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SPECIAL REPORT

We're beating back Opioids–

Now what?

Written by Peter Rousmaniere,
in cooperation with CompPharma

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We're beating back Opioids – Now what?

This WorkCompCentral Special Report shows how the workers' compensation industry responded to the introduction and phenomenally wide use of powerful pain killers to treat injured workers, and is at a turning point in treating chronic pain.

Advances in managing opioids, the leading form of powerful pain killer, and in addressing chronic pain more broadly would not have been possible without the intelligence and persistence of thousands of workers' comp professionals, far too many to give individual credit. Several organizations led in the detection and reporting on trends and solutions. They include the California Workers' Compensation Institute, CompPharma, the National Council for Compensation Insurance, Washington State, and the Workers' Compensation Research Institute.

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About WorkCompCentral Based in Camarillo, Calif., WorkCompCentral is the nation's only specialty media company producing daily news on the workers' compensation industry. With its own team of award-winning journalists located around the country, the niche outlet frequently breaks important news stories covering legal, medical, legislative/regulatory and business issues. The company also develops and maintains an extensive library of continuing educational content and can be reached at 805-484-0333 and via www.workcompcentral.com.

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1 The Twenty Year Crisis

Chronic pain is by far the most debilitating, and for claims payers the most costly, compensable condition in workers' compensation. This WorkCompCentral special report shows how a flawed treatment strategy, using drugs called opioids, played havoc with patients, workers' comp claims payers and regulators.

Chronic pain is pain that persists beyond expected healing time. Injured workers experience what is called "nonmalignant" or non-cancer-related chronic pain, typically while coping with musculoskeletal injuries. Ideally, pain is dealt with effectively in the acute stage. When it becomes chronic it is hard to recover from.

Every workday, some 5,000 workers sustain injuries which disable them for at least a week. Some of these workers acquire chronic pain. Over the years the number of "legacy claims," i.e., individuals who lead compromised lives due to pain, grows. Their future care and wage replacement can reach $1,000,000 in cost per claim. The importance of addressing this population cannot be understated. As CompPharma, a consortium of pharmacy benefit managers (PBMs) in workers' comp, says, "When you help these workers, there is a dramatic improvement for the person, family, employer, insurer, and society."

The nation's first reported death from prescribed opioids was that of an injured worker, a beneficiary of the Washington Department of Labor and Industries.

Pain is a very complex subject in its science, treatment, and public perception. Why some injured workers acquire chronic pain while others don't is not clear, but there are some thoughtful theories. Society needs to use all reputable practice tools and research within reach. This is especially true in workers' comp, because medical care for injured workers often does not yield as good results as it does for other patients.

This report does two things. First, it chronicles the two decade-long story of how opioid use greatly expanded in workers' comp, then halted and began to retreat in the face of fierce criticism. Workers' comp professionals can use this story to tell their friends about a war they still are fighting.

Second, it says, let's call this enough of an advance and change in fortune to reset our approach to chronic pain. It's time to restore balance in thought and action. The report closes with practical suggestions for a balanced claims and medical management effort, including industry messaging. It calls for a higher level of investment in conservative care, and far more open collaboration among practitioners.

The workers' comp industry was victimized by opioids and their well-resourced purveyors and ardent advocates. But it also made a costly, unforced strategic error. It paid more attention to wrestling with this flawed solution than to the underlying problem: chronic pain. Had the industry kept its eye on the real problem, claims payers would today be more successful in preventing chronic pain and aiding recovery.

Some may disagree with this narrative. For instance, opioids may indeed be the best of alternatives to address the needs of some injured workers; but, these workers have yet to be identified. Also, flawed ideas by surgeons and pain management "interventionalists" may have been as wearying on claims payers as was opioid prescribing. And it could be argued that greatly underutilized conservative care has never really been an option due to lack of access and to patient reluctance in an era where complete cures are expected to jump out of a pill bottle.

THE MOST DANGEROUS "JOB" IN AMERICA

Every spring, PBMs report on the past year's use of prescribed drugs to treat injured workers. Industry eyes look for trends in opioid prescribing. Opioids are among the most frequently used for pain relief. Plus, they trigger use of other drugs, leading to total monthly costs in the thousands.

But there is more: the use of opioids is by far the most controversial and risky kind of care in workers' comp. In direct and indirect ways, opioids are more risky and costly than all other controversial forms of care combined: questionable surgeries, unconstrained physical therapy and chiropractic care, doctor office profiteering off drug dispensing. *Combined*.

Many metrics paint this picture. Let's focus on iatrogenic risk; that is, the risk that medical treatment will inadvertently cause illness or death. The great majority of medical care for injured workers imposes trivial or no iatrogenic risk. Not so when opioids are used, notably for ongoing treatment. Workers on a medium-to-high dose of opioids for a year experience about 1.75 deaths per 1,000 patients per year. The riskiest jobs in America, such as logging and fishing, incur one death per 1,000 workers per year.

