GOING COLD TURKEY: OPIOIDS, PROP 215 AND OTHER DRUGS: STRATEGIES TO MANAGE AND MINIMIZE ABUSE

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THE IMPORTANCE OF THIS SESSION

- Understanding the difficult problems caused by opioids and other drugs from a Medical, Employment Law and Workers’ Compensation perspective
- Exploring how to identify, manage the medical care for best outcome
- Employment Law considerations for privacy, RTW and settlement
- Practical strategies for WC handling and potential settlement
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GOAL OF CHRONIC PAIN TREATMENT

- Reduced Pain
- Increased Function
- Avoid/Minimize comorbidities from treatment
- Cost-effective Medical Care
- Stay at Work (SAW) / Return to Work (RTW)
ANALGESICS FOR CHRONIC PAIN (CP)

- Pills most common method of CP treatment

- Pain meds can be a blessing for some in chronic pain, but they are not universally effective and in many cases result in increased disability and dysfunction
THE OPIOID DILEMMA: GUIDELINES FOR CHRONIC PAIN TREATMENT
THE OPIOID DILEMMA

- Marked increase in prescription drug Rx
- Increased drug use associated with:
  - Decreased function
  - Increased medical costs
  - Lower return to work rates
  - Increased claim duration and costs
- No scientific medical evidence to support effectiveness of opioids in chronic pain
MEDICATION SIDE-EFFECTS

- Nausea, vomiting, constipation, swelling, urinary retention, and respiratory depression
- Tiredness & daytime sleepiness (fatigue)
- Internal organ problems (liver, kidney, etc.)
- Poor coordination and balance
- Cognitive (memory/concentration) difficulties
- Depression
- Hormonal imbalance (endocrine problems)
- Weight gain
- Sexual dysfunction
IMPORTANT TERMS

- Physical dependence
- Withdrawal
- Tolerance
- Addiction
- Hyperalgesia
Physical dependence is a normally induced state such that abrupt stopping medication results in withdrawal symptoms.

Psychological dependence occurs when the individual becomes emotionally tied to taking a specific drug and develops anxiety with planned drug cessation.
Withdrawal is defined as a set of normal physiologic consequences (things that happen to your body) that occur as a response to abrupt cessation of a drug. Symptoms consistent with withdrawal include increased heart rate, sweating, body aches, nausea, vomiting, diarrhea, and abdominal pain and mood changes.
Tolerance is a simple observation of requiring larger opioid doses to produce the same effect.

In other words, it takes more pills to get the same or less pain relief.

Increase dose may lead to side-effects & dependence.
Addiction is an abnormal behavioral syndrome induced by a certain medication or drug in a susceptible patient.

Findings necessary to make a diagnosis of addiction include:

- Abnormal behavior focused on acquiring the offending drug
- Evidence of harm with the use of the drug
- Continued drug use despite the individual's awareness of harm with use
OPIOID HYPERALGESIA

- Opioid-induced hyperalgesia (OIH) refers to a phenomenon whereby opioid administration results in a lowering of pain threshold, clinically manifest as apparent opioid tolerance, worsening pain despite accelerating opioid doses, and abnormal pain symptoms such as allodynia (pain from stimuli which are not normally painful).
OPIOID FACTS*

- Opioid analgesics decrease pain in <50% patients with chronic non-cancer pain.
- Those who respond to opioids, report approximately 30% decrease in pain from baseline.
- Most studies show small to medium effect size for pain relief in the short term.
- There is no convincing evidence on long-term efficacy of opioids.

OPIOID FACTS

- Opioids are not superior to NSAID, tricyclic or anticonvulsant drugs in decreasing pain or disability.
- Opioid analgesic efficacy is not always sustained during continuous and long-term opioid therapy, even in patients with stable disease and despite dose escalation.
- Evidence for improved physical, emotional or cognitive function with long-term opioid therapy is inconclusive.
- There may be a greater risk for driving related accidents and psychomotor impairment in patients who have recently begun opioid therapy or who have recently increased their opioid dose.

