AIG Opioid Management Program

The National Opioid Epidemic

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"Over the past 10 years, the drug landscape in the United States has shifted, with the ... opioid threat ... having risen to epidemic levels...."[1] "Drug poisoning is the leading cause of injury death in the United States," outranking deaths by guns, car accidents and homicide.[1] There were 47,055 drug-related deaths in the U.S. in 2014,[3] with controlled prescription drugs (CPDs) including opioid pain relievers outranking cocaine and heroin deaths combined.[1] In 2014, 129 people died each day from drug overdoses[4] and 79 of these deaths were opioid/heroin-related.[4] The National Drug Threat Assessment concludes, "Sadly, ... opioids ... are killing people in this country at a horrifying rate."[4] For every opioid death, it is estimated that 9 to 10 people receive treatment for substance abuse, and 32 to 35 are seen in emergency rooms due to opioid misuse.[12]

Opioids account for 5 of the top 7 CPDs being distributed.[1] In 2014, 14.9 billion units of opioids were distributed to retail outlets.[1] Hydrocodone was the number one opioid drug dispensed from 2006 to 2014 at just under 8 billion units dispensed in 2014, dropping to 6.7 billion units in2015.[1] Oxycodone was second at around 5 billion units dispensed in 2014.[1] Hydrocodone and Oxycodone comprised 87% of the opioid units dispensed in 2014 and over 80% of opioids prescribed in 2015.[1]

The National Effort to Address Opioid Abuse

The U.S. Drug Enforcement Agency (DEA) issues required registrations for providers/pharmacies to legally dispense medications. The DEA has the authority to revoke DEA registrations via administrative and criminal proceedings.[1] However, the number of enforcement actions by the DEA has dropped significantly in the past few years. The DEA's enforcement actions began to diminish in 2013 according to a Washington Post investigation.[5] The Chief Administrative Law Judge who reviews DEA Diversion Control office caseloads stated, "There can be little doubt that the level of administrative diversion enforcement remains stunningly low for a national program."[5] In fact, caseloads decreased from 131 in 2011 to just 40 in 2014.[5] Suspension of DEA registered providers dwindled from 65 in 2011 to 9 in 2014, and surrender of licenses dropped by more than one third in 2016.[5] According to the Washington Post, legislation passed by Congress in 2016 raised the standard required for immediate suspension orders to a level that is almost impossible to meet.[5]

Over the past few years, several national, state and local initiatives have been adopted in an effort to improve public safety by seeking to decrease opioid misuse, addiction and overdose, while also balancing the needs of patients experiencing acute and chronic pain. At the state level, systems have been adopted to better monitor dispensing of opioids in an effort to reduce opioid abuse and diversion. For example, Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases used to monitor prescribing and dispensing of CPDs, including opioids. PDMPs are designed to give prescribers and pharmacists information on a patient's CPD use, identify high-risk settings and ideally protect the patients at risk. Forty-nine states have functioning PDMPs (Missouri is the only jurisdiction that does not).[17]

In addition, several states have enrolled in the InterConnect system, which allows state PDMPs to be linked, enabling providers and dispensers to share information regarding CPD use across state lines.[16] Forty-two states are already connected through InterConnect.[16] In addition, 3 more states are considering enrollment in InterConnect.[16] Experts have concluded that interstate sharing of prescription data has shown to be effective in reducing abuse.[1]

In an effort to improve the effectiveness and safety of opioid prescribing, the CDC issued guidelines for prescribing opioids for chronic pain in March, 2016. However, these guidelines are not mandatory.[1] Among other things, the guidelines recommend utilizing non-opioid options first, discussing goals and risks of opioids, using the lowest effective dose and exercising caution regarding high dose opioids, following patients to assess benefit versus harm, integrating opioids with other treatments, monitoring patients through PDMPs and urine drug testing to improve patient safety, considering naloxone for high risk patients and implementing medication assisted treatments for patients with opioid addiction.