On any given day in the United States, perhaps 500,000 injured workers are treated for chronic pain. The great majority of them digest opioids.

The annual PBM reports have been heralding a slowing down, then

decline, in opioid use. Helios' 2014 report says that "Our persistent emphasis on the global management of opioid analgesics reduced their utilization by 2.9%. This is due to 3.8% fewer prescriptions for opioid analgesics per claim and a 0.9% change in the average days' supply per prescription. The percent of injured workers utilizing opioid analgesics decreased from 61.8% to 60.2%."[1] This and other PBMs may have hit home runs in terms of reducing opioid use. But, as we shall see, all manner of forces have been pushing opioid prescribing downwards.

We have equated pain management with drug use, much to the benefit of the pharmaceutical industry. The workers' comp industry has focused on drug management as if it's detached from other forms of treatment (surgery, injections, functional restoration, etc.) and even from an up-to-date understanding of pain. And each claim payer tries to go it alone, although collaboration would be much more effective. Rebalancing our approach is the order of the day.

What Are Opioids?

Opioids are medications that relieve pain by reducing the intensity of pain signals reaching the brain. Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine, fentanyl, and others. Opium has been used for medicinal purposes for millennia with awareness of its addictive potential. Opium and opium-related drugs are controlled "Schedule II" drugs in the United States, due to health risks and potential for abuse. "Narcotics" is a less precise term.

2. Expansion, Halt, Pull Back

The mid 1990s set in motion prescribed opioids' deep penetration into general healthcare. Their presence in workers' comp was noted in the late 1990s. After 2005, researchers, claims payers and regulators began to push back, spawning many private and government initiatives. Opioid prescribing started to level off and then decline around 2010.

THE RISE IN OPIOID PRESCRIBING

Clinicians and healthcare advocates began in the 1970s to urge better treatment for pain, calling it the "fifth vital sign" after body temperature, blood pressure, heart rate, and breathing rate. This led to calls that pain medication be used not just within very restricted approved pathways, such as for cancer and palliative care, but also for a broad array of health conditions, such as nonmalignant pain (that is, pain not caused by cancer and other diseases.)

Pain medications, including the most powerful class of pain drugs, opioids, had been restricted due to patient safety concerns, such as risk of addiction. And pain drugs tended to produce unwanted side effects, which in turn triggered the use of other drugs.

> **"It takes doctors 17 years to implement best practice after best practice is set."**
> – occupational health physician

Those advocating broader use said that safety concerns were over-stated. As early as 1986, a research article reported, on the basis of a study of 38 relatively low-dosage patients, "that opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable nonmalignant pain and no history of drug abuse."[2] The American Academy of Pain Medicine and the American Pain Society jointly declared in 1996 that "studies indicate that the de novo development of addiction when opioids are used for the relief of pain is low."

Ceding to the advocates, government agencies and medical associations removed many restrictive barriers in the 1990s. By the late 1990s, at least 20 states passed new laws, regulations, or policies moving from near prohibition of opioids to liberal use, without even dosing guidance.

About that time, medical professionals saw demand for musculoskeletal pain relief growing. Nationwide, between 1987 and 2000 the incidence of treatment for back problems rose by half. And treatment intensified. Interventions of many sorts – surgery, injections, diagnostics, drugs – to relieve musculoskeletal pain multiplied in the early 1990s and into the 2000s.

The use of opioids in general outpatient care took off after Purdue Pharma, which had been creating pain medications for decades, introduced OxyContin, a controlled-release formulation of oxycodone in 1996. OxyContin sales grew from $48 million in 1996 to almost $1.1 billion in 2000. Purdue massively marketed OxyContin to front-line doctors such as primary care physicians. As it turned out, most opioid-related deaths arose from prescribing by these physicians.

OxyContin and other opioids gained further popularity through the 2000s. In that decade, when one fifth of office visits involved pain complaints, opioid prescribing rose while non-opioid pain relief drug prescribing declined.

Among injured workers, the National Council on Compensation Insurance reported that opioid prescribing in the first year post-injury jumped 75% between 1999 and 2004. Washington's Department of Labor and Industries found a 93% increase in opioid prescribing between 1996 and 2002, and the average daily dosage climbed by half to 132 milligrams (mg) a day. Washington State also reported that 42% of lost-time back injury claims involved an opioid prescription in the first year post-injury.

Over half of persons receiving 90 days of continuous opioid therapy remain on opioids years later.

– Martin BC et al. Long-term chronic opioid therapy discontinuation rates from the TROUP study. J Gen Intern Med. 2011 26(12):1450-7.

