EVALUATION OF CONTROLS OVER THE PRESCRIBING OF OPIOIDS IN THE WORKERS' COMPENSATION PROGRAM

STATE OF LOUISIANA

PERFORMANCE AUDIT SERVICES
DECEMBER 4, 2019

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

December 4, 2019

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our evaluation of controls over the prescribing of opioids in the state Workers' Compensation program. We found that prescribing controls in the program could be strengthened to reduce the risks associated with opioid use.

Specifically, we found the State does not require the use of such mechanisms as a drug formulary or reimbursement rules to help control the prescribing of opioids in workers' compensation. Louisiana did establish workers' compensation medical treatment guidelines in 2011, but the guidelines are not enforceable statewide for prescriptions due to conflicting court decisions. The lack of control mechanisms may be why the number of workers' compensation claims involving opioid prescriptions is not dropping as quickly in Louisiana as in other states. A report by the National Council on Compensation Insurance showed opioid prescriptions in workers' compensation claims with prescriptions decreased 14 percent nationally from calendar years 2013 to 2017, but Louisiana saw only a 7 percent drop.

In addition, while Louisiana has a law limiting first-time opioid prescriptions to a seven-day supply, the law does not indicate how much time has to pass after a patient's prescription has ended before the next one can be considered a first-time prescription. The company that oversees state employees' workers' compensation claims in Louisiana uses a six-month timeframe. However, the Louisiana Medicaid program uses a 90-day timeframe. Using a shorter timeframe would mean more opioid prescriptions could be limited to seven days.

We also found that, from calendar years 2016 to 2018, 24.6 percent of workers' compensation claimants with opioid prescriptions had an average daily morphine dose that exceeded the recommendations of the federal Centers for Disease Control and Prevention (CDC). The morphine equivalent dose is a measurement tool that converts the strengths of various prescription opioids into a standard value based on their relative potency compared to morphine. Louisiana does not have any specific daily morphine equivalent dose limits for opioid prescriptions in the Workers' Compensation program, unlike other states and Louisiana's

Medicaid program. Such limits may help reduce the risks of opioid overdose, addiction, and long-term use.

We found as well that, from calendar years 2016 to 2018, 29.9 percent of workers' compensation claimants with opioid prescriptions had them for 90 or more consecutive days. Taking opioids continuously for more than 90 days substantially increases the risk of addiction, according to the CDC. If Louisiana were to establish periodic documentation requirements, guidelines for tapering the use of the medications, and coverage requirements for tapering and addiction treatment, it could help prevent workers' compensation claimants from continuing to take opioids without justification, minimize withdrawal symptoms, and make sure claimants receive the appropriate care for addiction.

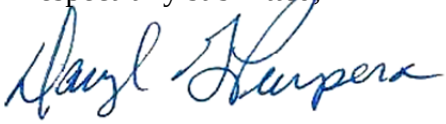
We noted, too, that, from calendar years 2016 to 2018, 16.4 percent of workers' compensation claimants with opioids were prescribed opioids and benzodiazepines at the same time. Benzodiazepines include such medications as Xanax and Valium. Both the CDC and the Federal Drug Administration recommend against concurrent prescriptions because of the increased risk of overdoses. If Louisiana were to set up controls to discourage or restrict these concurrent prescriptions, it could help reduce the risk of overdoses, addiction, and other problems among workers' compensation claimants taking opioids.

Louisiana also needs to establish other controls that could help prevent doctor shopping, as well as reduce claimants' risk of overdoses. We found that, from calendar years 2016 to 2018, 5.2 percent of workers' compensation claimants taking opioids received the medications from three or more prescribers in the same quarter. The CDC notes that this pattern could be associated with doctor shopping and an increased risk of overdoses.

I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the Office of Risk Management and the Louisiana Workforce Commission for their assistance during this audit.

Respectfully submitted,



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DGP/aa

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Louisiana Legislative Auditor

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Evaluation of Controls Over the Prescribing of Opioids in the Workers' Compensation Program

December 2019

Audit Control # 40170029

Introduction

We evaluated controls associated with the prescribing of opioids[1] in the Workers' Compensation (WC) program, including how Louisiana could strengthen these controls to reduce the risks associated with opioid use. Louisiana WC law requires public and private employers to provide benefits such as medical care and wages for lost work time through WC insurance or other secured means of payment to employees who suffer work-related injuries, illnesses, or death. In Louisiana, various entities including the legislature, the Louisiana State Board of Medical Examiners (LSBME), and the Office of Workers' Compensation within the Louisiana Workforce Commission (LWC-OWC) have authority to establish controls to prevent excessive opioid prescribing statewide or in WC claims.[3] The Office of Risk Management (ORM) is responsible for managing all state insurance policies, including WC insurance for state employees. ORM contracts with Sedgwick for claims administration, including enforcement of opioid controls.[4] While opioids are the most appropriate treatment of injured workers' pain in some cases, excessive opioid prescribing increases the risks of opioid addiction, overdose, and diversion.[5]

Risks Related to Opioid Use[2]

- Respiratory depression and overdose
- Development of lifelong addiction that can cause distress and inability to fulfill obligations
- Decreased psychomotor performance
- Falls and vehicle crashes
- Longer disability duration after injury, which results in longer periods of reduced earnings and decreases likelihood of ever returning to work
- Side effects such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, increased pain sensitivity, and withdrawal symptoms that often require additional treatment

[1] Opioids include illegal substances such as heroin as well as legal medications, including those derived from opium, such as morphine; semi-synthetic opioids synthesized from opium, such as hydrocodone and oxycodone; and synthetic opioids created in a lab, such as fentanyl. This report focuses on prescribing of legal opioids.

[2] Based on information from the Centers of Disease Control and Prevention (CDC), *Guideline for Prescribing Opioids for Chronic Pain, 2016*; the Louisiana and Colorado WC medical treatment guidelines; Louisiana R.S. 23:1221; CDC, *Workers Using Prescription Opioids and/or Benzodiazepines Can Face Safety and Health Risks*, 2018; and Workers Compensation Research Institute, *The Impact of Opioid Prescriptions on Duration of Temporary Disability*, 2018.

[3] See Appendix C for complete list of entities with oversight responsibilities related to Louisiana opioid prescribing.

[4] Beginning in August 2015, ORM contracted with Sedgwick to perform claims administration services, including case management for individual claims. Sedgwick uses Optum as its contracted pharmacy benefits manager (PBM) to process WC prescriptions at the point of sale and provide additional pharmacy-related claims management services.

[5] Diversion occurs when prescriptions are taken by someone other than the person for whom they were prescribed.

We conducted this audit because national research organizations have found that injured workers in Louisiana are prescribed opioids more often and for longer periods than injured workers in other states. For example, the National Council on Compensation Insurance (NCCI) found that 60% of Louisiana's WC claims with prescriptions had opioids in 2017 compared to 39% nationwide.[6] In addition, the Workers' Compensation Research Institute (WCRI) found that the percent of claims with prescriptions that had opioid prescriptions, the average amount of opioids per claim with opioids, and the average number of days with opioids per claim were higher in Louisiana than other study states,[7] as shown in Exhibit 1.

Exhibit 1
Selected WCRI Opioid Metrics for Louisiana Compared to Median of 27 Study States
October 2015 through March 2018*

Metrics of Opioid Prescribing	LA	Median State	Difference from Median State
Among Claims with Any Prescription			
Percent of Claims with Opioid Prescriptions	69%	52%	17 ppt** (second-highest)
Percent of Claims with Two or More Opioid Prescriptions	48%	26%	22 ppt (highest)
Among Claims with Opioids			
Average Number of Opioid Prescriptions per Claim	6.2	2.8	122% (highest)
Average Number of Opioid Pills per Claim	381	131	191% (highest)
Average Number of Days with Opioids per Claim***	115	36	218% (highest)
Average Morphine Equivalent Dose (MED) per Claim	3,287	999	229% (second-highest)

*Includes prescriptions filled through March 2018 for nonsurgical claims with more than seven days of lost work time and injuries occurring October 2015 through September 2016.
**Percentage point difference.
***Only calculated for 22 of the 27 study states, as these were the only states with necessary information available.
Source: Prepared by legislative auditor's staff based on WCRI's *Interstate Variations in Dispensing of Opioids, 5th Edition*, 2019.

Nationwide, increases in opioid-related deaths have led organizations such as the Centers for Disease Control and Prevention (CDC), the National Institutes of Health, and the Federation of State Medical Boards to recommend controls that states can implement to reduce the risk of excessive opioid prescribing. For example, in 2016, the CDC published the *Guideline for Prescribing Opioids for Chronic Pain* (*Guideline*), which provides evidence-based recommendations to clinicians for deciding whether to treat pain[8] with opioids, selecting the types and amounts of opioids to prescribe, prescribing the lowest effective dose, and assessing risks and addressing harms of opioid prescribing.[9] Several states have implemented controls for

[6] NCCI, *Medical Data Report: Opioid Utilization Supplement for the State of Louisiana*, 2018. NCCI's data does not include all states or all claims from study states. All references to NCCI refer to this report. See Appendix B for more information on NCCI.
[7] WCRI, *Interstate Variations in Dispensing of Opioids, 5th Edition*, 2019. All references to WCRI refer to this report unless otherwise specified. WCRI's data does not include all states or all claims from study states. See Appendix B for more information on WCRI.
[8] According to the CDC *Guideline,* acute pain is abrupt onset and is not ongoing, whereas chronic pain typically lasts more than three months or past the time of normal tissue healing. The *Guideline* addresses prescribing opioids for treating chronic pain, as well as how limiting opioids for acute pain can reduce the likelihood of long-term opioid treatment. The *Guideline* recommendations exclude active cancer treatment, palliative care (i.e., treatment to control symptoms of incurable diseases), and end-of-life care.
[9] See Appendix D for a table of the *Guideline* recommendations.
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

prescribing opioids statewide or in their WC programs based on the *Guideline* and other best practices, such as limiting duration and dose of prescriptions and preventing injured workers from going to multiple doctors. WC controls are established through various mechanisms, such as drug formularies, reimbursement rules, or treatment guidelines. The U.S. Department of Health and Human Services specified in 2019 that new opioid controls such as those based on the CDC *Guideline* should not apply to existing patients taking opioids as long as the benefits of their opioid treatment continue to outweigh the risks. LWC-OWC is currently in the process of updating Louisiana's WC medical treatment guidelines to include additional opioid controls and is currently seeking a vendor to update its reimbursement rules.

To evaluate how Louisiana could strengthen controls in WC, we analyzed state employees' WC claims that were opened or had a payment during calendar years 2016 through 2018 as well as findings from NCCI and WCRI reports that compare Louisiana's WC claims to those in other states, including WC claims from the private sector. We also compared the controls over opioid prescribing for Louisiana's WC claims to those recommended by best practices and used in other states and programs. The objective of this performance audit was:

To evaluate controls over the prescribing of opioids in the Workers' Compensation program, including how Louisiana could strengthen these controls to reduce the risks associated with opioid use.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains a summary of the response received from LWC-OWC, Appendix B details our scope and methodology, Appendix C contains an overview of entities overseeing opioid dispensing statewide and in the Louisiana WC system, and Appendix D contains a summary of the CDC *Guideline* recommendations. In addition, Appendix E compares changes of WCRI opioid metrics for Louisiana and the median of 27 study states from October 2012 to September 2018, and Appendices F through H contain examples of different types of opioid controls implemented by other states.