Opioid Use in the Workers' Compensation Arena

While there is evidence that opioids are effective for short term treatment of acute pain, there is less evidence of their efficacy to treat chronic musculoskeletal pain.[13] Despite this, opioids continue to be prescribed for chronic musculoskeletal, head and dental pain, etc., and have been associated with poor outcomes and increased costs. A recent Workers' Compensation Research Institute (WCRI) study of 25 states found that 65-80% of nationwide non-surgical lost time claims (over 7 days) involved opioid prescriptions as a pain medication in most of the states studied.[6] Twenty out of twenty five states had usage of 67% or greater in 2012, including California at 67%, New York at 69% and Texas at 76%.[6] Morphine equivalent dose (MED) provides a measure needed to understand the relative potency of opioid medications being prescribed to injured workers. Arkansas and Louisiana had the highest potency levels for strength of prescriptions at around 3,400mg of MED per claim.[6] This dosage is the equivalent of taking a 5mg Vicodin every 4 hours for almost 4 months.[6] A significant number of claims with opioid prescriptions also include prescribed muscle relaxants, like Soma or Flexeril, and some prescribed benzodiazepines, like Valium, or Xanax.[6] Of concern, some studies have observed that up to one-third of opioid overdose deaths also involved benzodiazepines.[14]

Opioids impact the cost of workers' compensation claims dramatically. Several studies have linked opioid prescribing for conditions like low back pain with longer duration of work loss, and increased workers' compensation claim costs.[15] In 2014, 29% of nationwide prescription costs in workers' compensation claims came from controlled prescriptions.[7] In 2015, opioids were responsible for 28.6% of prescription spend showing little change since 2014.[11] The costs typically increase rapidly as claims age, starting at 5% of medical spend for claims less than 1 year old and escalating to 45-50% by year 10.[7] Costs for CPDs continue to rise. For example, the cost for CPDs rose 16% in 2014[7] and the price of Oxycodone-acetaminophen increased 97% in 2014, followed by Oxycodone at a 72% increase and Hydrocodone-acetaminophen at a 16% increase.[8] With the 2017 production cuts proposed by the DEA, prices could be driven even higher based on supply and demand.

Opioid Management in the Workers' Compensation Arena

The workers' compensation system gains some advantage from national and state regulatory and other actions including actions involving DEA enforcement, interstate drug information (e.g. InterConnect) and state PDMPs. Workers' compensation state drug formularies can also add up to 10% or more in additional savings.[7] The intent of the formularies is to use evidence-based guidelines to enhance value based care, reduce costs and reduce over-prescribing of controlled pain medications.[7] Drug formularies have been adopted by 10 states (AR, AZ, DE, ND, NE, OH, OK, TN, TX, WA and WY).[7, 9] California plans to implement a formulary in 2018.[17]

Some states have adopted treatment guidelines to be used in conjunction with utilization review and drug formularies for better management of prescriptions.[9] Five states have adopted the American College of Occupational Environmental Medicine's (ACOEM's) Practice Guidelines, in whole or in part.[9] Eight (8) states have adopted the Official Disability Guidelines (ODG).[9] Others have custom/hybrid treatment guidelines. Nearly half of the states have not adopted formal treatment guidelines.[9]

Since implementation of these guidelines, there has generally been a downward trend in opioid utilization within the U.S. workers' compensation arena. Utilization in 2015 dropped 4.4%, continuing the trend.[8]

AIG's Approach to Opioid Management in the Workers' Compensation Arena

AIG began building an opioid control program in 2010. We now use a suite of tools to help ensure injured workers receive reasonable and effective treatment while reducing the potential risks of opioid misuse.

Treatment Guidelines – AIG leverages state mandated and nationally recognized treatment guidelines to determine if opioid prescribing is effective and compliant with best practice evidence based guidelines, reducing excessive, potentially harmful opioid prescribing. Our Pharmacy Management Services' vendor, Optum, identifies when prescription medications reach specific triggers of increased risk or are outside the treatment guidelines. The Claim Representative is then alerted for further authorization. Since 2010, AIG has reduced the number of injured workers receiving opioids by 11% nationwide; by 25% in California and by 16% in New York. AIG handled claims averaged 58% opioid use nationally in 2012, as compared to 70% found in the 25 states studied by the WCRI. In California, opioid usage in AIG claims was 46%, as compared to 67% found by the WCRI, and in New York, opioid usage was 65% for AIG claims, as compared to 69% found by the WCRI. For AIG claims, we reduced the percentage of opioid spend compared to overall prescription spend by 19% nationwide from 2010 to 2016, with a 51% reduction in California and a 25% reduction in all other states.*