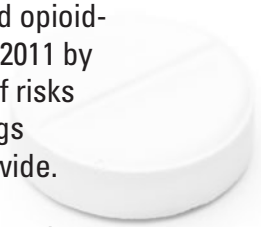
Physician preferences for opioids varied greatly among and even within medical specialties. In workers' comp, a relatively small number of physicians accounted for an extremely high share of prescriptions. The California Workers' Compensation Institute reported in 2011 that 3% of the prescribing physicians accounted for 55% of all "Schedule II" prescriptions (see "What Are Opioids?"). And patients behaved in radically different ways, from acting with caution to ravenously shopping for more. The top 10% of injured workers in terms of their morphine equivalent dosage (MED) wrangled prescriptions from an average of 3.3 different physicians.[3]

QUESTIONS ABOUT SAFETY

As opioid sales quadrupled, opioid-related overdoses and related fatalities multiplied. Many will agree with one pain expert's observation that "Washington State really did the yeoman's work" on alerting not just the workers' comp industry but the country to opioid safety problems. Much of the credit goes to Gary Franklin, since 1988 the medical director of the monopolistic state fund, Labor and Industries.

In the early 2000s, Franklin and his colleagues began to examine closely why injured workers died, even years after their injury. They found that in a significant number of cases, opioids prescribed for their work injury were a contributing factor. When one extrapolates their findings for the nation as a whole, it appears that over 2,000 injured workers died this way between 1995 and 2010.

The decade of the 2000s was a wake up call about opioid risks. Prescribed opioid-related deaths of all patients, work related or not, rose from 1999 through 2011 by 420% to a shocking 16,917. This steep rise was part of a larger epidemic of risks from all kinds of prescribed drugs. In 2009, deaths from all prescribed drugs exceeded for the first time the number of vehicle-related fatalities nationwide.



Fatalities were just part of the picture. Patient misuse, abuse, and addiction also factored in. A 2008 study estimated a 3.27% addiction rate for prescribed opioid patients. That's three times the 1% figure cited by Purdue sales staff to doctors. After accounting for all "aberrant drug-related behaviors," such as not taking prescribed drugs or taking illicit drugs at the same time, a 2008 report implicated some 11.5% of all patients and 20.4% among chronic pain patients.[4] In the unhurried pace of research, many investigators linked opioid use with fractures, myocardial infarction, sexual dysfunction and other side effects.[5]

In response to this mounting evidence of harm, some medical experts conceived the notion of proposing a dosage threshold, above which risks such as overdoses appeared to be much more likely. Washington State's inter-agency task force published the nation's first dosage advisory in April, 2007. The 2010 edition of Washington's opioid guidelines recommended a 120 mg/day MED threshold, above which the prescriber was to consult with a pain specialist. Six other states followed Washington in imposing dosage guidelines.

Opioid contributes to compensable death

Brandon Clark was 36 years old in 2008 when he fell about 10 feet from a roof while working as a carpenter for a California employer. The physician treating his occupational injuries prescribed the antidepressant Elavil, the neuronal pain reliever Neurontin and the opioid painkiller Vicodin. In January 2009, his personal physician prescribed the anti-anxiety medication Xanax, and sleep aid Ambien. Clark's wife found him dead on the morning of July 20, 2009. All five drugs were found in his system.

— As reported by WorkCompCentral on May 29, 2015 ("High Court Overturns Denial of Benefits for Overdose; Wrong Causation Standard Used")

That threshold was probably too high. "There is no completely safe opioid dose," the State's revised 2015 Guidelines concluded. Some guidelines chose lower dose thresholds, down to 50 MED. As it turned out, aberrant behavior has been as frequent among low as among high-dosage patients.

And, workers' comp claims payers began to order or encourage prescribers to subject their patients to "quantitative urine drug tests," or UDTs. This gold standard test confirms at an extremely high level of accuracy what drugs a patient has recently taken. Studies show that patients often (for whatever reason) misstate their prescribed drug use. Drugs are often diverted – given or sold to others. The marginal cost to a lab for performing a typical test for, say, four drugs, may be around $25. Nonetheless, the lab may charge $400. Adjusters have seen invoices exceeding $1,000 for a single test for certain drugs.

Perhaps they did not hear or discounted these alarms, for many primary care physicians persisted in prescribing opioids to risky patients. In fact, 67% of primary care doctors surveyed as recently as 2012 said they were "somewhat" to "highly likely" to prescribe opioids to a patient who was an active substance abuser.[6]

QUESTIONS ABOUT EFFECTIVENESS

Opioids have been shown to be effective in reducing acute pain, which arises directly from injury, and can result from surgery. In this scenario, opioids help the person focus on her or his recovery. But long-term use has never, even through mid 2015, been adequately assessed. It has been poorly researched.

