crisis.
U.S. Surgeon General issues August 2016 letter to all physicians in the United States asking them “pledge your commitment to turn the tide on the opioid crisis,” citing new CDC Opioid Prescribing Guideline. *

*August 2016 letter from United States Surgeon General, Vivek H. Murthy, M.D., M.B.A. to “Dear Colleague.”
The FDA is requiring new “boxed warnings,” its strongest category, on the dangers of combining opioids and benzodiazepines, including risks of “extreme sleepiness, respiratory depression, coma and even death.” *

The DEA directed the reduction of almost every opioid that can be manufactured in the U.S. in 2017 by 25% or more; hydrocodone will be reduced by 34% of 2016 levels.*

*10/17/16 WorkCompWire article referencing DEA Final Order published in the Federal Registry.
Before Chronic Use, Review the Initial Guidelines
The Back, Neck, Knee and Shoulder Guidelines each state:

- “Narcotics should be primarily reserved for the treatment of severe…pain.”

- Narcotics have “adverse effects,” and “addictive properties.”

- “Narcotic medications should be prescribed with strict time, quantity and duration guidelines, and with definitive cessation parameters. Pain is subjective in nature and should be evaluated using a scale to rate effectiveness of the narcotic prescribed.”
“Optimum duration: 3 to 7 days.

“Maximum duration: 2 weeks. Use beyond 2 weeks is acceptable in appropriate cases.”

“Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures.”

Narcotic/opiate medications are not mentioned in the carpal tunnel syndrome Guidelines other than a referral to the Non–Acute Pain Medical Treatment Guidelines for recommendations.
Back Guidelines also state:

- “Routine use of opioids for treatment of any acute or non–acute back pain condition is not recommended. There is quality evidence that other medications and treatments are superior to opioids.”

- Therefore, avoid chronic use.
Early Action – Nurse Case Management (NCM)

Narcotic use is not just a cost issue – it is a human issue.

- Educate IW to increase understanding of his/her own treatment plan and risks of opioids use.
- Educate treating provider (TP) on Medical Treatment Guidelines (MTG).
  - Implementation of tools set forth by MTG, e.g., trial opioid criteria, opioid risk tool, opioid agreements.
- Leverage relationships with TP to get the best care and treatment resulting in the best outcomes, avoiding abuse and dependence.
Long Term Use and Strategies to Obtain Weaning Direction
Know the Guidelines

- NAP–MTG require IW to sign:
  - Patient Informed Consent for opioid Treatment Form.
  - Patient Understanding of opioid Treatment Form.

See, NAP–MTG Sections F.2.a.iv; F.2.b.ii; F.2.c.ii and F.3.c.
NAP–MTG require use of an opioid risk tool.

- Required for risk stratification purposes pursuant to Section F.2.b.ii.
- Tells treating provider (TP) how frequently to do UDT.
  - TP to pay attention to information provided by family members, other providers, and case managers, so share relevant information with new TP. See, NAP–MTG Section F.3.d.i.
  - TP must certify to adherence to or non-compliance with Patient Understanding for Opioid Treatment Form. See, NAP–MTG Sections F.3.d.ii.
NAP–MTG require IW be transitioned to the long term use of opioid standards which include:

- “A comprehensive multidisciplinary approach to pain management that is individualized, functionally oriented (not pain oriented), and goal specific…” NAP–MTG, Section C.1.e.

- This multidisciplinary approach has been found to be the most effective treatment approach and “independent self management is the long term goal of all forms of functional restoration.” Id.
The NAP–MTG explicitly state that:

- “Absent objective functional improvement, physicians shall initiate efforts to wean and/or discontinue opioid use.” NAP–MTG, Section F.3.b.iii.
Voluntary Weaning with Oversight (NCM)

- NCM working *with* TP and IW.

- Implementing best practices to assist in the weaning process as outlined by the NAP–MTG’s.

- Providing support and monitoring to IW during weaning to ensure it is successful and medications are not just denied via NAP–MTG. This is significant to avoid future potential costs as CMS will include any medications related to the WC injury even if they had been covered by the IW’s private insurance and denied by WC.

- Ensure all the necessary documentation from TP is obtained to show CMS that these medications will no longer be prescribed in the future.
Success Story:

- MSA performed prior to MCN’s intervention and weaning with an estimated $380,000 lifetime cost. After initiating NCM and prior to any need of IME, NCM was successful working with TP, medications were weaned, proper documentation was obtained, the MSA was recalculated, submitted and approved by CMS for only $95,000. Creating a savings of $285,000.
WCB’s New Hearing Purpose for Opioid Weaning Issues

- RFA–2 now includes a new hearing purpose under “Medical Issues” entitled “Opioid Weaning under Non-Acute Pain Guidelines.”
- Board requiring an IME or records review which states weaning is appropriate and provides a weaning program or resource.
  - However, no such requirement in the MTG or regulations.
  - Burden is on the TP in the first place.
  - See, Tennent Co., 2016 WL 624583 (WCB No. 89413635, decided 2/12/16), (IME precluded but TP did not meet burden—weaning directed).
Streamlined process once RFA–2 filed.

- Hearing about 45 days after Board notifies claimant of request for a hearing on weaning issue.
- IW is to obtain a report from the TP, which must be filed by the date of the hearing.
- If IW and/or representative wish to depose your consultant, such transcript must be submitted to the Board for the hearing.
- If contrary medical is submitted, you may request cross-examination of the TP at the hearing.
WCLJ Decision:

- Directs weaning, or

- weaning *and* enrollment in an addiction treatment program, or

- no weaning.
You cover the cost of addiction treatment program or weaning protocol.

