

Opioid Prescriptions Under The LHWCA

When "Reasonable and Necessary" becomes "Unreasonable and Unnecessary"

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Section 7 Medical Benefits under the Act

> Very broad standard

- The employer shall furnish such medical surgical and other attendance or treatment, nurse and hospital service, medicine . . . for such period as the nature of the injury or the process of recovery may require.
 - > In order for medical expenses to be assessed against the employer the expense must be both reasonable and necessary. *Dupre v. Cape Romain Contractors, Inc.*, 23 BRBS 86, 94 (1989).
 - > It must be "appropriate" for the injury. *Weikert v. Universal Maritime Service Corp.*, 36 BRBS 38, 40 (2002).

Section 7 Medical Benefits under the Act

› Deference to attending physician

- When the patient is faced with two or more valid medical alternatives it is the patient, in consultation with his own doctor, who has the right to chart his own destiny. *Amos v. Director, OWCP*, 32 BRBS 144 (9th Cir. 1999), cert. den. 528 US 809 (1999).
- › To reject treating physician's opinion, the ALJ must "make findings setting forth specific legitimate reasons for doing so that are based on substantial evidence in the record." *Winans v. Bowen*, 853 F.2d 643, 647 (9th Cir. 1987).

Standard or Duty of Care

2017 ORS 677.095¹

Duty of care

• legal issues not precluded by investigation or administrative proceeding

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- (1) A physician licensed to practice medicine or podiatry by the Oregon Medical Board has the duty to use that degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or a similar community.

Controverting Treatment – Must Establish Standard of Care

- › Recent case before ALJ Clark concerning opiate medication

The issue concerns whether the prescriptive drug treatment is reasonable and necessary for the treatment or whether Employer has shown that Dr. Mampalam has strayed from the standard of care for prescribing opioid medications. After a thorough review of the evidence, I find that he has not and that Claimant is entitled to reimbursement for the prescription expenses, plus interest.

How to Establish Standard of Care & Assess Reasonableness of Opioid Prescriptions

- › In October 2018 the Oregon Health Authority published recommendations for patients with **acute pain** – not currently on opioids and patients with **chronic pain**.
 - Acute pain guidelines (potential standard of care)

In general, opioids should *NOT* be considered as first line therapy for mild to moderate pain. Mild to moderate pain can often be treated without opioids by recommending over-the-counter medications, and physical treatments such as ice and immobilization. If non-opioid interventions are ineffective and opioids are appropriate, prescribe the lowest effective dose of short-acting opioids for less than 3 days; in cases of more severe acute pain, limit initial prescription to less than 7 days.

Standard of Care - Acute

Evaluate the patient

- Identify cause and type of the acute pain (e.g., medical condition, post-op, injury). Determine which analgesics are most likely to be responsive to opioid or non-opioid therapies.
- Assess severity of pain.
- Determine likely period for resolution of acute pain.
- Assess age and other medical considerations that might affect opioid use.
- Review other medications patient may be taking for pain, such as acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). Note that these may cause drug interactions or produce toxic effects if taken with combination drugs, such as Tylenol 3.
- Document the results of this patient evaluation and the justification for prescribing an opioid.

Standard of Care - Acute

Assess history of long-term opioid use and/or substance use disorder

- Assess patient for history of substance use disorder (SUD). Opioids should be prescribed with great caution in patients with SUD. Include specific documentation of the indication for prescribing opioids in these patients.
- Assess patient for a history of long-term opioid treatment. Review records from other providers and be aware that, for a patient who could be tapering off opioids, a new opioid prescription could jeopardize this progress.
- Coordinate with other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) to the patient. If a patient on long-term opioids or benzodiazepines presents for an acute condition causing pain, communicate with the primary clinician overseeing the long-term opioid/benzodiazepines use.
- Assess patient's use of alcohol or sedative medication. Be aware that these may exacerbate the sedative effects of opioids and prescribe opioids with caution in these patients.

Standard of Care - Acute

Amount and type*

- Use opioids with caution and only if necessary.
- Do not prescribe opioids without a physical assessment, or document reason for the exception.
- Prescribe the lowest effective dose of short-acting opioids usually for a duration of less than 7 days; in cases of more severe acute pain limit initial prescription to less than 7 days.
- Do not recommend a more than two-fold range of amount or timing of opioids. **Example:** recommend 1-2 pills every 6 hours as needed for pain is appropriate, but 1-4 pills every 4-6 hours is not.
- If prescribing an opioid combination medication (e.g., Tylenol #3), assess patient's use of over-the-counter medications (e.g., Tylenol) to identify and explain potential acetaminophen or NSAID toxicity.
- Do not prescribe opioids and benzodiazepines simultaneously unless there is a compelling justification.
- When pre-packaged opioids are dispensed in emergency departments, ensure that a system is in place to share information via the Prescription Drug Monitoring Program (PDMP).