Over time, the research community began to make some broad conclusions about the usefulness of opioids in nonmalignant chronic pain. Starting in about the late 2000s, researchers were increasingly inclined to write off long-term effectiveness as a myth, albeit in the guarded language of published research. "No evidence of gain" turned gradually into evidence of no gain or even net harm to the average patient.

In 2013, the American Medical Association published a review of pain medications, in which it concluded that "Narcotics provide little to no benefit in acute back pain, they have no proven efficacy in chronic back pain, and 43% of patients have concurrent substance abuse disorders, with aberrant medication-taking disorders [in] as high as 24% of cases of chronic back pain."[7]

The "no evidence" concept has been stretched to raise more questions, as in this conclusion published in early 2015: "There is no evidence that opioids improve return to work or reduce the use of other treatments. They may even limit the effectiveness of other treatments."[8]

Perhaps the most damning conclusion, found in the 2015 Washington State guidelines, is that using opioids for these patients is worse than useless unless there is a meaningful improvement in functioning, even if pain intensity declines. Focusing "only on pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life." [9]

Yet many doctors continue today to prescribe for the long term without regard for lack of functional gain or even great symptom relief. Many injured workers say, when asked by case managers, that they'd rather stay on their pain-killers. When asked, a lot of long-term users say that they are satisfied with their drugs even if they report problems, including lack of complete pain relief. Do opioids over the long term treat the patient's distress, or the patient's pain? Even if distress and pain decline, does function improve? If a patient has never been introduced to other kinds of pain treatments, it is hard to accept her or his satisfaction as conclusive.

An Auto Mechanic in Pain

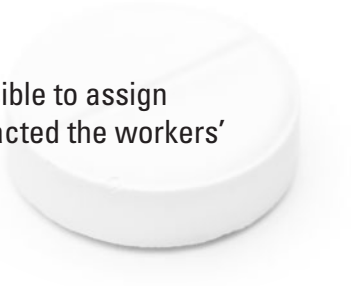
In 2001, a Plainsfield, MI, auto mechanic was diagnosed for thoracic outlet syndrome and nerve compression between the neck and the arm. Many specialists later evaluated him for carpal tunnel syndrome, degenerative disc and joint disease, complex regional pain syndrome, osteoarthritis, and other conditions. He was operated on twice. For years he was on opioids, sedatives, and other drugs for pain relief and to cope with the side effects of opioid use.

– From Peter Rousmaniere, Chronic Pain II: Carriers' Chronic Burden. Risk & Insurance, 2008.

Steven Moskowitz, a medical director at Paradigm Outcomes, reasons that many of these workers cling to the belief the drug is working, they note more pain when they don't take a pill (a temporary aspect of reducing dosage), and they see doctors who don't offer an alternative. They're stuck.

PULLBACK IN PRESCRIBING

The opioid curve eventually bended. Nationwide, prescriptions for opioids declined by 5% between 2012 and 2013. The high-water mark for opioid prescribing for injured workers probably was set in 2010 or 2011, depending on the jurisdiction. And opioid-related deaths have declined. In Florida, a 23% decline between 2010 and 2012 was aided by a crackdown on pill mills. Washington State's 27% decline in deaths was attributed largely to its innovative dosage guidelines. The leader in dosage control, Washington State reported in 2012 that dosages over the threshold of 120 MEDs dropped by 35% and that drug-related deaths declined by 50%.

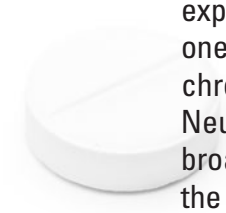


But so many factors influence opioid prescribing that it is not feasible to assign credit unambiguously. Here are a few changes that probably impacted the workers' comp industry.

Doctors thought again.

With alarms sounding off among clinician professional groups, news media horror stories and federal/academic research reports, physicians were bound at some point to draw back. Many primary care physicians probably responded to new federal or state agency prescribing controls. Unfortunately, no one has studied what happened to patients who were taken off opioids or not given opioids in the first place.

Nine out of ten primary care physicians who responded to a survey in 2014 declared prescription drug abuse to be a "big" or "moderate" problem in their communities, and 85% reported that opioids are overused in clinical practice.[10] They reported high frequencies of adverse events—such as tolerance (the drugs losing their effectiveness over time), physical dependence, and limits to pain relief. One half reported being less likely to prescribe opioids compared to one year before.



Yet a lot of physicians offer opioids with confidence. In one survey, nearly all (88%) expressed confidence in their clinical skills related to opioid prescribing, and nearly one-half (49%) were "very" or "moderately" comfortable using these drugs for chronic non-cancer pain.[11] At an April, 2015, meeting of the American Academy of Neurology in Washington, D.C., an advocate and an opponent (Franklin) debated the broad use of opioids; a modest majority of attendees was reported to have voted for the opponent.

Opioid prescribing came under guideline scrutiny.