Objective: To evaluate controls over the prescribing of opioids in the Workers' Compensation program, including how Louisiana could strengthen these controls to reduce the risks associated with opioid use.

Overall, we found that Louisiana could strengthen prescribing controls in WC to reduce the risks associated with opioid use. Specifically, we found the following:

- **Louisiana does not currently use mechanisms, such as a drug formulary or reimbursement rules, to implement controls for prescribing opioids within the WC program. Although Louisiana developed WC medical treatment guidelines in calendar year 2011, these guidelines are not enforceable statewide for prescriptions due to conflicting court decisions.** The lack of sufficient mechanisms may be the reason that prescriptions for opioids are not decreasing as rapidly in Louisiana as in other states. According to the National Council on Compensation Insurance (NCCI), the percent of prescription claims with opioids decreased 14% nationally from calendar year 2013 through 2017 but only decreased 7% in Louisiana.

- **Although Louisiana adopted a law that limits all first-time opioid prescriptions to a seven-day supply as recommended by the CDC, the law does not specify how much time must pass after a patient's last opioid prescription before their next is considered a first-time opioid prescription.** Currently, Sedgwick uses a six-month timeframe, which is longer than some other insurers and states. Specifying a shorter timeframe in law for identifying first-time opioid prescriptions, such as 90 days used by Louisiana Medicaid, would result in more prescriptions being limited to seven days' supply for claimants.

- **During calendar years 2016 through 2018, 24.6% of state WC claimants with opioids had an average daily morphine equivalent dose (MED) that exceeded CDC recommendations.** Because Louisiana does not currently have any controls in WC related to MED, implementing specific daily MED limits for opioid prescriptions similar to other states and Louisiana's Medicaid program may help reduce the increased risks of overdose, addiction, and long-term use.

- **Overall, 29.9% of state WC claimants with opioids had opioids for 90 or more consecutive days during calendar years 2016 through 2018. According to the CDC, receiving opioids for more than 90 days substantially increases the risk for addiction.** Establishing periodic documentation requirements, tapering guidelines, and coverage requirements for tapering and addiction treatment like other states could help to prevent claimants from continuing opioid treatment without justification, minimize withdrawal symptoms, and ensure claimants receive appropriate care for addiction.

- **During calendar years 2016 through 2018, 16.4% of state WC claimants with opioids were concurrently prescribed benzodiazepines (e.g., Xanax, Valium). However, both the CDC and Federal Drug Administration recommend that clinicians avoid prescribing opioids and benzodiazepines concurrently due to increased overdose risk.** Implementing controls to discourage or restrict concurrent prescribing of these drugs may help to reduce claimant risks of overdose as well as addiction and other serious harms.

- **During calendar years 2016 through 2018, 5.2% of state WC claimants with opioids received opioids from three or more prescribers in the same quarter. According to the CDC, this trend could be associated with doctor shopping and increased overdose risk.** Implementing additional controls used in other states such as claimant lock-in programs could help to prevent doctor shopping and reduce claimants' risk of overdose.

Our findings are discussed in more detail on the following pages along with matters that the legislature may wish to consider in order to strengthen Louisiana's controls around the prescribing of opioids in the WC program.

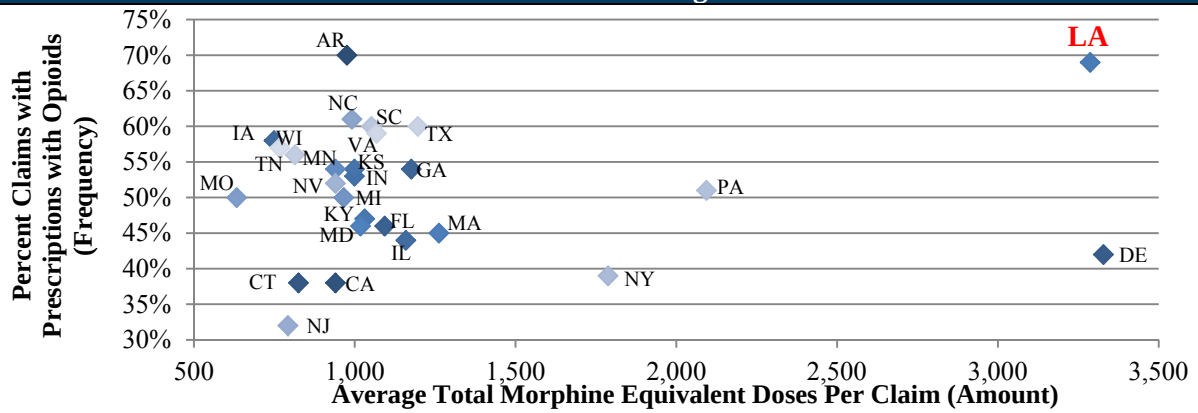
Louisiana does not currently use mechanisms, such as a drug formulary or reimbursement rules, to implement controls for prescribing opioids in the WC program. Although Louisiana developed WC medical treatment guidelines in calendar year 2011, these guidelines are not enforceable statewide for prescriptions due to conflicting court decisions.

Louisiana has implemented some statewide controls for opioid prescribing that align with CDC *Guideline* recommendations, including Prescription Monitoring Program (PMP) requirements and a seven-day limit for initial opioid prescriptions. However, unlike several other states, Louisiana has not established WC-specific opioid controls that are enforced for all WC claims. The lack of controls may be why NCCI and WCRI found that opioid prescribing in WC is not decreasing as rapidly in Louisiana as in other states. Specifically, NCCI found that the percent of prescription claims with opioids decreased 14% nationally from calendar years 2013 through 2017 but only decreased 7% in Louisiana. WCRI similarly reported in 2019 that Louisiana's metrics for the frequency, amount, and duration of opioids for WC claims did not decrease as much as the median state.[10] According to WCRI, Louisiana remains an outlier because unlike other study states, both the percentage of claims with opioids and the average amount of opioids dispensed per claim were high in Louisiana,[11] as shown in Exhibit 2.

[10] Appendix E shows a comparison of changes to Louisiana opioid metrics and those of the median state from the WCRI study.

[11] The WCRI study notes that although one may suspect that differences between states reflect differences in case mix and injury severity, adjusting for differences across states in demographics, injury types, and industry mix had little impact on interstate variations in opioid utilization.

Exhibit 2
Frequency and Amount of Opioid Prescribing for 27 WCRI Study States
October 2015 through March 2018*



*Includes prescriptions filled through March 2018 for nonsurgical claims with more than seven days of lost work time and injuries occurring October 2015 through September 2016. Claims analyzed included an average 24 months of experience.
Source: Prepared by legislative auditor's staff based on WCRI, *Interstate Variations in Dispensing of Opioids, 5th Edition*, 2019

One reason that Louisiana remains an outlier may be because it has not established a sufficient mechanism to establish and enforce WC-specific opioid controls. Other states have used treatment guidelines, drug formularies, reimbursement rules, or a combination of the three to implement opioid controls specific to WC. Exhibit 3 summarizes several mechanisms that other states have used to implement controls and whether Louisiana has taken similar action.

Exhibit 3
Mechanisms Used to Implement Opioid Controls for WC Claims

Mechanism	Description	States	Does Mechanism Exist in Louisiana?
Prescription Formulary	List of preferred and non-preferred prescription drugs, in some cases including duration, dose, or other limits to opioid prescriptions. Non-preferred drugs or drugs exceeding limits require prior authorization.	16 states*	**No**. In the past five years, four bills have been filed proposing a WC formulary, but none were enacted. According to LWC-OWC, it did not support two bills that specifically authorized the adoption of a national company's formulary, as it does not support the LA Medical Treatment Guidelines (MTGs) developed in-state.
Medical Treatment Guidelines (MTGs)	Evidence-based treatment protocols for specific injuries that foster consistent and quality care for injured workers in a cost-effective manner that limits inappropriate and unnecessary care. In many states, reimbursement for variances requires prior authorization or approval through post-procedural review or dispute resolution.	22 states**	**Yes, but are not enforced statewide for prescriptions.** MTGs including a chronic pain chapter were promulgated in regulation in 2011. Louisiana Revised Statute (R.S.) 23:1203.1 establishes the MTGs as the standard of reasonable and necessary "medical care, services, and treatment" due in WC claims; however, according to LWC-OWC, the courts have interpreted the law differently because the law does not specifically address "prescriptions." In addition, the MTGs do not include several *Guideline* recommendations, such as limits on opioid dose and dangerous drug combinations.
Reimbursement Rules	Regulations that set conditions for coverage and reimbursement of opioids and other treatment provided to injured workers. May include requirements to comply with statewide restrictions, MTGs, or formulary; limits to opioids that will be reimbursed; or prior authorization or utilization review requirements.	31 states**	**Yes, but not used to establish opioid controls.** Louisiana has a pharmacy reimbursement schedule, but it does not establish limits on opioids or require that prescribing comply with the MTGs; it only establishes reimbursement amounts, billing instructions, and broad coverage parameters. By contrast, the medical reimbursement schedule specifically states that it should be used in conjunction with utilization review to check for compliance with the MTGs. In addition, Louisiana's WC law and rules require providers to submit prior authorization requests for all non-emergency treatment exceeding $750, whereas several other states require prior authorization only for treatment that varies from its MTGs or prescription formulary.

*Formulary states based on WCRI, *Interstate Variations in Dispensing of Opioids, 5th Edition*, 2019.
** States with pain or opioid MTGs and states with reimbursement rules (i.e. rules requiring prior authorization or utilization review for opioids, compliance with MTGs or formulary, or other opioid coverage limits) based on WCRI report above; WCRI, *Workers' Compensation Prescription Drug Regulations: A National Inventory*, 2018; WCRI, *State Policies on Treatment Guidelines and Utilization Management: A National Inventory*, 2019; and limited review of other states' regulations.
Source: Prepared by legislative auditor's staff based on cited WCRI reports and limited review of other states' WC regulations.

As shown above, Louisiana does not currently have a mechanism to establish controls limiting opioid prescribing for all WC claims. Although LWC-OWC plans to revise the MTGs later this year to include additional *Guideline* recommendations,[12] the legislature should first clarify in law whether the MTGs apply to prescriptions because insurers will not be able to enforce new opioid limits for WC claims in jurisdictions where the Louisiana Circuit Courts of Appeal have ruled that the MTGs do not apply to requests for prescriptions. Clarifying that the MTGs apply to prescriptions or establishing opioid limits in a prescription formulary or reimbursement rules would provide a clear mechanism for implementing and enforcing opioid controls.

In addition, R.S. 23:1142, which was implemented before the MTGs, requires providers to obtain prior authorization for all non-emergency medical treatment above $750.[13] According to WCRI,[14] WC systems that strongly support implementation of MTGs encourage adherence by only requiring prior authorization when a requested treatment is not recommended or requires prior authorization in the MTGs, is outside parameters set by the MTGs, or is not addressed by the MTGs. Several states have also adopted similar prior authorization rules supporting a prescription formulary. Limiting prior authorization requirements based on the MTGs or a formulary would encourage adherence with opioid controls established in the enforcement mechanism.