OPIOID FACTS

- Opioid therapy is associated with high rates of multiple side effects in majority of patients.
- Treatment with long-acting opioids causes hypogonadotrophic hypogonadism in both males and females.
- A strong association is reported between daily opioid dose and mortality, even at intermediate doses.
- Methadone causes prolonged QTc interval and heart arrhythmias in susceptible individuals.

OPIOID FACTS

- Treatment with high daily doses (>120 mg/day MED), greater day supply of prescription opioids and use of short-acting schedule II drugs increases risk of opioid misuse.
- Risk factors for abuse are younger age, white males, history of mental health disorder, and personal or family history of substance abuse.

WHAT IS APPROPRIATE OPIOID USE?

The issue of appropriate use of opioids in the treatment of Chronic Pain is complex, controversial, and timely.
THE OPIOID CONUNDRUM

• Ever increasing problem of increasing deaths and dysfunction from the inappropriate use of prescription opioids  
  - versus -  
• Needs of patients for adequate pain control to facilitate comfort, activity, function, and return to work
The Opioid Conundrum

For the medical practitioner and patient, achieving a balance across the spectrum of outcomes from pain alleviation and increased function as opposed to untoward side effects, aberrant drug-related behavior, drug addiction, drug abuse, drug diversion and potential death, remains problematic.
THE 4 A’S

- Analgesia (pain relief)
- Activities of Daily Living (physical and psychosocial functioning)
- Adverse Events (untoward side effects)
- Aberrant Drug-Taking Behaviors (addiction-related outcomes)
STRATEGY FOR PRESCRIBING OPIOIDS

- Careful assessment and formation of an appropriate diagnosis
- Does the physical pathology support opioid prescription
- Psychological assessment including risk of addictive disorders
  - Assessment of the benefit and the risk of likelihood of abuse, misuse, or addiction
Opioid Agreement including:

- Goals of treatment (benefits)
- Expectations (physician and patient)
- Risks and alternatives

Monitoring the patient including UDT
SAFELY MANAGING OPIOIDS IN CHRONIC PAIN

- Initiation and Titration of Chronic Opioid Therapy
  + Treatment individualized & always a trial
  + Use of adjunctive medications
- Monitoring patients on opioids
  + Level of function
  + Progress toward predetermined goals
  + Presence of adverse events
  + Compliance (or lack of)
IDENTIFYING AT RISK PATIENTS

- Predictive tools
- Aberrant behaviors
- Urine drug testing
- Prescription monitoring programs
- Severity and duration of pain vs. objective pathology
- Pharmacist communication
- Family and friends
RISK ASSESSMENT TOOLS

- **ORT**: Opioid Risk Tool
- **SOAPP**: Screener and Opioid Assessment for Patients with Pain
- **DIRE**: Diagnosis, Intractability, Risk, Efficacy
- **COMM**: Current Opioid Misuse Measure
- **PMQ**: Pain Medication Questionnaire
- **DAST-10**: Drug Abuse Screening Test
# Opioid Risk Tool Clinician Form

(includes point values to determine scoring total)

Mark each box that applies.

1. Family History of Substance Abuse:
   - Alcohol: ☐ 1 ☐ 3
   - Illegal Drugs: ☐ 2 ☐ 3
   - Prescription Drugs: ☐ 4 ☐ 4

2. Personal History of Substance Abuse:
   - Alcohol: ☐ 3 ☐ 3
   - Illegal Drugs: ☐ 4 ☐ 4
   - Prescription Drugs: ☐ 5 ☐ 5