Standard of Care - Acute

Check the Prescription Drug Monitoring Program

- Check the PDMP to understand the patient's prescription history before prescribing opioids.
- Take note of any concurrent or recent prescription for a benzodiazepine or other sedative hypnotics.

Standard of Care - Chronic

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will usually suffice; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.


Standard of Care - Chronic

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate strategies into the management plan to mitigate risk, including:
 - If risk factors for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state Prescription Monitoring Program (PMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
 - If clinicians suspect their patient might be sharing or selling opioids and not taking them, or intentionally missing opioids, clinicians should consider urine drug testing to consider whether opioids can be discontinued abruptly or tapered, and clinicians should consider referral to substance use disorder (SUD) treatment.
 - Urine drug testing is a tool that can be used to assist providers in assessing whether patients are using opioids as prescribed, using other substances or potentially diverting opioids.



Opioid Use – Claim Implications of Addiction & Overdose

- › Opioid use can lead to abuse, overdose, and heroin use.
- › Prescription opioids and heroin can produce a similar high. Heroin may be cheaper and easier to get than opioids.
- › *Bludworth Shipyard v. Lira*, 700 F. 2d 1046 (5th Cir. 1983)– work related back surgery. Prescribed opioids. Worker failed to disclose prior heroin addiction. Opioids were not enough for pain and he began using heroin again.
 - Issue was whether employer had to pay for drug detox program. Court found claimant’s failure to disclose prior addiction was “supervening independent cause” of addiction. Doctor would not have prescribed opioids if claimant had disclosed.



Addiction/Overdose - Natural or Unavoidable Result

- › To be compensable, a second injury must result “naturally or unavoidably” from the original injury. See *Cyr v. Crescent Wharf & Warehouse Co.*, 211 F.2d 454 (9th Cir. 1954.)
- › What if Mr. Lira had not had prior addiction or if he had disclosed addiction? Would detox program be compensable?



Other Methods for Managing Opioids

- › Nurse Case Managers are able to tap into Standards of Care guidelines (MDG, ODG, etc.) and use these as a framework to make recommendations to the treating provider.
- › Open discussions with provider.
- › Recommendations for worker to see pain management if receiving pain meds.
- › If not referred to pain management, ensuring certain steps are taken by physician: random urine screens, comprehensive plan for weaning/tapering.



Red Flags

- › Doctors who continue to prescribe same level or increasing levels of opioids after agreeing to taper/wean.
- › Doctors who do not wish to have care conferences with NCMs.
- › Clinics that privately label and dispense medications. (usually not in Oregon).
- › Polypharmacy.

Prescriptions – Barrier to settlement (Medicare Set-Aside)



Workers' Compensation Medicare
Set-Aside Arrangement (WCMSA)
Reference Guide

Version 2.8

October 1, 2018
CBA-01-2018-v2.8

- › CMS - prices set-asides at 100% of the future costs related to the work injury.
 - Does not recognize any apportionment of future medical items and services or prescription drug costs related to the work injury.
 - › For example, opioid medication may be prescribed for multiple conditions – injury and non-injury related. Cannot apportion

Drug Weaning/Tapering – Reduce Cost of Set-Aside

- › Drug weaning commonly occurs with pain medications.
 - CMS says it takes all evidence of drug weaning into account but also will not assume that the weaning process will be successful.
 - › Usually, the latest weaned dosage is extrapolated for the life expectancy.
- › CMS will consider opinion of attending physician concerning success of tapering.

Opioid Guidelines – Tapering

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All	All	All	Enter Keyword...	All
+ Chronic	No pain classification	ANALGESICS - OPIOID	BUPRENORPHINE (BUP) (Suboxone)	<input type="radio"/> Yes, Insufficient Evidence (3)
+ Chronic	No pain classification	ANALGESICS - OPIOID	BUPRENORPHINE HCL/NALOXONE (Suboxone)	<input type="radio"/> Yes, Insufficient Evidence (3)
- Chronic	No pain classification	ANALGESICS - OPIOID	METHADONE HCL (Dolophin)	<input type="radio"/> Yes, Insufficient Evidence (3)

Comments for Physicians

Certain black box warnings for methadone, abuse with misuse, respiratory depression, accidental ingestion, neonatal opioid withdrawal syndrome (NOWS), drug interactions, QT prolongation, concurrent use with CYP2D6 substrates (including bupropion and vortioxetine). Generally not recommended for those with no demonstrated functional pain receptors; use of black box warnings, use of methadone with buprenorphine, and/or adverse effects of opioids (e.g., cognitive impairment, falls, mood changes, decreased stress, respiratory depression, use of buprenorphine). Transition to only an HLRD or acetylsalicylic acid or complete cessation of analgesics is not generally indicated. Methadone has a particularly high risk of overdose and fatalities. Most patients are treated without use of a controlled substance treatment. Methadone is sometimes used