Matter for Legislative Consideration 1: The legislature may wish to evaluate what mechanism or combination of mechanisms would be most appropriate to implement statewide opioid controls for the WC program. These mechanisms could include the following:

- Revising state law (R.S. 23:1203.1) to clearly establish whether the workers' compensation medical treatment guidelines apply to prescriptions.
- Developing a workers' compensation prescription formulary that functions in support of Louisiana's medical treatment guidelines.
- Authorizing reimbursement rules that outline conditions and limits for prescribing opioids.

Summary of LWC-OWC's Response: If a drug formulary is considered, it must be compatible with the existing MTGs. Regarding the MTGs, LWC-OWC stated that LLA's suggestion to draft a rule stating that prescriptions are subject to the MTGs would be

[12] Although R.S. 23:1203.1 requires the Louisiana MTGs to be updated every two years, they have not been updated since 2011. The Colorado MTGs on which the Louisiana MTGs were based were updated in 2017 and include CDC recommendations not in Louisiana's current MTGs. In addition, Colorado has a reimbursement rule that requires prior authorization for all prescriptions that are "not recommended" in its MTGs, whereas Louisiana does not.
[13] Prior authorization is required once each provider's medical bills exceed $750, not when a claimant's medical bills total $750 overall. The Louisiana Supreme Court ruled in *Burgess v. Sewerage & Water Board of New Orleans* (2017) that "treatment" in R.S. 23:1142 includes prescriptions, affirming that the prior authorization requirement applies to prescriptions. However, the Supreme Court did not specifically address if "treatment" also includes prescriptions in 23:1203.1, which would have clarified if the MTGs apply to prescriptions.
[14] WCRI, *State Policies on Treatment Guidelines and Utilization Management: A National Inventory*, 2019.

ineffective for controlling opioid use because the Medical Director receives very few requests for approval of prescriptions. However, LWC-OWC also stated that if the Louisiana Supreme Court or legislature specified that prescriptions are subject to the MTGs, the department would need substantial resources in order to replicate the Medical Director process for review of prescriptions.

LLA Additional Comments: This matter for legislative consideration focuses on the legislature evaluating the appropriate mechanism or combination of mechanisms to implement statewide opioid controls for the WC program, not on LWC-OWC drafting a rule. In addition, differing appellate court opinions on whether the MTGs apply to prescriptions shows the need for the legislature to clearly establish whether or not they apply. Given that LWC-OWC stated they would need more resources if all prescriptions were subject to the MTGs, establishing the MTGs as a statewide mechanism of implementing opioid and other prescription controls may result in increased insurer enforcement of the MTGs for prescriptions. In addition, it is not clear why LWC-OWC would need to replicate the Medical Director process for review of prescriptions since this process is already in use in jurisdictions where prescriptions are subject to the MTGs.

Matter for Legislative Consideration 2: The legislature may wish to consider revising state law (R.S. 23:1142) to require prior authorization after $750 only for treatment, including prescriptions, that is not recommended or requires prior authorization in the MTGs or formulary, exceeds parameters in the MTGs or formulary, or is not addressed by the MTGs or formulary.

Although Louisiana adopted a law that limits all first-time opioid prescriptions to a seven-day supply as recommended by the CDC, the law does not specify how much time must pass after a patient's last opioid prescription before their next is considered a first-time opioid prescription.

According to the CDC *Guideline*, long-term opioid use often begins with treatment of short-term acute pain, and excessive initial prescriptions increase risks of serious harms and diversion. The CDC *Guideline* states that more than a seven days' supply of opioids will rarely be needed for acute pain. Effective August 2017, Louisiana state law prohibited all prescribers from prescribing more than a seven-day supply when issuing a "first-time opioid prescription" for outpatient use to an adult patient with an acute condition.[15] However, the law does not specify a timeframe for how long a patient must go without taking opioids before their next opioid prescription would be considered a first-time opioid prescription for acute pain. As a result, insurers define their own timeframes. For example, Sedgwick identifies an opioid

[15] R.S. 40:978 provides for exceptions to this limitation if, in the professional medical judgment of a medical practitioner, more than a seven-day supply of an opioid is required to treat the adult or minor patient's acute medical condition or is necessary for the treatment of chronic pain management, pain associated with a cancer diagnosis, addiction or opioid dependence, or for palliative care.

prescription as a first-time prescription if the claimant has had no opioid prescriptions in the previous six months, whereas the Louisiana Medicaid program uses a 90-day timeframe.

Specifying a shorter timeframe in law for identifying first-time opioid prescriptions such as 90 days used by Louisiana Medicaid would result in more prescriptions being limited to a seven-day supply for claimants. Using Sedgwick's six-month timeframe, we found that the percent of state WC claimants' first-time opioid prescriptions with more than a seven-day supply decreased from 57.6% (53 of 92) in the second quarter of calendar year 2017 to 14.5% (8 of 55) in the fourth quarter of calendar year 2018.[16] Based on these results, it appears that implementing this control to comply with the law significantly decreased the percent of first-time opioid prescriptions with over seven days' supply.[17] However, when we evaluated state WC claimants' opioid prescriptions based on the stricter 90-day timeframe used by Medicaid, we found that 121 (42.5%) more opioid prescriptions would have been considered first-time opioid prescriptions in calendar year 2018. Because these prescriptions were not considered first-time prescriptions based on the six-month timeframe, they were not automatically limited to seven days' supply. Based on the 90-day timeframe, 33.8% of first-time opioid prescriptions still received over seven days' supply in the fourth quarter of calendar year 2018, as shown in Exhibit 4.

Applying Six-Month and 90-Day Timeframes

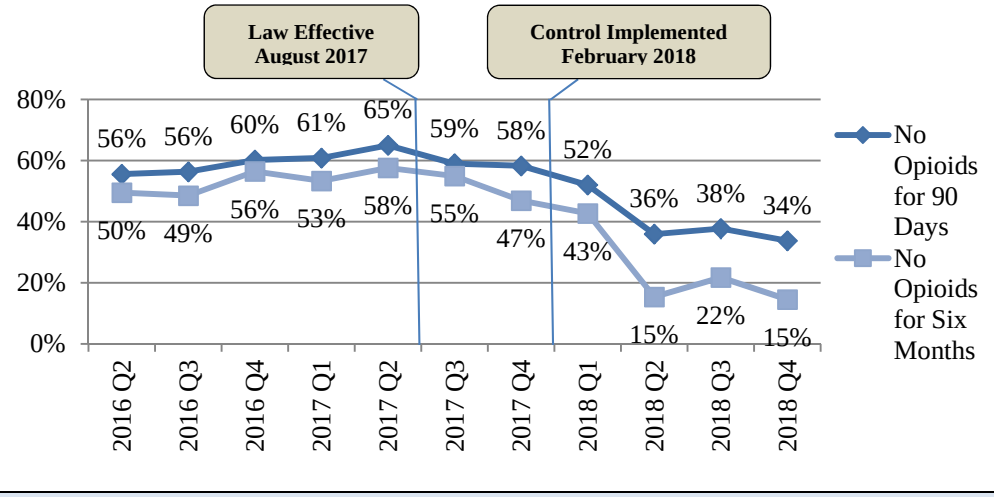
One state WC claimant with back and knee injuries received a first-time opioid prescription with seven days' supply in January 2018, and then received a second opioid prescription in June 2018. When the second prescription was dispensed, it was not considered a first-time prescription under the six-month timeframe, but would have been considered a first-time prescription based on the 90-day timeframe. After receiving the second prescription with 30 days' supply, the claimant received one opioid prescription per month through at least December 2018.

Source: Prepared by legislative auditor's staff using data provided by ORM.

[16] Non-point-of-sale prescriptions were included to identify first-time opioid prescriptions, but were excluded from results because days of supply is not a mandated billing field and is not consistently provided on paper bills created for medications which have already been dispensed. Buprenorphine and naloxone were also included to identify first-time opioid prescriptions but excluded from results, as the law allows exceptions for opioids used to treat addiction.

[17] The law allows for some exceptions, which could explain why 14.5% still received over seven days' supply.

Exhibit 4
Percent First-Time Opioid Prescriptions with Over Seven Days' Supply
April 2016 through December 2018



Source: Prepared by legislative auditor's staff using data from ORM.

Although enforcing the law using a six-month timeframe did impact the number of opioid prescriptions limited to a seven-day supply, more prescriptions would be limited using a shorter timeframe. Other states with similar statewide prescribing laws or regulations limiting the days' supply of first-time opioid prescriptions have specified the timeframes that must be used to identify them. For example, Arizona specifies a 60-day timeframe, and Vermont and Rhode Island specify a 30-day timeframe to identify first-time opioid prescriptions.

In addition, some states limit days of supply for all opioid prescriptions for acute pain rather than just first-time prescriptions. At least six states[18] apply limits on days of supply to all opioid prescriptions issued for treatment of acute pain. As a result, opioid prescriptions must continue to be issued in seven-day[19] increments until the acute pain stops or the claimant receives a chronic pain diagnosis. Extending the seven-day limit to all prescriptions for acute pain would increase the impact of the control, and the necessity of returning to the prescriber every seven days for an opioid prescription might deter claimants who no longer need opioids from obtaining more.

Matter for Legislative Consideration 3: The legislature may wish to consider specifying a timeframe for identifying first-time opioid prescriptions or expanding the seven-day limit on opioid prescriptions to all prescriptions for acute pain.

Summary of LWC-OWC's Response: Proposed revisions to the Chronic Pain MTGs address a mechanism to determine when a patient is opioid naïve (i.e., when a patient has stopped receiving opioids long enough for their next opioid prescription to be considered a first-time opioid prescription).

[18] Florida, Kentucky, Maine, Michigan, Utah, and Washington.
[19] Unlike other example states, Florida and Kentucky limit opioid prescriptions for acute pain to a three-day supply, with some exceptions.

LLA Additional Comment: The proposed revisions to the Chronic Pain MTGs only state that "opioid naïve patients or those changing doses are likely to have decreased driving ability." They do not specify a timeframe to determine when an opioid prescription should be considered a first-time opioid prescription.

During calendar years 2016 through 2018, 24.6% of state WC claimants with opioids had an average daily morphine equivalent dose (MED) that exceeded CDC recommendations. Because Louisiana does not currently have any controls in WC related to MED, implementing specific daily MED limits for opioid prescriptions similar to other states and Louisiana's Medicaid program may help reduce the increased risks of overdose, addiction, and long term use.

The CDC *Guideline* stresses that risks for serious harms related to opioid therapy increase as opioid doses increase. MED is a unit of measurement that converts various prescription opioids' strengths into one standard value based on their relative potency compared to morphine.[20] This measure allows for calculation of total daily dose across all available opioid prescriptions. Based on research of overdose risk, the *Guideline* recommends that opioid prescribers start with the lowest effective dose, carefully reassess evidence of individual benefits and risks when increasing daily dose to greater than 50 MED, and avoid or justify increasing daily dose to greater than 90 MED. WCRI reported in 2019 that Louisiana (4.0%) had the second-highest percent of opioid claims with greater than 50 daily MED for at least 60 days, compared to the median state of 1.6%. In addition, NCCI found that Louisiana's average yearly MED per opioid claim was 22.5% higher than the national average in 2017.