By 2014 there existed at least 13 opioid treatment guidelines endorsed by states or professional bodies. Most recommended a daily threshold of MED, a written prescriber-patient treatment agreement, and urine drug testing.

The Feds stepped up.

In May, 2007, Purdue Pharma and three of its current or former executives pleaded guilty to federal criminal charges that they deceived regulators, doctors, and patients about the addictive properties of OxyContin. Since then, several public sector employers have sued Purdue and other drug companies to recover workers' compensation costs. To date, these efforts have failed to advance through the courts.

Federal agencies pressured drug manufacturers to make their drugs less susceptible to patient abuse. Along that line, the Food and Drug Administration published in 2012 guidelines for safer prescribing.

States responded.

Almost every state has taken at least one initiative, from closing down pill mills to specific reforms in workers' compensation.[12]

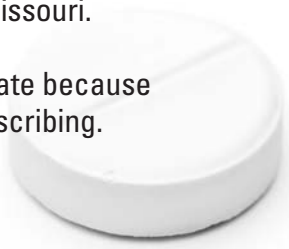
Inter-agency coordination. The International Association of Industrial Accident Boards and Commissions cautioned its members that workers' comp regulators need to coordinate with other agencies/departments within their jurisdiction in order to wield sufficient clout to control overuse.

Treatment procedures. The IAIABC highlighted treatment guidelines, utilization review, doctor-patient treatment agreements, and urine drug testing.

Continuing education. The IAIABC also highlighted continuing education requirements specifically addressing opioids, "carefully coordinated with the licensing/certification bodies within a jurisdiction."

Prescription drug monitoring programs are in place in all states but Missouri.

Drug formularies. This initiative has been getting intense attention of late because of Texas' success in using a formulary to reduce the rate of opioid prescribing.



Claims payers and PBMs partnered up.

It's practically impossible for a claims payer to make sense of drug spending without engaging a PBM firm. These companies began showing up around 2000, and in 2004 created an association, CompPharma, whose members process today about three-quarters of drug payments in workers' comp. Over time, PBMs and their clients integrated their claims and medication payment systems, a difficult and expensive investment.

PBMs started to track opioid use closely and reach out to prescribing doctors to advise on alternative drug regimens, using teams of pharmacists and nurses. They launched early intervention programs. Healthcare Solutions, for example, uses a trigger of 30 days' continued use of opioids by recently injured workers to prompt a review. It and other PBMs report reductions in dosage and opioid prescribing, for which they credit their interventions early in a claim history. (The impact on old "legacy" cases has been less impressive.)

THE END OF THE BEGINNING?

As of mid-2015, opioid use in workers' comp is subject to much stronger controls and transparency than as recently as 2010. The general medical community is more cautious. Governments, researchers, medical associations and claims payers are incrementally heading towards a common policy to limit opioid use to scenarios that are supported by evidence.

Given that critics such as Gary Franklin view opioids for nonmalignant pain as the "worst man-made epidemic in modern medical history," these tepid results might be considered only a kind of victory – the end of the beginning of a solution to chronic pain among injured workers.

But these advances expose the workers' comp industry's need to put forth a coherent, balanced strategy for preventing and treating chronic pain. Too much attention was diverted to fighting the opioid threat. For example, when states introduce hard hitting formularies, such as Texas did and others are doing, hardly any thought is given to making sure patients and physicians have access to a balanced array of non-opioid treatment. This needs to change – now.

A Surgeon Changes His Mind

David Hanscom MD completed his orthopedic surgery residency in 1985 and plunged into private spine practice. It took over a decade for him to look at his patients and his role as physician in a radically new way.

He became interested in the concept of "cognitive distortions," or ingrained patterns of misperceptions. Cognitive reframing caused his personal symptoms such as anxiety, back pain, and headaches to disappear. Over the years, he absorbed behavioral therapy methods, and achieved better work-injured patient outcomes from behavioral coaching than from surgery. One of his methods is to engage the patient in writing as a way to address anger. Hanscom's day may include telling a patient that a prior failed surgery should never have been done, or sitting in front of a patient as he or she unleashes their anger.

Hanscom works in a surgical setting in Seattle. He relates how he integrated behavioral and conventional methods in his book, Back in Control, and on his website, www.drdavidhanscom.com.

3 Reframing the Challenge

Claims payers need to bring their strategies for chronic pain into better balance. This includes addressing prevention as well as recovery, and embracing the full array of available interventions. Conservative care deserves being at the highest order of priority. Advances will require frank and accountable collaboration among parties, more than claims payers, managed care vendors and physicians practice today.

Conservative care puts primary emphasis on behavioral, psychological, and alternative types of treatment. Without in any way blaming the patient, it sets its goal for the patient to be an active partner in recovery, to acquire long-lasting skills at self-management.