3. Age (mark box if between 16-45): ☐ 1 ☐ 1

4. History of Preadolescent Sexual Abuse: ☐ 3 ☐ 0

5. Psychological Disease:
   - Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia: ☐ 2 ☐ 2
   - Depression: ☐ 1 ☐ 1

Scoring Totals: ______  ______

Total Score Risk Category:
- Low Risk: 1-3
- Moderate Risk: 4-7
- High Risk: ≥8
"You're fired, Jack. The lab results just came back, and you tested positive for Coke."
**URINE DRUG TESTING**

**Advantages**
- Can confirm that prescribed drug is taken and that other drugs are not
- Makes a strong statement potentially useful in monitoring

**Disadvantages**
- Cannot confirm that the proper dose is taken
- Can be misinterpreted
- Can be stigmatizing

**When to Test?**
Initial testing (lab or POC) done with class-specific immunoassay drug panels

- Typically do not identify individual drugs within a class (rapid results, not quantitative, low specificity)

Followed by a technique such as GC/MS

- To identify or confirm the presence or absence of a specific drug and/or its metabolites

The California Prescription Drug Monitoring Program (PDMP) - Controlled Substance Utilization Review and Evaluation System (CURES)

- https://pmp.doj.ca.gov/pdmp/index.do
- http://oag.ca.gov/cures-pdmp
TREATMENT APPROACHES

- Limit/avoid opioid usage absent clear and continued efficacy
- Identify at risk IWs for delayed recovery
- Treatment
  - Detoxification / Weaning
  - Biopsychosocial functional restoration approach per the MTUS / ODG / ACOEM
FUNCTIONAL RESTORATION APPROACH

- Multidisciplinary & Interdisciplinary
- Individualized
- Educational
- Functionally oriented (not pain oriented) to reengage in home and work activities
- Locus of control shifts to individual
TREATMENT GOALS

- Provide each patient with education and a range of tools that assist them confidently and more effectively manage pain, increase function, and return to life activities including work.
EDUCATION ISSUES

- Understanding the cause and meaning of pain
- Learning to live with chronic pain
- Locus of control within the person
- Becoming a person with a manageable pain problem rather than a chronic pain patient
- Education to prevent relapse (backsliding)
PHYSICAL RESTORATIVE SERVICES

- Active & Functional
  - Improved body mechanics
  - Spine stabilization, stretching & strengthening
  - Aerobic conditioning
  - Aquatics therapy
  - Tai Chi, Yoga, Qi Gong, etc.
  - Flare-up management
  - Self-directed fitness program
Interventions to change perception or emotional response to pain

- Acceptance / Reduce negative thought patterns

- Cognitive restructuring, relaxation training, guided imagery, desensitization, & pacing

- Communication skills training

- Promotion of a self-management perspective

- Reduce anger and entitlement issues
Use of opioids may be appropriate
- Pathology that fits the problem
- Improved level of function and increased ADLs
- Decreased pain
- Manageable side effects

Best to avoid long term use of opioids
CONCLUSIONS

- Balanced multimodal care
  + Use of opioids as part of complete pain care
  + Anticipation and management of side effects

- Maintain standard of care
  + History & physical exam
  + Follow-up
  + Referrals as needed
  + Measure functional outcomes
  + Documentation
REFERENCES

- Managing Chronic Pain with Opioids in Primary Care, 2nd Edition

  [http://download.journals.elsevierhealth.com/pdfs/journals/1526-5900/PIIS15265900008008316.pdf](http://download.journals.elsevierhealth.com/pdfs/journals/1526-5900/PIIS15265900008008316.pdf)

- Guideline For the Use of Chronic Opioid therapy in Chronic Non-Cancer Pain by The American Pain Society in Conjunction with The American Academy of Pain Medicine

- Responsible Opioid Prescribing: A Physician’s Guide by Scott M. Fishman, MD, Federation of State Medical Boards, 2012
  [http://www.fsmb.org/pain-overview.html](http://www.fsmb.org/pain-overview.html)

- Opioid Prescribing Toolkit by Nathanial Katz, MD, Oxford University Press, 2011