During calendar years 2016 through 2018, 379 (24.6%) of 1,541 state WC claimants receiving opioids had an average daily dose of greater than 50 MED and 123 (8.0%) claimants had an average daily dose of greater than 90 MED.[21] Exhibit 5 shows the five claimants with the highest total MED in calendar years 2016 through 2018. These claimants had injury dates between calendar years 1987 and 2011, and their claims were all still open as of March 2019. Although implementing MED limits may not affect existing claimants,[22] requiring prior authorization for daily MED exceeding limits established in the MTGs, a formulary, or reimbursement rules would incentivize prescribers to maintain doses below the limits for new claimants when no exceptions were required.

[20] MED is sometimes called morphine milligram equivalent (MME).
[21] This analysis excluded non-point-of-sale prescriptions, buprenorphine and naloxone (due to the irregular MED amounts of these medications for addiction treatment), and prescriptions with blank days' supply or quantity fields.
[22] The U.S. Department of Health and Human Services cautions against applying CDC dose thresholds as mandates for dose reduction when benefits of opioids outweigh risks for patients already receiving higher doses.

Exhibit 5
State WC Claimants with Top Total MED
Calendar Years 2016 through 2018

Claimant	Total Days with Opioids*	Total MED Received	Avg. Daily MED	Median Daily MED	Max Daily MED	Major Surgery in Scope	Part of Body Injured	Types of Opioids
Overall Population (1,541 Claimants)	516,295	31,365,430	61	40	3,600	35.7% Yes		
Claimant 1	1,091	578,410	530	450	1,349	Yes	Cervical Vertebrae	Oxycodone (ER & IR),** Hydromorphone (IR)
Claimant 2	1,095	514,744	470	424	2,192	No	Lumbar and/or Sacral Vertebrae	Fentanyl (ER), Hydromorphone (IR)
Claimant 3	1,074	489,165	455	400	1,280	No	Upper Back Area (Thoracic Area)	Fentanyl (ER), Hydrocodone (IR), Oxycodone (ER & IR)
Claimant 4	1,067	448,020	420	420	840	No	Lumbar and/or Sacral Vertebrae	Fentanyl (ER), Oxycodone (IR)
Claimant 5	1,083	444,915	411	405	840	No	Back (All Other)	Fentanyl (ER), Oxycodone (ER & IR)

* Days with opioids includes unique days on which claimants had opioids available if taken as prescribed, which might include more than one prescription. There were 1,096 days in calendar years 2016 through 2018.
**ER refers to extended release opioids. IR refers to instant release opioids.
Source: Prepared by legislative auditor's staff using data from ORM.

Implementing MED limits for opioid prescriptions such as those in other states and the Louisiana Medicaid program may help to limit claimants' risk of overdose, addiction, and other negative health outcomes. Louisiana does not have any statewide or WC-specific controls establishing MED limits for opioid prescriptions. As of September 2019, LWC-OWC's proposed revisions to the Chronic Pain chapter of the MTGs[23] include recommended thresholds ranging from 50 to 120 daily MED, but do not set specific limits or require prior authorization to exceed them. While clinical variation exists in patients' responses to opioid therapy at any given dose, many states and programs have adopted dosing guidelines similar to the *Guideline* recommendations. For example, the Louisiana Medicaid program implemented a policy in 2017 that recipients' opioid prescriptions cannot have a combined daily dose greater than 90 MED.[24] All prescriptions that would cause a claimant's daily dose to exceed this amount are

[23] The proposed revisions were published in the September 2019 volume of the *Louisiana Register*. https://www.doa.la.gov/osr/REG/1909/1909.pdf
[24] The Louisiana Medicaid program phased in this policy by first implementing a limit of 120 MED in July 2017, then reducing the limit to 90 MED in September 2017.

automatically denied at the point of sale, although the policy does provide for some exceptions.[25] In addition, at least 11 other states[26] have implemented daily MED limits as part of their statewide or WC laws, regulations, or guidelines that range from 40 MED to 120 MED. These limits may be recommendations not to exceed a certain dose, thresholds that cannot be exceeded without prior authorization, or hard limits allowing for few exceptions. In addition, some states establish MED limits specifically for initial prescriptions, acute pain, or post-operative pain, which reduces the risk of overdose and long-term use for claimants when starting opioid treatment. See Appendix F for the MED limits in other states and the mechanism used to implement these limits.

Matter for Legislative Consideration 4: Once a control mechanism has been implemented, as recommended in MLC 1, the legislature may wish to consider directing LWC-OWC to add controls establishing overall and time-based MED limits, including criteria for exceptions.

Summary of LWC-OWC's Response: Proposed revisions to the Chronic Pain MTGs address the appropriate MED that should be prescribed to an injured worker. LWC-OWC also stated that the MTGs do not prescribe a specific recommendation regarding daily MED because they believe this decision is best left to the injured workers' treating physician.

LLA Additional Comment: Although the proposed revisions to the Chronic Pain MTGs address ranges of appropriate MED, they do not set specific limits or require prior authorization to exceed them. If MED limits were implemented, including criteria for exceptions would enable prescribers to exceed limits when necessary.

[25] Exceptions are provided for recipients treated for cancer, palliative care, burn diagnoses, and buprenorphine prescriptions. Prescribers can also request an override if higher doses are medically necessary.
[26] Arizona, Arkansas, California, Colorado, Connecticut, Maine, New York, Ohio, Tennessee, Vermont, Washington.

Overall, 29.9% of state WC claimants with opioids had opioids for 90 or more consecutive days during calendar years 2016 through 2018. According to the CDC, receiving opioids for more than 90 days substantially increases the risk for addiction. Establishing periodic documentation requirements, tapering guidelines, and coverage requirements for tapering and addiction treatment like other states could help to prevent claimants from continuing opioid treatment without justification, minimize withdrawal symptoms, and ensure claimants receive appropriate care for addiction.

The CDC *Guideline* states that continuously taking opioids for three months or longer substantially increases the risk for addiction. In addition, WCRI found in 2018 that longer-term opioid prescriptions resulted in durations of temporary disability that were three times longer compared to receiving non-opioid pain medications for the same injury. In contrast, a small number of opioid prescriptions, over a short period of time, did not lengthen temporary disability.[27] Both WCRI and NCCI found that claims in Louisiana receive opioids for longer periods than other states. WCRI reported in 2017 that 17.9% of Louisiana claims with opioids received longer-term opioids, compared to 3.4% to 10.1% in 25 other study states.[28] NCCI also found that in calendar year 2017, 63% of Louisiana's claims with opioids had been open more than a year, compared to 47% nationwide.

The percent of state WC claimants with opioids who had opioids for 90 or more consecutive days[29] increased from 27.5% (292 of 1,061) in calendar year 2016 to 28.2% (260 of 921) in calendar year 2018.[30] We also found that during calendar years 2016 through 2018, 611 (38.5%) of the 1,586 unique claimants receiving opioids received at least one opioid prescription in all three years, accounting for 82.6% of all opioid prescriptions dispensed.[31] These three-year opioid claimants each received an average of 34.1 opioid prescriptions during calendar years 2016 through 2018, compared to an average of 4.5 opioid prescriptions for other claimants in the same time period. In addition, the claims of claimants with opioids all three years remained open much longer than those of other claimants, and a lower percentage of these workers returned to normal work duty, as shown in Exhibit 6 on the following page.

[27] WCRI, *Impact of Opioid Prescribing on Duration of Temporary Disability*, 2018. The study examined opioid prescriptions paid within 24 months of injury for claims from 28 states that had more than seven days of lost work time and injuries between 2008 and 2013.
[28] WCRI, *Longer-Term Dispensing of Opioids, 4th Edition*, 2017. The study examined prescriptions filled through March 2015 for claims from 26 states that had more than seven days of lost work time and injuries between October 2012 and September 2013.
[29] This refers to the number of unique days with opioids if taken as prescribed, not the sum of days' supply for each prescription. Claimants could have taken opioids from multiple prescriptions on the same day.
[30] This analysis calculated unique days with opioids based on the MED analysis, so it does not include non-point-of-sale prescriptions, buprenorphine and naloxone, and prescriptions with blank days' supply or quantity.
[31] This analysis includes all opioid prescriptions, as days' supply, quantity, and MED were not calculated.

Exhibit 6
Comparison of Timelines for State WC Claimants with Opioids All Three Years and Other Claimants
Calendar Years 2016 through 2018

Measure	Claimants with Opioids All Three Years	Other Claimants*
Number of Claimants	611	975
Median Days from Injury to Last Opioid Prescription**	3,304	262
% with Open Date Before 2016	95.1%	38.4%
% with Claim Still Open***	93.9%	43.4%
% on Normal Work Duty***	8.0%	50.7%

*Claimants that did not have opioids in all three years of scope
**For claimants with more than one claim with opioids, we used their earliest injury date and their latest opioid prescription date.
***As of March 2019, when the table of overall claims was provided by ORM to LLA.
Source: Prepared by legislative auditor's staff using data provided by ORM.

Implementing periodic documentation requirements in the WC reimbursement rules could help to prevent claimants from continuing opioid treatment indefinitely without justification. Louisiana's WC law requires prior authorization for all non-emergency services over $750; however, unlike other states, it does not have any statewide or WC-specific documentation requirements for prescribing opioids past a certain amount of time. Several states, including Louisiana, have requirements in their MTGs for conservative treatment[32] or opioid trials before beginning long-term opioids. However, some states have also implemented reimbursement rules to ensure that prescribers report to the insurer that these or other requirements have been met before a claimant receives opioids beyond a certain number of days. Required documents must be submitted at established intervals before opioid use can continue, and can include documentation of failed conservative treatments, risk assessment or screening, improvements in pain and function, plans for treatment and tapering, and patient-provider agreements. See Appendix G for specific examples of other states' time-based documentation requirements for opioid reimbursement.

Establishing clear guidelines for when and how to taper[33] a patient's opioid dose could help reduce the amount of time that claimants stay on opioids and help minimize claimant's withdrawal symptoms. LSBME's regulations for treating chronic pain state that indicators of substance abuse or diversion should be followed by tapering and discontinuation of controlled substance therapy. In addition, the Louisiana MTGs state that long-term opioid claimants should sign a patient-provider contract detailing reasons for tapering, and that patients should be tapered off of opioids if the claimant is not maintaining reasonable levels of activity or if they break terms in the contract. However, they do not provide other guidance on how to determine when to taper opioids or how to taper doses in a way that minimizes withdrawal symptoms.

CDC *Guideline* Criteria for Considering Opioid Tapering:

1. Benefits no longer outweigh harms (e.g., adverse side effects)
2. No clinically meaningful improvements in pain and function
3. High-risk regimens (e.g., high-dose opioids and concurrent opioids and benzodiazepines) without evidence of benefit
4. Patient requests dose reduction or discontinuation
5. Patient experiences overdose or other serious adverse events (e.g., an event leading to hospitalization or disability)
6. Warning signs of serious adverse events such as overdose or addiction (e.g., unexpected PMP or urine screening results)

[32] This can include non-opioid pain medications, such as NSAIDs (nonsteroidal anti-inflammatory drugs), or non-pharmacologic treatment, such as cognitive behavioral therapy.
[33] Tapering is a gradual reduction in a drug's dose that minimizes withdrawal symptoms.