The workers' comp industry has a special appointment with conservative care. Workers' comp, in contrast to group health insurers and government-run health plans, focuses far more on musculoskeletal conditions, the type which conservative care is well suited to address. Thus, workers' comp claims payers are directly responsible for ensuring access to good conservative care programs, through how they support these services.

Some types have been around for decades. Endorsements appear in treatment guidelines. One corporate medical director opined that the low visibility of conservative care today is due to it requiring more customization for each patient. Also, doctors and business ventures have yet to find how they can make a lot of money out of it. Conservative care has no professional associations on the level of those for surgeons and pain management specialists.

Conservative care often fails to restore injured workers back to pre-injury functioning and the ability to return to work. Better collaboration among claims payers and medical providers will point out how to improve the success rate.

Examples of conservative care

- **Multi- /inter-disciplinary functional restoration programs**
- **Work hardening programs**
- **Cognitive behavioral therapy**
- **Coaching**

GET SMARTER ABOUT MATCHING INJURED WORKERS WITH INTERVENTIONS

Claims payers could view chronic pain as a condition that appears in a variety of claims scenarios, each of which calls for a nuanced, balanced selection from available interventions. These scenarios, prepared with the advice of Paradigm Outcomes, include:

- The patient is only one month post-injury but has been on opioids from the first medical encounter and has a problematic predictive profile.
- The patient is within six months post-injury, has not recovered according to normal expectations, and has not elected surgery.
- The patient, also recently injured, takes a very high dosage of opioids and may be "polypharmic" – taking a large number of other drugs such as benzodiazepines and gabapentin.
- The patient has undergone surgery but remains on opioids several months post-surgery.
- The patient shows signs of addiction and/or abusive behavior.
- The patient has been on opioids for years – a so-called "legacy claim."
- A new state drug formulary induces the prescribing physician to taper or completely discontinue opioids for the patient.

The claims adjuster and case manager can access surgeons, pain management specialists, conservative care providers and detox services, as well as PBM data, and apply these resources optimally. Many of these scenarios involve behavioral or psychological factors, which can be addressed without needing a psychological diagnosis.

Claims payers often rule out interventions that could be useful. Prium's Mark Pew notes that behavioral treatment like cognitive behavioral therapy was until recently considered "outside the mainstream." He says that payers can "do harm by drawing firm lines on chiropractic and physical therapy" for certain cases just because they were often over-used. In pursuit of available resources, Pew himself interviewed upwards of one hundred functional restoration programs across the country.

Information systems today are markedly more powerful than in the past, to enable claims payers to predict these scenarios and record the key facts about worker and

treatment, return-to-work, and eventual claims resolution. For instance, CompPharma reports that claims payers and PBMs are more likely today to create comprehensive medication databases and predict the future course of treatment.

GET AWAY FROM TALKING ONLY ABOUT DRUGS

Society and the workers' compensation industry framed the chronic pain challenge as pain management, and more narrowly as a medication problem. Industry-funded research organizations, conferences, and private firms typically report on opioid issues divorced from the broader context of managing pain.

This narrow focus likely helped the industry and state regulators to focus attention on patient safety risks, and then to introduce private sector and state initiatives to control opioid use. Now it's a distraction.

Better collaboration may be the only way to understand a puzzling phenomenon: why many opioid patients seem satisfied with long-term use despite high pain scores.

EMBRACE OPEN COLLABORATION

Claims payers need to learn how to collaborate with each other, and with their medical providers, to a greater scale and depth than they are used to.

What does this mean? Claims organizations tend to operate in isolation from other claims organizations. Medical providers may not share their experiences with other providers. Presently there is virtually no sharing of experience within the workers' comp industry; no research group engaged in collecting and distilling this experience. This limits how far claims payers and providers can improve outcomes.

On Opioids for Years

A 45-year-old laborer had a ditch cave in on him in 2009 and survived after a delayed rescue with a badly injured leg. Delay in care led to complex regional pain syndrome (CRPS). Physical therapy proved unsuccessful, as did a neurostimulator. His pain management physician placed him on opioids (80mg daily), which he took for years with no other treatment. The affected leg was recently amputated below the knee. He is back to physical therapy and his doctor is trying to taper him off methadone.

— Case provided by Southern Behavioral Medicine Associates, Hattiesburg, MS.

The need for open collaboration is made vivid in the bedeviling problem of "patient selection." Experienced case managers and chronic pain treaters know how to select certain injured workers for certain kinds of care. This know-how rarely gets beyond the confines of personal or closely shared anecdotes, and is influenced by local factors—for instance, provider access and state laws.

The problem may be particularly severe with conservative care, which is often delivered by providers with limited personnel and financial resources. The oxygen they need – well-thought-out referrals, informed feedback, and broad claims payer support – is not made available. It is particularly hard for them to thrive.