If an addiction treatment program is directed, after 30 days you will only be liable for payment of narcotic prescriptions written by an addiction treatment program physician.

See WCB brochure created in cooperation with the NYS Office of Alcoholism and Substance Abuse Services (OASAS). Provides a simple way for determining who provides addiction services in a claimant’s area.

Link: oasas.ny.gov/treatment

- TP prescribed an opiate for “ongoing pain after his surgery,” which was in 2011, and to “help him function appropriately.”

- IME determined that the use of opioids for post-operative pain or acute injury was reasonable, but in this case IW was three years post-surgery and the opiate therapy was no longer indicated.
Board held that the treating provider continued use of opioids on a long term basis with insufficient evidence of compliance with the NAP-MTG. There was no evidence of improved function and decreased pain as documented by objective measures despite TP reference to allowing the claimant to “function appropriately.” The Board affirmed a direction for a “step-down plan.”

Notably, the Board Panel also affirmed that the muscle relaxant be ceased as chronic use is not authorized, and that Lidoderm patches be ceased as there was no variance requesting them.
IIMAK, 2016 WL 2607675, (WCB No. 80016782, decided 5/2/16).

- Cited Back MTG in directing cessation of topical cream (D.7.f) and duplicative muscle relaxant (D.7.j).

- Cited Back and NAP–MTG in directing weaning from opioids, muscle relaxant and benzodiazepine.

- Board noted it was “unpersuaded by Dr. Gosy’s testimony,” a provider “who earns his living by prescribing pain medication….”
• Board directed carrier to pay for medications for a “reasonable period of time, but no longer than three months.”

• Directed “attending physician to submit a written plan for the claimant’s transition/weaning within 30 days.”

- Board reversed WCLJ’s direction that Actiq continue, in conjunction with another opioid.

- Board directed a 4 week weaning program, and found SFCC was not responsible for payment of Actiq after 4 weeks.
Board Ordered Weaning with Oversight (NCM)

- **Highland Hospital, 2016 WL 4720271 (WCB No. 70801527, decided 9/7/16).**
  - NCM was assigned. MD was reluctant to work with nurse on weaning. A Drug Utilization Review was performed outlining need for weaning and compliance with NAP-MTG.
  - WCLJ’s Reserved Decision found no basis for cessation of the medications that the claimant is currently being prescribed.
On appeal the Board modified the decision finding the continued use of Baclofen and Neurontin (Gabapentin) is not authorized, and directed IW to enroll in an addiction treatment program within 30 days.

This claim went back to NCM for oversight of the weaning and coordination of the addiction program.

The success of weaning properly will yield significant savings.
It Takes a Village, So Let’s Do Our Part
Practice Tips

- Avoid chronic use of opioids in the first place by requiring that the treating providers strictly comply with each Medical Treatment Guideline with respect to strict time, quantity, and duration guidelines and with definitive cessation parameters when first prescribing opioid medications. – Engage your NCM to educate IW and TP.

- Once claimant is being trialed on or is on long term medications, review reports for evidence that the claimant signed the “Patient Informed Consent for Opioid Treatment Form” and “Patient Understanding for Opioid Treatment Form.”

- If attending physician continues treatment without reassessment/re-evaluation, without consideration of alternative treatments and without transitioning to management and treatment according to the principles for safe long-term opioid management and the guidelines for optimizing opioid care, consider using your NCM to facilitate voluntary weaning.

- If claimant and TP do not agree to voluntary weaning, consider an IME.
If there is no evidence of improved pain and objective functional improvement, consider filing a C-8.1 against the treating provider’s bill if treatment with medications is his/her only form of treatment; also file an RFA-2 requesting a hearing as the TP’s treatment is inconsistent with the NAP-MTG. Also follow WCB RFA-2 hearing process for weaning purposes.

Any C-8.1 that objects to a bill regarding MTG issues should reference the particular objection on the MTG issue and give the specific basis.

Since the NAP-MTG state “absent objective functional improvement, physicians shall initiate efforts to wean and/or discontinue opioid use,” testimony of the treating physician is not necessarily required to push the issue of weaning; consider waiving it. We then argue that the treating provider did not meet his burden of complying with the NAP-MTG, and weaning must be imposed.
Frequently the goal is a full and final Section 32 settlement. Therefore, you want not only the direction to wean, but actual weaning.

Engage NCM to facilitate and ensure weaning is completed properly, and that payments for RX were not simply shifted elsewhere.

Otherwise, CMS may discover another payor is paying for the RX and this could still result in a cost prohibitive MSA for settlement purposes.

Also, if causally related RX cause or contribute to death, settlement does not preclude a death claim.
WCB considering implementation of a drug formulary to provide stronger oversight of RX to ensure high-quality cost effective RX are used. Recommends:

- RX Drug Formulary;
- You contract with Pharmacy Benefit Manager;
- Payment for drugs only if FDA-approved route of administration;
- Limits on compounds;
- Compliance with MTG both in and out of state;
- Pre-approval program for non-preferred and non-formulary RX;
- Drug Utilization Review (DUR) to help assess appropriate and medically necessary RX utilized, and to avoid adverse consequences/interactions;
- Limits on physician dispensing.
Questions?

Renée E. Heitger  
Hamberger & Weiss  
716–852–5200  
rheitger@hwcomp.com

Jeanne Battaglia  
Managed Care Network  
battaglia@managedcarenetwork.com