According to the U.S. Department of Health and Human Services' 2019 *Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (*HHS *Guide)*, risks of rapid tapering or sudden discontinuation of opioids in physically dependent patients include acute withdrawal symptoms, exacerbation of pain, serious psychologic distress, thoughts of suicide, and seeking other sources of opioids, including illicit opioids. The CDC *Guideline* recommends that clinicians regularly evaluate patients to determine if opioids are meeting treatment goals and if they can be tapered to a lower dose or discontinued. However, the HHS *Guide* stresses that the CDC *Guideline* does not recommend opioid discontinuation when benefits of opioids outweigh risks, and that clinicians should consider individual patient situations.[34] California, Colorado, and Washington have sections in their WC MTGs that address opioid tapering, which include the CDC *Guideline* and other criteria for when prescribers should taper a claimant's opioid dose. The *Guideline* and these states' MTGs also include information on how to taper opioids in a way that minimizes symptoms of opioid withdrawal. Adding criteria and guidance for tapering opioids based on evidence-based practices into Louisiana's MTGs would help to ensure that new claimants will not continue receiving opioid treatment indefinitely without confirming their effectiveness, but also will be protected from overaggressive tapering or sudden discontinuation of opioids by established tapering standards. As of September 2019, LWC-OWC's proposed revisions to the MTGs include criteria and guidance for tapering.

Clarifying coverage of medication-assisted treatment (MAT) and other addiction services for claimants who meet the criteria for tapering opioids would help to ensure that claimants receive appropriate treatment while discontinuing opioids or recovering from opioid addiction. The CDC *Guideline* recommends that clinicians not dismiss claimants addicted to opioids without offering or arranging evidence-based treatment, specifically recommending MAT with buprenorphine[35] or methadone in combination with behavioral therapies. In addition, the HHS *Guide* states that if patients on high opioid doses are unable to taper, clinicians should consider transitioning to buprenorphine (used to treat opioid addiction or pain) whether or not addiction criteria are met. Louisiana's 2019 Opioid Response Plan includes initiatives to expand availability of addiction services, including MAT providers. The Louisiana MTGs do not address coverage of services for claimants with difficulty tapering opioids, such as MAT or other addiction services.[36] In addition to providing schedules for tapering, the California, Colorado, and Washington MTGs all specifically address situations in which MAT and other services can be used to treat addiction or ongoing pain. Specifically addressing such treatment in Louisiana's MTGs or reimbursement rules would help to ensure that claimants have access to necessary services while discontinuing or reducing opioids. As of September 2019,

[34] The HHS *Guide* states that while the CDC *Guideline* recommends avoiding or carefully justifying increasing doses above 90 daily MED, it does not recommend abruptly reducing opioids of patients already taking higher doses.

[35] Buprenorphine is an opioid partial agonist used in MAT to help people reduce or quit their use of opioids. Unlike methadone, it can be prescribed on an outpatient basis, and any prescriber can apply for certification to prescribe it. Buprenorphine may also be used for pain management in those with a history of addiction or at high risk for addiction who otherwise qualify for chronic opioid use. Buprenorphine is often combined with naloxone to reduce abuse and diversion potentials.

[36] The MTGs recommend interdisciplinary pain rehabilitation programs for complex cases of chronic pain and psychological issues including drug dependence, but do not specifically list addiction as criteria for receiving this service or describe the involvement of addiction specialists in this treatment.

LWC-OWC's proposed revisions to the MTGs establish coverage of addiction services including MAT, behavioral therapy, and inpatient programs.

Matter for Legislative Consideration 5: Once a control mechanism has been implemented, as recommended in MLC 1, the legislature may wish to consider directing LWC-OWC to add controls addressing requirements for periodic prescriber reporting to insurers, tapering guidelines, and coverage of addiction services.

Summary of LWC-OWC's Response: Proposed revisions to the Chronic Pain MTGs address urine screenings, improvements in pain and function, plans for treatment and tapering, and patient-provider agreements.

LLA Additional Comments: Although the proposed revisions to the Chronic Pain MTGs address some types of documentation used to assess the appropriateness of claimants' opioid treatment, neither the revised MTGs nor the reimbursement rules require that prescribers submit this documentation to insurers at set timeframes as a condition for continued reimbursement of opioids.

During calendar years 2016 through 2018, 16.4% of state WC claimants with opioids were concurrently prescribed benzodiazepines (e.g., Xanax, Valium). However, both the CDC and Federal Drug Administration recommend that clinicians avoid prescribing opioids and benzodiazepines concurrently due to increased overdose risk. Implementing controls to discourage or restrict concurrent prescribing of these drugs would help to reduce claimant risks of overdose, addiction, and other serious harms.

Benzodiazepines include medications such as Xanax and Valium and are prescribed to treat anxiety, insomnia, and seizures. The CDC *Guideline* and a 2016 Federal Drug Administration (FDA) safety bulletin[37] state that clinicians should avoid concurrently prescribing opioids and benzodiazepines whenever possible, as they both cause central nervous system depression, resulting in increased respiratory suppression and four to 10 times increased risk of overdose. Taking these drugs together can also cause extreme drowsiness, decreased psychomotor performance, and increased risk of falls and motor vehicle crashes. The CDC *Guideline* cites three studies[38] that found benzodiazepines were also involved in 31% to 61% of opioid overdose deaths. NCCI reported that in calendar year 2017, 6% of Louisiana claims with prescriptions had both opioids and benzodiazepines, compared to just 3% nationwide. WCRI

[37] https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-serious-risks-and-death-when-combining-opioid-pain-or

[38] Arch Intern Med, *Opioid Dose and Drug-Related Mortality in Patients with Nonmalignant Pain,* 2011; Pain Med, *Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality*, 2015; Am J Prev Med, *Emergency Department Visits and Overdose Deaths from Combined Use of Opioids and Benzodiazepines*, 2015.

also reported that Louisiana's rate of concurrent dispensing of opioids and benzodiazepines was higher than the median state.[39]

In calendar years 2016 through 2018, 253 (16.4%) of the 1,541 state WC claimants with opioids were concurrently prescribed benzodiazepines.[40] These claimants had an average of 235 days with concurrent opioid and benzodiazepine intake, ranging from one to 1,089 days. Due to increased overdose risk, the Colorado MTGs recommend that no more than 30 MED should be used when both are prescribed. However, during the 59,344 total days with concurrent intake of the two drugs, claimants took an average of 99 daily MED, ranging from 5 MED to 2,192 MED.

Example of Extreme Concurrent Opioid and Benzodiazepine Prescribing

One state WC claimant with back and leg injuries had a total of 1,089 days with both drugs, with an average of 17 opioid and benzodiazepine pills per day. The claimant had an average of four and a maximum of eight prescriptions available on the same day, with all but one prescription from the same prescriber. The claimant had an average of 530 daily MED, with a maximum of 1,349 MED available on the same day. Overall, the claimant received:

- 3,710 Diazepam pills
- 4,090 Hydromorphone pills
- 3,437 extended release Oxycodone pills
- 6,882 short-acting Oxycodone pills

Source: Prepared by legislative auditor's staff using data provided by ORM.

Controls that limit concurrent prescribing of opioids and benzodiazepines similar to those implemented in the Louisiana Medicaid program and other states would help to reduce the number of claimants exposed to related risks of overdose, addiction, and other serious harms. Louisiana has no statewide or WC-specific controls related to concurrent opioid and benzodiazepine prescribing. The Louisiana MTGs state that benzodiazepines are not routinely recommended due to their habit-forming potential. However, the MTGs do not address concurrent opioid and benzodiazepine prescribing, and instead state that benzodiazepines may be useful in some patients with chronic pain. As of September 2019, LWC-OWC's proposed revisions to the MTGs state that benzodiazepines should not be prescribed when opioids are used; however, the revised MTGs do not require prior authorization or set reimbursement limits for concurrent prescribing of the two drugs.

The Louisiana Medicaid program implemented a policy effective May 1, 2018, to automatically deny benzodiazepine or opioid prescriptions for recipients with an active prescription on file that would result in concurrent prescribing of the two drugs. In addition, some other states have implemented statewide or WC-specific controls related to concurrent prescribing of the two drugs. These controls can include warnings about co-prescribing these drugs, prior authorization requirements, or reimbursement limits. See Appendix H for specific examples of other states' controls for concurrent opioid and benzodiazepine prescribing and the mechanism used to implement these controls.

[39] Although Louisiana was ranked 11th of 27 study states for concurrent opioids and benzodiazepines, Louisiana ranked first in concurrent opioids and central nervous system (CNS) depressant drugs overall. In addition to benzodiazepines, CNS depressants include other sedatives and muscle relaxants that similarly increase risks of respiratory depression and death when taken with opioids. We limited our analysis to benzodiazepines but attention should also be given to concurrent prescribing of opioids and CNS depressants in general.

[40] This analysis excluded non-point-of-sale prescriptions, buprenorphine and naloxone, and opioid prescriptions with zeros in the quantity or days of supply.

Matter for Legislative Consideration 6: Once a control mechanism has been implemented, as recommended in MLC 1, the legislature may wish to consider directing LWC-OWC to add controls addressing concurrent prescribing of opioids and benzodiazepines, such as prior authorization requirements or reimbursement limits.

Summary of LWC-OWC's Response: Proposed revisions to the Chronic Pain MTGs specifically prohibit the prescribing of opioids and benzodiazepines concurrently.

LLA Additional Comments: Although the proposed revisions to the Chronic Pain MTGs state in one section that benzodiazepines "should not be prescribed when opioids are used," they state in a different section that benzodiazepines "should be avoided or limited to very low doses" when opioids are used. In addition, the proposed revisions do not require prior authorization or set reimbursement limits for concurrent prescribing of the two drugs.

During calendar years 2016 through 2018, 5.2% of state WC claimants with opioids received opioids from three or more prescribers in the same quarter. According to the CDC, this trend could be associated with doctor shopping and increased overdose risk. Implementing additional controls used in other states such as claimant lock-in programs could help to prevent doctor shopping and reduce claimants' risk of overdose.

The CDC *Guideline* states that along with patients receiving high total daily opioid doses, most fatal overdoses are associated with patients receiving opioids from multiple prescribers. In addition, claimants receiving prescriptions from multiple prescribers could be doctor shopping,[41] which is a potential indicator of addiction. State Law[42] establishes injured workers' right to select one treating physician. The injured worker must obtain the payor's prior consent to change to another treating physician in the same field; however, no approval is needed to be treated by a physician in another field or specialty. Unlike some other states, Louisiana's WC law does not authorize LWC-OWC or insurers to limit workers' choices to certain providers or exclude problematic providers from receiving reimbursement for treating injured workers.

