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The Workers Compensation Research Institute (WCRI) is a not for profit public policy research organization located in Cambridge MA. WCRI was established in 1983 and has member support of all stakeholders in the workers compensation (WC) systems – insurers, employers, state agencies, worker advocates, and health care providers. Our research includes multistate benchmark reports to compare metrics within WC claims across states using methods to create a meaningful basis, and reports on important topical issues. A copy of our annual report is located here: https://www.wcrinet.org/images/uploads/files/2018_WCRI_Annual_Report.pdf.

Several WCRI studies provide information about rates of opioid prescriptions. These include Interstate Variations in Use of Opioids and Longer-Term Dispensing of Opioids. In these reports we also discuss the policy environment in states with significant reductions in opioids, to provide information for stakeholders in other states about policy tools available to reduce unnecessary opioid utilization.

The latest editions reported large decreases in opioids dispensed to injured workers in many states. Comparing opioid utilization for workers injured in 2010 and 2013 over an average two-year period following the injury, we found 20 percent or higher reductions in the average amount of opioids dispensed to injured workers in 15 of the 26 states in the study, with reductions exceeding 30 percent in Kentucky, Maryland, Michigan, and New York. Other studies outside workers' compensation also noted a reversal in trends of opioid prescribing over this period, after a consistent and rapid increase starting in the 1990s. This turning point may be associated with the numerous changes made at the federal, state, and organization levels in recent years to combat opioid overuse and abuse.

Kentucky and New York, for instance, adopted comprehensive reforms over the study period. Kentucky's House Bill (HB) 1, which went into effect in July 2012, regulated pain clinics and established standards for the dispensing and prescribing of opioids, including mandating prescription drug monitoring program (PDMP) use (Impact of Kentucky Opioid Reforms). New York adopted opioid reforms at the state level[1] as well as reforms specific to workers' compensation.[2] Examples include mandatory PDMP use, up-scheduling of products containing hydrocodone, and the adoption of medical treatment guidelines.

Looking beyond these two states, there have been legislative and regulatory changes implemented by workers compensation programs which may have an impact on opioid prescriptions.

[1] In New York, the Internet System for Tracking Over-Prescribing (I-STOP) legislation was passed to mandate that physicians check the PDMP database prior to prescribing opioids starting in August 2013. New York also rescheduled hydrocodone-containing products to Schedule II in February 2013, which led to a decrease in the hydrocodone-acetaminophen prescribing rate, as discussed later in Chapter 5.

[2] In 2010, the New York State Workers' Compensation Board adopted guidelines that include recommendations for opioid use for treating injuries by body part, which contain quantity limits. The Board also adopted non-acute pain medical treatment guidelines effective December 2014.

The following are among the policies implemented by workers compensation jurisdictions around the country addressing opioid prescribing and dispensing, and the more prominent state policies outside workers compensation.

(1) Chronic and acute/sub-acute pain treatment guidelines:

Several workers' compensation jurisdictions, including CA, CO, CT, LA, MA, MN, NY, OK, and WA adopted treatment guidelines for chronic pain. CA and WA have guidelines for acute and subacute opioid use.

Source: Interstate Variations in Use of Opioids, 4th Edition.

Washington State and Colorado were the first states that had guidelines for chronic opioid management. Several studies examined the impact of Washington's opioid dosing guideline and found a decrease in opioid use after the implementation of the opioid dosing guideline. For example, Garg et al. (2013) reported a 53 percent decrease in chronic opioid users between the first quarter of 2004 and the fourth quarter of 2010, after the implementation of the state opioid dosing guidelines on safe prescribing for chronic non-cancer pain. [3]

Some of the recently updated guidelines in California, Connecticut, and Washington include recommendations about prescribing opioids for acute and sub-acute pain. In general, they recommend a limited use of opioids for severe acute pain or use of opioids when non-opioid therapy is ineffective. For example, Washington guidelines recommend the lowest necessary dose of immediate release opioids for the shortest duration (less than two weeks) for acute pain.[4]

(2) State-mandated workers' compensation drug formularies:

12 states implemented or passed legislation to implement a drug formulary or preferred drug lists.

(3) Limits on physician dispensing of opioids:

8 states have quantity limits on physician dispensing of opioids. Florida and Kentucky, for instance, enacted legislation limiting physician dispensing of certain opioids. Other states, like Pennsylvania and North Carolina, limit workers' compensation reimbursement of opioids to a certain number of days of supply.

Source: A Multistate Perspective on Physician Dispensing, 2011-2014, Technical Appendix A.

(4) Limits on opioid first fills:

Day supply limits on initial fills were implemented in 21 states as of the end of last year, starting with Massachusetts in March 2016. Source: https://ballotpedia.org/Opioid_prescription_limits_and_policies_by_state (as of November 2017).

(5) Prescription Drug Monitoring Programs (PDMP):

PDMPs are tools to address prescription drug diversion and abuse. All states have PDMPs but they

[3] Garg, R., D. Fulton-Kehoe, J. Turner, A. Bauer, T. Wickizer, M. Sullivan, and G. Franklin. 2013. Changes in opioid prescribing for Washington workers' compensation claimants after implementation of an opioid dosing guideline for chronic noncancer pain: 2004 to 2010. *Journal of Pain* 14 (12): 1,620–1,628. https://www.jpain.org/article/S1526-5900(13)01180-2/pdf.