- Opioid Clinical Management Guide by CARES Alliance
INTERNET RESOURCES

General Pain Sites
+ painACTION – http://www.painaction.com
+ American Pain Society (APS) – http://www.ampainsoc.org
+ International Association for the Study of Pain (IASP) – http://www.iasp-pain.org

For a more complete list go to www.FeinbergMedicalGroup.com and click on References and then Internet Links
INTERNET RESOURCES

**Laws or Legal Issues Regarding Opioid Treatment**
- Federation of State Medical Boards – [http://www.fsmb.org](http://www.fsmb.org)
- Drug Enforcement Administration, Office of Diversion Control - [http://www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov)

**Risk Assessment Tools**

**Resources for Chronic Pain Patients**
The Employment Law Perspective
WHY IS DRUG TREATMENT/MANAGEMENT IMPORTANT TO EMPLOYERS WHEN THE CARE IS PROVIDED BY DOCTORS?

- Public agencies are targets for disability rights attorneys, particularly when individuals use Disability/Retaliation allegations to:
  
  Preserve/protect jobs and/or obtain “replacement” financial benefits

- Prescription drug use/abuse can trigger “accommodation” requests as part of “return to work” or “leave of absence” programs that, if not properly managed, can result in civil liability (not limited by workers compensation damages caps) and/or increased operating costs

- Workers’ compensation lawyers are focusing on “civil” claims because workers’ compensation claims are less profitable for them; Civil claims are expensive to defend and plaintiffs’ attorneys often leverage these claims to their financial advantage
SAFETY ..... SAFETY ..... SAFETY

• Duty to provide a safe workplace for employees

• Duty to avoid foreseeable risks of harm to members of the public

• Duty to comply with “drug free” workplaces

What You Don’t Know, If You Can Legally Monitor And/Or Manage It, Can Cost You (Dearly) Because You Cannot Escape, Avoid Or Delegate These Duties
PROTECTING THE COMPANY ... AND ITS EMPLOYEES

- Adopt Appropriate Policies
  - In compliance with governing laws, regulations and collective bargaining agreements

- Implement Appropriate Training
  - Employees need to understand adopted policies and safe workplace practices – and the roles of Supervisors and H.R.

- Take Steps to Ensure Appropriate Reporting
  - Affirmative efforts need to be made to ensure that reports of safety concerns are received by Human Resources and acted upon in a timely and appropriate manner.
Prescription and over-the-counter drugs are not prohibited when taken in standard dosage and/or according to a physician's prescription. Any employee taking prescribed or over-the-counter medications will be responsible for consulting the prescribing physician and/or pharmacist to ascertain whether the medication may interfere with safe performance of his/her job. **If the use of a medication could compromise the safety of the employee, fellow employees or the public, it is the employee's responsibility to use appropriate personnel procedures (e.g., call in sick, use leave, request change of duty, notify supervisor, notify company doctor) to avoid unsafe workplace practices.**

The illegal or unauthorized use of prescription drugs is prohibited. It is a violation of our drug-free workplace policy to intentionally misuse and/or abuse prescription medications. **Appropriate disciplinary action will be taken if job performance deterioration and/or other accidents occur.**
TRAINING ...
TO AVOID THE MINEFIELDS

- FMLA/CFRA
  - Requests for leave can trigger rights/obligations under ADA/FEHA, as well as the obligation to provide leaves of absence as authorized by law
    - **Affirmative Duty to Identify Potential Right to Leave Benefits**
    - **Affirmative Duty to Offer/Assist with Leave Requests**

- Disability Accommodation
  - **Affirmative Duty to take Action upon Notice of an Actual or Potential Need or Desire for Accommodation**
    - Action may solely involve a general inquiry, but may require commencement of the “interactive process” to determine (i) the existence of a disability, and (ii) a reasonable accommodation, that (iii) does not unduly burden the employer.
    - Must pull these situations into Human Resources to ensure (i) consistency in approach/communications, and (ii) ensuring that “medical” information is not improper sought or obtained by supervisors
Return to Work/Disability Accommodation/Leave of Absence