[41] Doctor shopping refers to the practice of a patient requesting controlled substances from multiple prescribers without the prescribers' knowledge of the other prescriptions.
[42] Louisiana R.S. 23:1121

In calendar years 2016 through 2018, 80 (5.2%) of 1,539 state WC claimants received opioids from three or more prescribers in the same quarter.[43] As shown in Exhibit 7, we found up to five different prescribers wrote opioid prescriptions for the same claimant in the same quarter in calendar years 2016 through 2018. Claimants also had prescriptions dispensed by up to five different pharmacies in the same quarter in this period. Receiving opioids from multiple prescribers at the same time increases the chance that claimants will receive high-risk combinations of opioids due to a lack of coordination between the prescribers. For example, we identified one state WC claimant with chronic pain who had up to four different opioid prescribers in the same quarter. In one quarter, this claimant had buprenorphine prescriptions[44] from a pain management prescriber in one city and a prescriber at a hospital's acute care center in another city that overlapped with hydrocodone prescriptions from a surgeon and the surgeon's physician's assistant in a third city. The claimant was ultimately discharged from treatment by the pain management prescriber due to confusion between prescribers on what had been prescribed and later received inpatient treatment for opioid addiction.

Exhibit 7
Max Number of Prescribers Visited in One Quarter Per State WC Claimant
Calendar Years 2016 through 2018

Number Prescribers Visited	Number Claimants	Percent of Claimants	Average Prescriptions per Claimant
5	2	0.1%	11
4	11	0.7%	31
3	67	4.4%	32
2	451	29.3%	26
1	1,008	65.5%	10
Total	1,539	100.0%	16

Source: Prepared by legislative auditor's staff using data provided by ORM.

Using claimant lock-in programs to require claimants to obtain all prescriptions from one prescriber could help to prevent doctor shopping and enforce established opioid limits. Louisiana law requires all prescribers to access the Prescription Monitoring Program (PMP) initially and every three months thereafter when prescribing controlled substances to check what other medications patients have received. Louisiana's MTGs state that claimants receiving long-term opioid treatment must receive all opioid prescriptions through one prescriber and that prescribers should consider claimants' use of multiple prescribers as a risk factor before prescribing controlled substances. However, the MTGs do not apply to prescriptions for all WC claims statewide due to conflicting appeals court decisions.

The Medicaid program, in Louisiana and elsewhere, identifies recipients with behaviors of doctor shopping or other signs of overutilization for enrollment in a Lock-In program. Sometimes referred to as "coordinated service programs" (CSP), such programs require patients meeting certain high-risk criteria to obtain all prescriptions from one prescriber and/or one pharmacy. In 2012, Ohio implemented a law to establish a similar CSP for WC claimants. Ohio

Ohio Criteria for Claimant Lock-In

Must meet one or more of the following criteria within a three-month timeframe:
- Three or more prescribers for the same or comparable medications
- Three or more pharmacies
- Three or more monthly opioid prescriptions
- Three or more concurrent opioid prescriptions
- Three or more types of opioids, two or more benzodiazepines, and two or more sedative-hypnotics

[43] This analysis excluded non-point-of-sale prescriptions.
[44] Buprenorphine is a partial opioid agonist used for treatment of opioid addiction, but can also be used to treat pain for patients with history or high risk of addiction.

found that members who participated in a CSP generally experienced better outcomes, including 27% fewer prescriptions for opioids and controlled substances, a decrease in opioid consumption by 293 milligrams, a 13% reduction in emergency department visits, and $172.89 reductions in average monthly member costs. Implementing a similar program for Louisiana WC claimants could help to identify claimants to screen for addiction, reduce the risk of dangerous drug combinations, and produce better outcomes for claimants.

Matter for Legislative Consideration 7: The legislature may wish to consider authorizing the creation of a claimant lock-in program with criteria similar to that used in the Medicaid program.

Summary of LWC-OWC's Response: Proposed revisions to the Chronic Pain MTGs address urine screenings, improvements in pain and function, plans for treatment and tapering, patient-provider agreements, and periodic review of the PMP to ensure that no doctor shopping is occurring.

APPENDIX A: MANAGEMENT'S RESPONSE

LOUISIANA WORKFORCE COMMISSION
The Department of Labor

November 25, 2019

Mr. Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

In Re: Evaluation of Controls Over the Prescribing of Opioids in Louisiana's Workers' Compensation Program
November 2019

Dear Mr. Purpera:

Thank you for the opportunity to speak with your auditors regarding the Evaluation of Controls Over Prescribing Opioids in Louisiana's Workers' Compensation system. Thank you for making the edits to your initial report as was discussed in our latest meeting. The agency response to the edited version of your report begins below.

Shortly, the information contained in your audit will become obsolete. The Louisiana Workforce Commission filed a Notice of Intent to publish an evidence-based update to its Chronic Pain Guideline. Many of the controls you find lacking over the prescribing of opioids in the Louisiana workers' compensation system are addressed in the Chronic Pain Guideline, which was published in the September 2019 edition of the Louisiana Register. Furthermore, the proposed evidence-based guideline does implement "controls for prescribing opioids in the Louisiana workers' compensation system and other best practices, such as limiting duration and dose of prescriptions and preventing injured workers from going to multiple doctors." This Guideline provides parameters for prescribing opioids for chronic and acute injuries in keeping with the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. For example, the guideline does not prescribe a specific recommendation regarding the morphine equivalent dose (MED) that should be prescribed daily, for we believe this decision is best left to the prerogative of the injured workers' treating physician as are many of the other patient focused decisions to be made on an individual basis.

The report concludes that national organizations like the Workers' Compensation Research institute (WCRI) and the National Council on Compensation Insurance (NCCI) find that injured workers in Louisiana are prescribed opioids more often and for longer periods than injured workers in other states. However, neither the WCRI report nor the NCCI report take into consideration the types of hazardous occupations in Louisiana when compared to the hazardous occupations in other states. Neither does this report take into consideration that while the frequency of claims in Louisiana is declining, the severity of claims is increasing. Increased severity of claims requires a greater degree of medication to control chronic pain than would otherwise be necessary without a severe injury.

In a medical data report, opioid utilization supplement for the state of Louisiana issued by NCCI in September 2019, the data indicates that the distribution of prescription drug payments in Louisiana by the Controlled Substances Act (CSA) is substantially the same as the distribution of prescription drug payments by the CSA schedule in the region and countrywide. For example, the distribution of medical payments in Louisiana for Schedule II drugs was 16%, when compared to the payment of all drugs. Region wide, 15% of medical payments are for Schedule II drugs and country wide the distribution is 17%. The data used in both the WCRI and the NCCI reports mentioned in this audit lag 2 years behind the most recent data mentioned in the medical data report referenced above. While the numbers reflected in the audit are

concerning, they are not current and neither do they show that Louisiana's numbers regarding opioids in the workers' compensation system are declining or that Louisiana's numbers compare favorably to other states in the country and in the region.

The synopsis of WCRI's Interstate Variations of Opioids, 5th Edition, is that fewer injured workers are receiving opioids, and more are receiving non-opioid medications and non-pharmacologic treatments, like physical therapy. While opioid prescribing is still prevalent in workers' compensation cases, the report further indicates that fewer injured workers received opioid prescriptions paid under workers' compensation and prescriptions in general that were paid under workers' compensation.

My response to the specific conclusions in your report follow, to-wit:

1. **Louisiana does not currently use mechanisms, such as a drug formulary or reimbursement rules, to implement controls for prescribing opioids within the WC program. Although Louisiana developed medical treatment guidelines in calendar year 2011, these guidelines are not enforceable statewide due to conflicting court decisions**.

   A drug formulary was discussed with your auditors at our meeting on August 23, 2019. At that time, they were advised that a drug formulary was only one tool, among others, that could be used to address the opioid issue. However, choosing the wrong product for the right reasons is not an option. The Louisiana medical treatment guidelines contain its utilization review rules. These guidelines were modeled after the Colorado guidelines. Therefore, any drug formulary must be compatible with the existing guidelines or otherwise more harm than good will result from implementation. Additionally, the proposed Chronic Pain Guideline specifically address workers' compensation specific opioid controls.

   As mentioned during our discussion of the audit, the medical treatment guidelines are absolutely enforceable throughout the state. There is a difference of opinion, however, among the appellate courts regarding whether prescriptions are subject to the medical treatment guidelines. In those jurisdictions where the appellate court found that prescriptions were subject to the guidelines, the parties are at liberty to pursue the 1009 and 1010 process for approval or denial of a recommended prescription. In those jurisdictions where the appellate court found that prescriptions are not subject to the guidelines, a party may seek approval of a prescription through the usual 1008 process. (Mediation would be required. Summary process would not be unavailable) Your auditors suggested that the administration draft a rule stating that prescriptions are subject to the medical treatment guidelines to cure the conflict among the appellate courts. Such a rule, to have legal effect, would need to be promulgated pursuant to the Administrative Procedures Act. At this time, the administration does not see the need for such a rule, inasmuch as, the Medical Director receives very few requests for approval of prescriptions. Therefore, such a rule would be virtually ineffective for the purpose of controlling the use of opioids in the workers' compensation system.

2. **Although Louisiana adopted a law that limits all first time opioid prescriptions to a seven-day supply as recommended by the CDC, the law does not specify how much time must pass after a patient's last opioid prescription before their next is considered a first-time opioid prescription**.

   The proposed Chronic Pain Guideline addresses the issue of opioid prescribing and a mechanism to determine when a patient is opioid naïve so that additional opioids may be considered.

3. **During calendar years 2016 through 2018, 24.6% of state WC claimants with opioids had an average daily morphine equivalent dose (MED) that exceeded CDC recommendations**.

The proposed Chronic Pain Guideline addresses the appropriate MED that should be prescribed to an injured worker.

4. **Overall, 29.9% of state WC claimants with opioids had opioids for 90 or more consecutive days during calendar years 2016 through 2018. According to the CDC, receiving opioids for more than 90 days substantially increases the risk for addiction**.

To reiterate, some consideration must be given to the fact that while the frequency of claims has decreased in Louisiana, the severity of claims has increased. More severe injuries that occur in industries that other states do not have, like mining, require additional medication to control chronic pain. Again, the proposed Chronic Pain Guideline addresses urine screenings, improvements in pain and function, plans for treatment and tapering, patient-provider agreements and periodic review of the PMP (physician monitoring program) to ensure that no doctor-shopping is occurring.

Washington, Colorado and California, states that have "whole sections in the WC MTGs that address opioid tapering are medical and recreational marijuana states. Louisiana workers' compensation was specifically excluded for the recent medical marijuana provisions.

Medication Assisted Treatment (MAT) was just approved in Louisiana during the 2019 regular legislative session and is part of the state's Opioid Response Plan. While MAT has been available in our state on a physician-by-physician basis, only in 2019 did the Louisiana legislature approve the use of MAT clinics for purposes, as many other states have had for years. MAT is not just the prescribing of a drug to taper the use of opioids in a patient with a substance use disorder. MAT is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient" approach to the treatment of substance use disorders.

5. **During calendar years 2016 through 2018, 16.4% of state WC claimants with opioids were concurrently prescribed benzodiazepines. However, both the CDD and Federal Drug Administration recommend that clinicians avoid prescribing opioids and benzodiazepines concurrently due to increased overdose risk. Implementing controls to discourage or restrict concurrent prescribing of these drugs would help reduce claimant risks of overdose, addiction, and other serious harms.**

The proposed Chronic Pain Guideline specifically prohibits the prescribing of opioids and benzodiazepines, concurrently.