AN EMPLOYER'S OPEN CULTURE

The second largest private employer in California, Albertsons / Safeway / Vons, is adept at picking promising ideas, piloting them, and sharing its experience with anyone who cares to ask.

Albertsons / Safeway / Vons' claims and medical management team believes that treating chronic pain is a sign that an opportunity was missed. Over ten years, it has evolved a preventive and recovery strategy that focuses on the individual predicament of the injured worker. It downplays the use of opioids, often considering them as a sign of over-treatment, and surgery. The company has learned through experience.

Albertsons / Safeway / Vons started a pilot with five Kaiser occupational health clinics in 2005. It introduced early screening for delayed recovery risk, resulting in a sharp decline in surgeries. It offered the screening protocol to any claims payer who wished to use it.

More recently, the company has piloted a program modeled after cognitive behavioral therapy, or CBT. It partnered with Integrated Medical Care Solutions to introduce COPE with Pain. Selected injured workers are referred to a network of psychologists whom Integrated Medical Care Solutions has trained to provide, over the course of some three to twelve sessions, a version of CBT. These sessions are billed under behavioral treatment codes that do not require a psychological diagnosis. (The codes are CPT 96150 and CPT 96152.)

Albertsons / Safeway / Vons wants to focus on behavior and attitudes, not the pathology, and to promote self-management of symptoms, according to its medical director Melvin Belsky MD. It's a conservative care approach, which Albertsons / Safeway / Vons is ready to discuss with any claim payer.

ADAPT A SYSTEMS ENGINEERING MODEL

The workers' comp industry's travails with chronic pain invites comparison with the city of Boston's struggle to modernize its downtown traffic flow through the immensely ambitious and costly Central Artery/Tunnel Project, aka Big Dig.

Both are super big ticket challenges. The Big Dig project went from ground breaking in 1992 to official but not final completion in 2006. It reorganized 160 lane miles of surface and below-surface roads and bridges, with additional subway and bus system alterations, at a cost which in constant dollars was over double of original estimates.

The Big Dig was the largest single public infrastructure project in the country's history. Compare that with chronic pain, the greatest injury response challenge of the workers' comp industry since insurers first learned to manage exclusive remedy claims in the 1910s.

What makes the analogy informative is that challenges of this scale demand an extraordinary degree of collaboration distributed over a large number of parties. It's a massive systems engineering challenge. It was American competence in systems engineering that created the internet. It's what enables space travel, and the creation and penetration of self-driving vehicles into our road network.

The Big Dig required close, frank, and accountable collaboration of hundreds of contractors, public agencies, and other actors. (It proved an astounding success with respect to one risk: there was only one work-related death reported.)

The goal of the Big Dig was to improve the livelihood of the Boston metropolis – more than reworking traffic flow. The goal of a chronic pain initiative is to keep workers productive – more than managing drugs. Claims payers need to share more information about their experience with what works – and does not – in prevention and recovery.

Service providers need to share results as well, among managed care organizations, medical providers, and an increasing array of nonmedical coaching, return-to-work, injury prevention, and other interventions. Huge data coordination investments are called for.

The livelihoods of hundreds of thousands of workers, and tens of billions in claims costs, hang in the balance.

The neuroplastic model of chronic pain

Pain that persists for months, well beyond normal recovery times, is understood today as a dysfunction of the central nervous system including the brain.

This concept departs from a popular idea that pain persists when a damaged part of the body insists on reporting the pain as a message to the brain. This "messenger" model has the virtue of simplicity to recommend it. There is a clinical name for it: nociceptive pain.

But more recent studies suggest that chronic pain is likely to be a central nervous system disorder, in which the brain plays a surging, creative role. A clinical label is neuropathic pain.

The brain forms, according to today's leading theory, opinions about the sensations it receives. Not only does the brain wire itself in part from experience but the patient can induce her or his brain to rewire itself. Thus, chronic pain can arise from faulty wiring and pain can be dramatically reduced when the wiring is corrected.

Similar patients experiencing the same injury can have starkly different experiences. The brain can assign pain to a body part that is different from the one which had received the injury and it can cause a person to react with alarm to even a zephyr-like touch to the skin.

This neuroplastic theory of pain not only helps to explain huge variations in a victim's experience of pain over time –it opens new approaches to diagnosis and treatment. Yet the notion that brain and body conspire to create pain experience still baffles people in and outside of the workers' comp system.

– The seminal article for this view of chronic pain is Melzack R and Wall PD, Pain mechanisms: a new theory. Science. 1965

Endnotes

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CompPharma

CompPharma, LLC is a national organization comprised of the industry's leading workers' compensation pharmacy benefit managers. Member PBMs handle more than 12 million prescriptions – representing $2.5 billion every year. Their clients, which are private insurers, third-party administrators, self-insured employers, state funds, and other work comp payers, process approximately 80% of all work comp scripts annually.