High Risk Management – Screening for high dosages, drug interactions and duplication of therapy (e.g. dual prescribers), when resulting in an intervention letter, has a 43% success rate in changing therapy and saves an average of $1,200-$1,400 annually per workers' compensation claim. In claims where multiple providers are prescribing opioids, AIG is 95% successful in reverting back to one provider after contact. Drug testing is another AIG patient safety initiative to monitor consistent, proper use of medications. AIG has reduced the average morphine equivalent dose (MED) per injured worker by 29% on lost time injured workers with an open claim at 2 years nationwide. The impact in California was a 50% reduction, 40% in New York and 38% in Illinois. AIG reduced 25% in all other states.*

Clinical Escalation Alerts (CEA) – In general, AIG Claims begins monitoring with the first prescription and alerts Medical Management Services (MMS) when an opioid prescription reaches specific triggers. Utilization Review (UR) is conducted in states where regulations permit UR of medications. UR, peer review and peer-to-peer outreach for targeted claims evaluates factors such as efficacy of opioid therapy, side effects, risks, guideline recommended monitoring, patient safety and other considerations. Peer-to-peer outreach has shown average cost savings of approximately $5,100 per injured worker. Seventy-five percent of claims subject to an alert to MMS are negotiated to bring prescriptions within appropriate guidelines. In 2015, AIG blocked 1,799 opioid prescriptions that were not supported by medical evidence and applicable guidelines, and also prompted weaning in 6,690 patients. AIG has reduced the average number of opioid prescriptions per lost-time injured worker at 2 years nationwide by 23% from 2010 to 2014. Reductions in California and Illinois were 28% and were 24% in all other states.*

Productivity Edge – AIG's Productivity Edge program engages the injured worker with a nurse from day one, to act as a guide in finding a provider who can offer quality treatment based on our Outcome Based Network. Early assistance may help to prevent potential inappropriate use of opioids up front and saves an average of 16% in overall claim costs.

Telephonic Case Management (TCM) – Integrated with AIG Claims Operations and subject to regulations, the TCM program provides a nurse who telephonically manages medical treatment information and interacts with injured workers and providers to monitor the treatment plan, facilitate care, and coordinate early return to work, driving up to 18% overall savings on lost time claims.

*All other states except CA, FL, IL, NJ, NY, and PA

1 – US Department of Justice 2016 National Drug Threat Assessment (NDTA)

2 – DEA article on Drug Threat Assessment: https://www.dea.gov/divisions/hq/2016/hq120616.shtml

3 – US Centers for Disease Control (CDC) sited in NDTA

4 – DEA Reducing Opioid Production: https://www.dea.gov/divisions/hq/2016/hq100416.shtml

5 – Washington Post Investigation: https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html?utm_term=.81bbcf6e0b9a

6 – WCRI Interstate Variations in Use of Opioids 3rd Edition

7 – NCCI Research Brief - Workers' Compensation and Prescription Drugs: 2016 Update

8 – Optum (Helios) Drug Study, 2015

9 – Drug Formularies in Workers' Compensation Systems (ACOEM): http://www.acoem.org/uploadedFiles/Public_Affairs/Policies_And_Position_Statements/Guidelines/Position_Statements/DrugFormulariesinWorkersCompensationSystems.pdf

10 – American Pain Society and American Academy of Pain Medicine

11 – Helios 2015 Workers' Compensation Drug Trends Report

12 - MMWR 61(1) 2012: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm

13 - Franklin Clin J Pain 2009: https://www.ncbi.nlm.nih.gov/pubmed/19851153

14 - Jones AmJPrev Med 2015: https://www.ncbi.nlm.nih.gov/pubmed/26143953

15 - Volinn Pain 2009: https://www.ncbi.nlm.nih.gov/pubmed/19181448 , Webster Spine 2007: https://www.ncbi.nlm.nih.gov/pubmed/17762815, White JOEM 2012 https://www.ncbi.nlm.nih.gov/pubmed/22821070)

16 – National Association of Boards of Pharmacy: https://nabp.pharmacy/initiatives/pmp-interconnect/

17 – PDMP TTAC: http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq

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