6. **During calendar years 2016 through 2018, 5.2% of state WC claimants with opioids received opioids from three or more prescribers in the same from more than one prescribers in the same quarter. According to the CDC, this trend could be associated with doctor shopping and increased overdose risk.**

See response to #4 above.

Generally, the proposed evidence-based Chronic Pain Guideline provides that all prescribing will be done in accordance with the laws of the state of Louisiana as they pertain respectively to each individual licensee, including, but not limited to the Louisiana State Board of Medical Examiners' regulations governing medications used in the treatment of non-cancer-related chronic or intractable pain; Louisiana Board of Pharmacy Prescription Monitoring Program; Louisiana Department of Health and Hospitals licensing and

certification standards for pain management clinics; other laws and regulations affecting the prescribing and dispensing of medications in the state of Louisiana. Additionally, the proposed Guideline repeatedly references the CDC Guideline regarding the use of opioids and are incorporated therein as if copied in extension.

While we agree that opioids are a problem in Louisiana, injured workers are not the face of the opioid epidemic. The problem did not occur overnight and it will not be conquered with one tool or even two, but rather with a combination of approaches that the state has taken beginning with 2019 legislation and ending with the proposed evidence –based Chronic Pain Guideline. Again, a pharmacy formulary is being considered. Yet, the numbers for prescriptions per claim, the numbers of opioid related deaths and the number of opioid overuse disorder hospital admissions continues to decline. This indicates that Louisiana is on the right road to tackling the issues identified in your audit.

Furthermore, the administration is on the brink of entering into a contract with a vendor to overhaul the medical fee reimbursement schedule, which is currently more than twenty-five years old. The medical fee reimbursement schedule will further control which drugs a carrier pays for pursuant to appropriate utilization review rules. Should it become clear, either through jurisprudence or legislation that prescriptions are subject to the medical treatment guidelines, a substantial fiscal note would be necessary. In such event, the agency would be required to implement a 1010/1009 process for the approval and denial of prescriptions. Perhaps, the agency would consider a contract with a PBM like Optum, which currently contracts with the ORM, to process workers compensation prescriptions at the point of sale and to provide other pharmacy-related claims management services. In such case, a staff for this purpose would mirror the current 1010/1009 staff which consists of a Medical Director, two registered nurses, one registered nurse candidate and two administrative coordinators. If required, replicating this process for the utilization review of prescriptions could cost the agency an additional $1,000,000.00 in personnel resources.

With kindest personal regards, I am

Sincerely,

Sheral C. Kellar, Assistant Secretary
Office of Workers' Compensation Administration
Louisiana Workforce Commission

SCK/cu

cc Ava Dejoie
Chris Magee
Lauren Pendas
Karen Leblanc
Bennett Soulier
file

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our audit of controls over opioid prescribing in the Louisiana Workers' Compensation program. We conducted this audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit covered calendar years 2016 through 2018. Our audit objective was:

To evaluate controls over the prescribing of opioids in the Workers' Compensation program, including how Louisiana could strengthen these controls to reduce the risks associated with opioid use.

The scope of our audit was less than that required by *Government Auditing Standards*. We believe the evidence obtained provides a reasonable basis for our findings and conclusions. To answer our objective, we performed the following steps:

- Researched and reviewed Louisiana Revised Statutes, Administrative Code, Executive Budget documents, and Office of Risk Management (ORM) and the Office of Workers' Compensation within the Louisiana Workforce Commission (LWC-OWC) policy documents and annual reports.

- Met with the ORM, Sedgwick, Optum, the Office of Public Health, and LWC-OWC and attended a meeting of the Workers' Compensation Advisory Council and a public hearing on the proposed updates to the Chronic Pain chapter of the medical treatment guidelines to obtain stakeholder input on existing and potential opioid controls in Louisiana's workers' compensation (WC) system.

- Researched various WC and general studies regarding the prescribing of opioids across various states, including Louisiana. This included research from the following organizations:

    - The Centers for Disease Control and Prevention (CDC) is one of the major operating components of the U.S. Department of Health and Human Services. Its mission is to work 24/7 to protect America from health, safety and security threats, both foreign and in the U.S. To accomplish its mission, the CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise.

    - The National Council on Compensation Insurance (NCCI) is an insurance rating and data collection bureau specializing in WC. In the 41 states where NCCI is the advisory organization, WC insurance carriers must report paid medical transactions if they write at least 1% of the market share. For Louisiana in calendar year 2017, NCCI's 2018 *Medical Data*

Report: Opioid Utilization Supplement for the State of Louisiana included claims data for 84% of the WC premium written. This report analyzed all data for prescriptions provided in calendar year 2017, so it shows overall trends for all claims with prescriptions in that time period, regardless of injury date or severity.

- The Workers' Compensation Research Institute (WCRI) is an independent, not-for-profit research organization that provides data analysis and information through studies that conform to recognized scientific methods, including peer review procedures. The cited WCRI reports focus on claims with injury dates in certain periods where workers were out of work more than seven days but did not have surgery. This methodology excludes claims that were closed quickly that would not be expected to have opioids as well as claims with greater severity that would be expected to have more opioids. In addition, it excludes legacy claims and shows how new claims developed within a certain time period.

- Researched and reviewed best practices for opioid prescribing as well as legal and policy information on opioid controls implemented in other states and the Louisiana Medicaid program.

- Obtained claims and payments data from ORM's system, billing review data from Sedgwick's system, and prescription data from Optum's point-of-sale system to analyze WC claims, specifically the prevalence of opioids. In addition, obtained access to Sedgwick's claims management system in order to access claims documentation for case studies.

  - Analyzed all unique opioid prescriptions for injured Louisiana state employees by using Sedgwick and Optum data. Also analyzed additional claims information through joins with the ORM claims and payments tables. The Sedgwick and Optum data include all prescriptions billed after being provided to the claimant; however, not all of those prescriptions were paid. We included all opioid prescriptions in the data, regardless of if they were paid since they were prescribed and filled. In addition, our analysis focused on prescriptions received by unique claimants, who may have received opioid prescriptions on more than one claim.

  - Most prescriptions are submitted through Optum's point of sale system, but some are billed directly to Sedgwick. Optum's data does not contain information for those prescriptions. In calendar years 2016 through 2018, 797 (3.2%) of the total 25,259 opioid prescriptions were billed directly to Sedgwick. Non-point-of-sale prescriptions were excluded from the analyses where information needed was not available due to a variance in billing requirements for already dispensed medications.

- Sent report to ORM and LWC-OWC for their review and gave them the opportunity to formally respond to the report. ORM chose not to respond.

APPENDIX C: ENTITIES OVERSEEING OPIOID DISPENSING STATEWIDE AND IN THE LOUISIANA WORKERS' COMPENSATION SYSTEM

Entity	Agency	Description
Louisiana Board of Medical Examiners	Louisiana Department of Health	Responsible for licensing all who engage in the practice of medicine and taking appropriate actions when it identifies violations, including those of statewide laws and regulations related to prescribing opioid medications and continuing education requirements for controlled substance prescribers. Also, establishes rules for medications used in the treatment of non-cancer-related chronic or intractable pain in LAC Title 46 § 6915 through 6923.
Louisiana Board of Pharmacy	Louisiana Department of Health	Responsible for licensing all pharmacies and those who operate them, as well as enforcing laws established in the Pharmacy Practice Act and the Prescription Monitoring Program Act.
Office of Workers' Compensation (OWC)	Louisiana Workforce Commission	Responsible for making and enforcing regulations for the state's WC program according to state WC law, including Medical Treatment Guidelines that establish the standard of reasonable and necessary treatment, services, and care due to injured workers from employers. Also administers the dispute resolution processes for the WC program.
Office of Risk Management (ORM)	Louisiana Division of Administration	Responsible for managing insurance policies for claims filed against the state, including WC insurance for state employees.
Sedgwick	Private Business	ORM's contracted third-party administrator beginning August 1, 2015, to perform claims administration services, including enforcement of opioid controls.*
Optum	Private Business	Sedgwick's contracted pharmacy benefits manager to process WC prescriptions at the point of sale and to provide additional pharmacy-related claims management services.

*ORM first contracted out its claims administration activities to F.A. Richard and Associates in 2010.
Source: Prepared by legislative auditor's staff using information from Louisiana law and ORM.

APPENDIX D: CDC GUIDELINE RECOMMENDATIONS*

Determining When to Initiate or Continue Opioids for Chronic Pain
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation
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 often be sufficient; 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.
Assessing Risk and Addressing Harms of Opioid Use
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk 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 drug monitoring program (PDMP) 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 PDMP 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.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Assessing Risk and Addressing Harms of Opioid Use (Cont.)
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*These recommendations are for treatment of chronic pain outside of active cancer, palliative, and end-of-life care.
Source: Prepared by legislative auditor's staff based on recommendations in CDC *Guideline*.

APPENDIX E: COMPARISON OF CHANGES IN WCRI OPIOID METRICS FOR LOUISIANA AND MEDIAN OF 27 STUDY STATES OCTOBER 2012 THROUGH SEPTEMBER 2018

Metrics of Opioid Use	2012/2014*			2016/2018**			LA Change 2012/2014 to 2016/2018	Median Change 2012/2014 to 2016/2018
	LA	Median State	Difference from Median State	LA	Median State	Difference from Median State		
% of Claims with Prescription with Opioid Prescription	79%	67%	**12 ppt*** **	69%	52%	**17 ppt**	-10%	-13%
% of Claims with Prescription with Two or More Opioid Prescriptions	55%	38%	**17 ppt**	48%	26%	**22 ppt**	-7%	-12%
Average Total MED Per Claim with Opioids	3652	1641	**123%**	3287	999	**229%**	-10%	-36%

***Includes prescriptions filled through March 2014 for nonsurgical claims with more than seven days of lost work time and injuries occurring October 2011 through September 2012.

**Includes prescriptions filled through March 2018 for nonsurgical claims with more than seven days of lost time and injuries occurring October 2015 through September 2016.

***Percentage point difference

Source: Prepared by legislative auditor's staff using information from WCRI, *Interstate Variations in Dispensing of Opioids, 5th Edition*, 2019.