Formed in 2004, CompPharma provides a platform for members to share their government affairs and clinical expertise as well as costs to research and implement solutions to challenges that impact their ability to cost-effectively provide pharmacy care to injured workers. CompPharma informs, works with, and educates public policy makers who are responsible for regulating the workers' compensation marketplace.

The organization also commissions and conducts its own research on work comp issues, including those involving patient safety and work comp pharmacy cost drivers. Initiatives include compound drugs, physician dispensing, and analyzing the differences between work comp PBM processes and those of non-work comp PBMs.

As of June 2015, CompPharma's PBM members are:

- Catamaran
- Express Scripts
- Healthesystems
- Healthcare Solutions, a Catamaran Company
- Helios
- myMatrixx

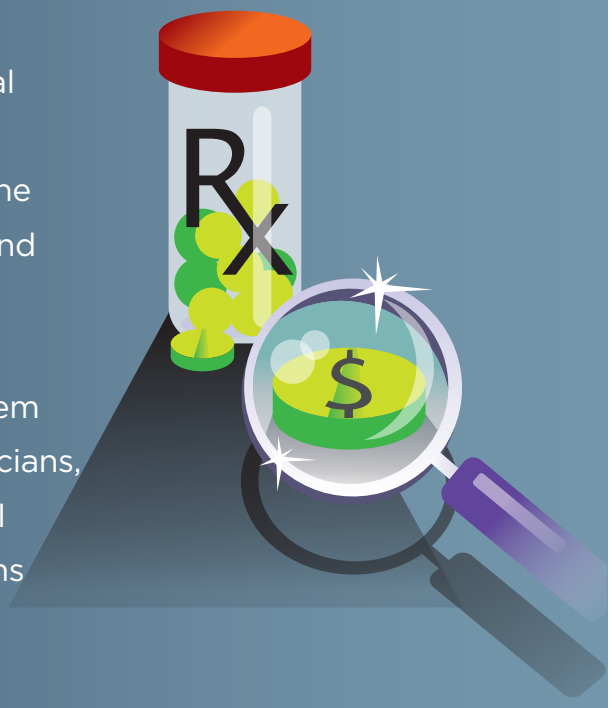
Contact: Joe Paduda, jpaduda@comppharma.com or Helen Knight, hknight@comppharma.com.

WORKERS' COMPENSATION PHARMACY BENEFIT MANAGERS PROTECT HEALTH AND SAVE LIVES

When injured workers obtain all their prescriptions through a pharmacy network managed by a pharmacy benefit manager (PBM), their safety and health are protected.

Injured workers often see several physicians who prescribe medications for the injury. These doctors are often unaware of other prescriptions the patient receives. Additionally, injured workers may fill prescriptions at different pharmacies, doctors' offices or through out-of-network mail order houses. Because none of these entities have the full picture of the pharmacy regimen, patient safety is compromised. They may take drugs that interact poorly with each other and/or receive similar or duplicative medications that can cause adverse reactions.

This is especially important with opioids. The total morphine equivalent dosage an injured worker receives may exceed clinical guidelines, putting the injured worker at risk of dependency, addiction and even overdose and death.



PBMs are the only entities in the work comp system able to compile all pharmacy data and alert physicians, patients, claims managers and others to potential drug problems. In order to do that, all prescriptions need to be processed through the PBM.

HERE ARE SOME OF THE THINGS WC PBMS DO TO PROTECT PATIENTS AND PAYERS:

WORKERS' COMPENSATION PBM ACTIVITY	BENEFIT
 MONITOR PRESCRIPTIONS to minimize risk of adverse effects: ▶ Identify potential drug interactions ▶ Detect duplicate therapy	PROMOTE EVIDENCE-BASED TREATMENT: ▶ Speed healing ▶ Improve patient outcome functionality 
 MONITOR OPIOID PRESCRIPTIONS and alert physicians and claims managers to potential problems	IMPROVE PATIENT SAFETY by minimizing risk of dependency, addiction and overdose. 
 NOTIFY MULTIPLE PRESCRIBERS OF OPIOIDS	PROTECT PATIENT SAFETY, IMPROVE OUTCOMES AND REDUCE RISK OF FRAUD 
ESTABLISH DRUG FORMULARIES based on clinically accepted guidelines with prior authorization criteria 	ENSURES that injured employees receive appropriate medications 
 PREVENT EARLY REFILLS	AVOID STOCKPILING of medications to prevent sharing or diversion 
 COMMUNICATE TO COORDINATE CARE by alerting claims professionals/case managers, prescribers, patients, and/or pharmacies when prescriptions fall outside of clinical guidelines	PROMPTS ADJUSTMENT TO DRUG REGIMEN: ▶ Promote clinically sound care ▶ Improve outcomes 

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