[4] See Part II. Prescribing Opioids in the Acute and Subacute Phase of the Washington Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain.

have varying features. All but 11 states mandate prescribers to query the PDMPs before prescribing certain controlled substances at least for the first time. In states like Kentucky and New York which were early adopters of PDMP prescriber mandates, we saw a large decrease in opioids dispensed to injured workers.

Source: http://www.pdmpassist.org/pdf/Mandatory_Query_20180319.pdf (as of March 2018)

Studies have reported evidence of the positive impact of PDMPs in reducing opioid prescriptions as well as opioid overdose deaths. For example, Bao et al. (2016) used National Ambulatory Medical Care survey data from 2001 to 2010 across 24 states that implemented a PDMP during the study period.[5] They found an immediate decrease in the rate of prescribing of opioids, especially Schedule II opioids, by 30 percent. Patrick et al. (2016) found that PDMPs resulted in 1.12 fewer opioid overdose deaths per 100,000 people on average in the year following the implementation of the PDMP, using data from 1999 to 2013 across 35 states that adopted a PDMP during the study period.[6] Greater reductions were seen in states monitoring more schedules of drugs and updating the PDMP at least weekly, compared with states that did not have these characteristics.

(6) Mandating continuous medical education (CME) on appropriate opioid prescribing and chronic pain management:

Several states like KY, MA, NJ, TX, and UT adopted legislation or regulations to mandate CME. In several other states, medical boards require CME in these areas.

Source: Interstate Variations in Use of Opioids, 4th Edition.

As of July 2014, five states (Kentucky, Massachusetts, New Jersey, Texas, and Utah) adopted legislation or regulations mandating continuing education about pain management for licensees.[7] More states required continuing medical education on opioid prescribing and chronic pain management as part of the criteria for license renewal. According to the Federation of State Medical Boards' board-to-board review, a number of states adopted CME requirements for opioid prescribing and/or chronic opioid management, including California, Florida, Kentucky, Maryland, Massachusetts, New Hampshire, New Mexico, Oklahoma, South Carolina, and Vermont.

We observe these policy tools as the beginning of state policy changes to address opioid use. As a result of the substantial changes in opioid utilization over the study period, the extent of interstate variations narrowed across most study states. But, we still see unusually higher amounts of opioids prescribed to injured workers in some states in the latest study year. Among workers whose injuries did not result in a major surgical intervention but led to the worker staying out of work for at least 7 days, 2 out of 3 workers with a pain medication received at least one opioid prescription. And there was 4-fold variation in the average amount of opioids filled by injured workers across the 26 states. Louisiana and Pennsylvania continued to have a higher average amount of opioids per claim compared with the other study states. With

[5] Bao, Y., Y. Pan, A. Taylor, S. Radakrishnan, F. Luo, H. Pincus, and B. Schackman. 2016. Prescription drug monitoring programs are associated with sustained reductions in opioid prescribing by physicians. *Health Affairs* 35 (6): 1,045–1,051. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5336205/pdf/nihms852208.pdf.

[6] Patrick, S., C. Fry, T. Jones, and M. Buntin. 2016. Implementation of prescription drug monitoring programs associated with reductions in opioid-related death rates. *Health Affairs*. Published online before print June 2016, DOI:10.1377/hlthaff.2015.1496. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5155336/pdf/nihms834608.pdf.

[7] See the Pain & Policy Study Group (PPSG) report entitled *Achieving Balance in State Pain Policy: A Progress Report Card (CY 2013)*. The report is available at http://www.acscan.org/content/wp-content/uploads/2014/07/PRC-2013.pdf.

a substantial decrease in the frequency and amount of opioids per claim, New York was not one of the highest states on opioid use (as it previously was), but it was still higher than the median of the 26 states.

Large differences were seen in the frequency of claims receiving opioids on a chronic basis and at higher doses, 4-fold variation across states – 7 to 29 percent of claims with opioids received at least 60 days of opioids supply over any 90-day period (our measure of chronic opioid use) across the study states. The proportion was higher in Louisiana (29 percent) and also higher than the median state in Kentucky, Massachusetts, Michigan, New York, North Carolina, South Carolina, and Texas (15–19 percent).

A sizable proportion of Louisiana and New York claims received high-dose opioids for at least 60 days. Among injured workers receiving opioids in these two states, 5–6 percent had a morphine equivalent daily dose (MED) exceeding 50 milligrams for at least 60 days during the study period. In New York, 2.3 percent of injured workers had an MED exceeding 90 milligrams for at least 60 days.

Injured workers with opioids concurrently received other central nervous system depressant drugs. For example, at least 1 in 15 injured workers with opioids in three states (Massachusetts, Louisiana, and Wisconsin) filled a benzodiazepine prescription within one week of the opioid fill. The rate was even higher among claims receiving opioid prescriptions on a chronic basis. By contrast, the rate was less than 1 percent in Texas, where preauthorization has been required prior to prescribing benzodiazepines since the implementation of the Texas formulary.

We observed that opioids and centrally acting muscle relaxants were frequently filled concurrently across study states. In seven states with frequent physician dispensing, concomitant dispensing of the two classes of drugs was more prevalent among injured workers receiving opioid prescriptions from both physicians' offices and pharmacies. For example, in California, 59 percent of claims that received opioid prescriptions from both physicians' offices and pharmacies had concomitant use of muscle relaxants. The measure was 39 and 32 percent among workers who only had physician-dispensed opioids and pharmacy-dispensed opioids, respectively.