APPENDIX F: EXAMPLES OF OTHER STATES' DAILY MED LIMITS

State	Level of Implementation	Description of Daily MED Limit	Exceptions
MED Limits for All Opioid Prescriptions			
AZ	Statewide Law and Statewide Opioid Guidelines	Prescriber may not issue a new outpatient prescription that exceeds 90 MED. Reassess treatment regimen if prescribing doses over 50 MED to treat chronic pain.	Continuation of prior prescription within the previous 60 days, opioid prescriptions with maximum approved total daily dose in FDA labeling, prescriptions after surgery with maximum 14-day supply, prescriptions issued where pain specialist agreed with the prescribed dose through consultation, cancer, palliative care, traumatic injuries, burns, addiction treatment, or inpatient treatment.
AR	WC Formulary	Shall not exceed 50 MED without prior authorization and shall not exceed 90 MED.	
CA	WC Opioid MTGs	50 MED is the maximum daily oral dose recommended. In rare cases with documented functional improvement above 50 MED, up to 90 MED may be considered. If over 50 MED, greater monitoring including at least semi-annual attempts to wean (taper) below 50 MED is recommended.	
CO	WC Chronic Pain Disorder MTGs	Should remain at 50 MED or below; provider should consider lowering (tapering) the dosage above that amount. Appropriate to taper or refer to specialist for over 90 MED.	
CT	WC Opioid MTGs	Should not be increased or maintained above 90 MED. Second opinion from pain specialist recommended if considering over 90 MED.	May receive over 90 MED if the patient demonstrates measured improvement in function, pain and/or work capacity.
ME	Statewide Law	Prescribers may not issue combination of prescriptions with over 100 MED. Patients with active prescriptions over 100 MED may receive up to 300 daily MED until one year after implementation of control, when 100 MED limit will apply to all patients.	Treatment for cancer, palliative care, hospice care, substance abuse disorder, inpatient administration, or other circumstances determined by Department of Health and Human Services.
NY	WC Non-Acute Pain MTGs	Total of all oral prescriptions should not exceed 100 MED. If dose reaches this amount without pain relief, reduction or discontinuation is warranted. Persistent doses more than 100 MED may be subject to a secondary review by an external consult in pain management or addiction medicine.	If the opioid treatment is benefitting the patient as demonstrated by objective measures of function and pain, then it may be appropriate to continue the high dose while maintaining appropriate rigorous patient monitoring.

OH	WC Reimbursement Rules	For over 80 MED, no reimbursement without documentation prior to dose escalation of tried and failed alternative treatments, treatment plan, risk assessment, and meaningful improvement in function. For over 120 MED, no reimbursement without documentation prior to dose escalation of tried and failed alternative treatments, treatment plan, risk-benefit assessment, pain specialist consultation, appropriate additional consultations if warranted, and injured worker's informed consent and receipt of written educational materials.		WC administrator may grant exemptions if the injured worker's injuries or treatment history is such that strict application of this rule would offer no improvement in the injured worker's overall health, safety, or quality of life, or continuing care of the injured worker will require a prolonged course of surgeries or multiple surgical interventions.
TN	Statewide Law	In cases where non-opioid treatments do not work and the risk of adverse effects from pain exceeds the risk of development of substance abuse disorder or overdose event, prescribers may not issue a prescription for more than a thirty-day supply with a total dosage of 1,200 MED (average of 40 daily MED). The prescriber must include the phrase "medical necessity" on the prescriptions issued pursuant to this law.		Cancer, palliative care, hospice care, sickle cell disease, severe burns, major physical trauma, inpatient administration, prescriptions issued by pain management specialists or pain management clinic, preexisting patients, addiction treatment, or treatment with an opioid antagonist that does not contain an opioid agonist.
VT	Statewide Rules	Prior to prescribing a patient 90 MED or more, prescriber must document reevaluation of pain management plan, patient's adherence to treatment regimen, potential for use of non-opioid alternative treatments, functional examination, worker's informed consent, comorbid conditions, and any other risk factors.		Cancer, patients in nursing homes.
WA	WC Reimbursement Rules	Reimbursement for above 120 MED not provided without specialist consultation prior to dose escalation.		Exceptions in the Department of Health's pain management rules.
Time-Based MED Limits				
AR	WC Formulary	Initial Prescription	Shall not exceed 50 MED per day without prior authorization.	
CA	WC MTGs	Acute Pain	Maximum recommended oral dose is 50 MED for acute pain patients not already taking opioids. Should use lower doses for patients at higher risk of dependency, addiction, or other adverse effects.	In rare cases with documented functional improvement, higher doses may be considered; however, greater monitoring is recommended.
CA	WC MTGs	Post-Operative Pain	Maximum recommended dose is 50 MED for acute pain patients not already taking opioids.	High doses beyond 50 MED may be needed for major surgeries in the first two post-operative weeks to achieve sufficient pain relief; however, greater caution and monitoring are warranted and reductions below 50 MED at earliest opportunity should be sought.

NV	Statewide Law	Initial Prescription	Maximum of 90 MED if not issued an opioid in more than 19 days before initial prescription for acute pain.	If a practitioner prescribes or dispenses over 90 MED, the practitioner must document in the medical record of the patient the reasons for prescribing that quantity.
OH	Statewide Regulations	Acute Pain	Maximum of 30 MED for treatment of acute pain. Prescriptions that exceed the 30 MED average are subject to additional review by the state medical board. Dosage, days supplied, and condition for which the opioid analgesic is prescribed will be considered as part of this additional review.	Severe surgical outcomes or injuries such as traumatic crushing of tissue, amputation, major orthopedic surgery, severe burns; physician determines that exceeding 30 MED is necessary based on clinical judgment; hospice care; palliative care; terminal condition; cancer; addiction treatment; inpatient treatment.
RI	Statewide Regulations	Initial Prescription	Maximum 30 MED for a maximum of 20 doses for acute pain for an individual who has not received opioids in the last 30 days.	Chronic pain management, cancer, palliative or nursing home care.
VT	Statewide Regulations	Initial Prescription	For moderate acute pain, maximum of 120 MED for 5 days (average 24 daily MED per day). For severe acute pain, maximum of 160 MED for 5 days (average 32 daily MED). For extreme acute pain, maximum of 350 MED for 7 days (average 50 daily MED). Averages allow for tapering from higher doses at beginning to lower doses at end of prescription.	Trauma, complex surgical interventions, prolonged inpatient care, substance use disorders, or other circumstances determined by Commissioner of Health.

Source: Prepared by legislative auditor's staff based on limited review of other states' laws and regulations.

APPENDIX G: EXAMPLES OF TIME-BASED DOCUMENTATION REQUIREMENTS FOR CONTINUING OPIOIDS IN OTHER STATES' WC REIMBURSEMENT RULES

State	Required Prescriber Reporting to Payor Before Reimbursement
AR	**For opioids beyond initial 5-day prescription:** (1) Follow-up visit (2) Medication taken so far has proven effective in controlling pain associated with the employee's work-related injury or illness (3) Continuing the opioid medication therapy is medically necessary **For opioids beyond 90 days:** (1) Follow-up visits (2) Improved function under the medication (3) Plan for periodic drug screening (4) Detailed plan for future weaning off opioid medication (5) Conservative care rendered to worker that focuses on increased function and return to work (6) Statement on prior or alternative conservative measures that were ineffective or contraindicated
MI	**For opioids beyond 90 days after initial fill and every 90 days thereafter:** (1) Review of medical history and PMP (2) Summary of conservative care rendered that focused on increased function and return to work (3) Statement on why prior alternative conservative measures were ineffective or contraindicated (4) Statement that prescriber has considered results from industry-accepted screening tools to detect factors that may increase risk of abuse or adverse outcomes (5) Treatment plan including goals, functional progress, periodic urine drug screens, effort to reduce pain through non-opioid treatment, and consideration of weaning from opioids (6) Opioid treatment agreement signed by worker and prescriber that is reviewed, updated, and renewed every six months
OH	**For opioids beyond six weeks after date of injury or surgery:** (1) Individualized treatment plan that is justified with clinical rationale (2) Risk assessment through use of clinically validated tool for screening and assessment and drug testing methodology (3) Worker's clinically meaningful improvement in pain and function **For opioids beyond 12 weeks after date of injury or surgery:** (1) Requirements listed for six weeks (2) Reasonable alternatives to opioids have been tried and failed (3) Risk-benefit assessment to determine whether to continue opioids or initiate weaning (4) Evidence that injured worker signed informed consent and was provided written educational materials (5) Appropriate additional consultations when applicable

State	Required Prescriber Reporting to Payor Before Reimbursement
WA	**For opioids between six and 12 weeks after injury or surgery:** (1) Clinically meaningful improvement in function and pain with opioids in first six weeks (2) If indicated, use of validated instrument to screen worker for comorbid psychiatric conditions, current substance use disorder, or history of opioid use disorder (3) Worker has no contraindication to use of opioids (4) Review of PMP information and baseline urine drug test (5) Use of a validated screening instrument to verify the absence of a substance use disorder (excluding nicotine) or a history of opioid use disorder (6) Worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use **For opioids beyond 12 weeks after injury or surgery:** (1) Clinically meaningful improvement in function has been established with opioids, which should result in improved work capacity or ability to progress in vocational retaining (2) Reasonable alternatives to opioids have been tried and have failed (3) Signed pain treatment agreement (4) Worker has no contraindication to use of opioids; is not at high risk for serious adverse outcomes; and has no pattern of recurrent aberrant behavior identified by PMP, urine drug testing, or other source (5) Time-limited treatment plan that demonstrates how ongoing opioid therapy is likely to improve work capacity or ability to progress in vocational retraining **Every 90 days (or more frequently based on worker's risk) thereafter:** (1) Clinically meaningful improvement in function or pain interference with function score of less than or equal to four on the two item graded chronic pain scale is maintained with stable dosing. If dose increased, clinically meaningful improvement in function must be demonstrated in response to dose change. (2) Current signed pain treatment agreement (3) Worker has no contraindication to use of opioids; is not at high risk for serious adverse outcomes; and has no pattern of recurrent aberrant behavior identified by PMP, urine drug testing, or other source (4) Worker receives chronic opioid therapy through single prescriber; if prescriber unavailable, then refills are addressed by covering provider and allowed on a limited basis only.

Source: Prepared by legislative auditor's staff based on limited review of other states' laws and regulations.

APPENDIX H: EXAMPLES OF OTHER STATES' CONTROLS OVER CONCURRENT OPIOIDS AND BENZODIAZEPINES

State	Level of Control	Control
AZ	Statewide Opioid Guidelines	Avoid concurrent use of opioids and benzodiazepines (BZD). If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications. Abrupt discontinuation is not recommended, as it could cause serious adverse events. It is important to coordinate a patient's care with other providers and check the PMP to determine if patients are receiving dangerous drug combinations. For high complexity patients, consider consultation with specialists.
CA	WC Opioids MTGs, WC Formulary	Considerable caution is warranted when prescribing opioids with BZD. All BZD are "Non-Exempt" on the formulary, meaning they require prior authorization.
CO	WC Chronic Pain MTGs	BZD should not be prescribed with opioids. Maximum of 30 daily MED should be used when BZD are prescribed. All BZD are "Not Recommended" by MTGs for treatment of chronic pain, meaning they require prior authorization.
NY	WC Non-Acute Pain MTGs	BZD are not generally recommended. They should be used with extreme caution when the patient is on chronic opioids. When used, extensive patient education should be documented.
OH	Statewide Chronic, Non-Terminal Pain Guidelines, WC Formulary	Providers should avoid prescribing BZD with opioids. Reimbursement for BZD restricted to maximum daily dose listed for each drug on formulary and prior authorization required past 30 days of use, excluding clobazam for seizures.
TX	WC Formulary	All BZD drugs are "N" on the formulary, meaning they require prior authorization.
WA	WC Opioid MTGs, WC Outpatient Formulary, WC Rule	Any combination of opioids with BZD not recommended. Pain specialist consultation strongly recommended in cases where both are prescribed. All BZD on the WC formulary require prior authorization or denial. Reimbursement for BZD limited to hospitalized patients, patients with psychiatric disorders, or other outpatients for not more than 30 days for the life of the claim.

Source: Prepared by legislative auditor's staff based on limited review of other states' laws and regulations.