- These all involve the key issue of the ability to safely perform the essential functions of his/her job, or another alternate position for which they are qualified,
- If impaired by medication, on an intermittent or “dependency” basis, the employee probably cannot “safely” perform one or more essential job functions
- Evaluate whether the condition renders the employee “disqualified” from holding his/her position

Information Sharing

- **Supervisors** – No access to “medical” – best practice – refer to capabilities (recognizing most physicians write in terms of “restrictions”)
- **W/C vs. H.R. vs. Disability Insurers**
  (Can only share “authorized” information, directly relating to the issue in question – no “extraneous” sharing)
Drug Testing: When/How

+ Was there objectively reasonable cause to believe an employee was impaired during the course or scope of employment and/or was it a DOT or “Safety Sensitive” Position
+ You can create a “duty” for employees to disclose right policy.

The Tension Point

Supervisors - Manages/Disciplines/Wants Information on People to Meet Production/Performance Goals

vs.

HR Manages Policies/Information/Processes to Protect the Company and Employee Rights
REPORTING .... TO AVOID CLAIMS AND LOSSES

- There needs to be a positive culture of reporting safety (drug/alcohol) concerns through the appropriate channels.
- In the case of an immediate safety concern, employees should be empowered to contact 911 if they cannot quickly find an immediate supervisor or manager.
- An “Incident Report” form should be immediately prepared by witnesses.
  - The Report should be reviewed for completeness, but not for comment on the actual observations.
  - The Report is a “risk management” document; it is confidential and privileged – shared only upon the advice of counsel or as part of actual disciplinary/litigation proceedings.
- Risk Management/Human Resources/Department Managers should all quickly be advised of such situations.
WORKER’S COMPENSATION PERSPECTIVE

- Red flags in claims handling
- Medical management of chronic pain, UR/IMR, handling potential non-certifications
- MPN dispute process, IMR comparison
- Consider Nurse case managers were possible
- Inquire for CURES reporting from PTP and Pharmacy
- Consider “Peer to peer” and specialty reviewers
- Consider Litigation as medical management-deposition of PTP re training, pain contract, MTUS, functional improvement/documentation, testing protocols
- Analyze RTW for potential compensable consequences, & prospect for new claims avoid §132a
WORKER’S COMPENSATION PERSPECTIVE

- PD & RTW assessment complicated by multiple specialties
- SB863 new §4660.1 limits psyche PD, unless victim/violence, or “catastrophic injury”
- 100% PD still available per Le Boeuf, or §4662 “in accordance with the fact”
- Consider *Benson* as a defense for multiple injuries
- Anticipate added risk and costs of vocational experts to address drug effects on employability/earning capacity
WORKER'S COMPENSATION PERSPECTIVE

- Remember post 2004 DOI - Life pension and permanent total cases will enjoy SAWW/ COLA increases §4659
- Many chronic pain cases will be career ending, requiring life care plan, and/or MSA evaluations

- CMS thresholds of review $25k /$250k require approval of MSA
- Identify cost driver(s) of the MSA/life care plan
Consider the willingness for medication adjustment or detox

Negotiation to identify any settlement “motivators” for applicant to consider drug change or detox

Distinguish MSA covered and non-covered medications; compare eg. OxyContin vs. Actiq

Documentation for detox of covered CMS vs. non-covered medications
Settlement requires teamwork
Aggressive review of nonindustrial medical records may impact life expectancy/age rating of MSA/annuity values
Consider appropriate releases for SJDB voucher rights, new §4658.7, and especially Rodgers release for potential injury consider new time for o/a DOI 2013 limitation of 2 years after issued or 5 years post DOI, whichever later
Careful coordination of medical info and legal advice requires team work for complex settlement provisions
Consider funding cost to draft Special Needs Trust - SSI
THE END...