WORKERS COMPENSATION AND OPIOID USE: HELPING HAND OR CONTRIBUTING TO THE CRISIS

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Connecticut's Workers Compensation Act is Intended to Benefit Injured Workers

"Workers' Compensation should be broadly construed to accomplish its humanitarian purpose." Cummings v. Twin Mfg., Inc. 29 Conn. App 249, 256 (1992); see also, Dubois v. General Dynamics Corporation/Electric Boat Div. 222 Conn. 62, 67 (1992)

Conn. Gen. Stat. Sec. 31-294d.(a)(1) The employer… shall provide a prescription drugs, as the physician or surgeon deems reasonable or necessary.

"Reasonable or necessary is that which seeks to repair the damage to health caused by the job even if not enough health is restored to enable the employee to return to work.... [or] **any therapy designed to eliminate pain** .... Bowen v. Stanadyne, 2 Conn. Workers' Comp. Rev. Op. 60, 232 CRD-1-83 (6-19-84) (emphasis added)

WC PHARMA IS BIG BUSINESS IN CT

I: WHO BENEFITS?

1. DRUG DISPENSORY / PHARMACUETICAL INDUSTRY

According to the National Council on Compensation Insurance (NCCI) (2016) using 2014 statistics:

A: Controlled RX prices increased 16% while utilization decreased 7%.

B: NCCI estimates that for every $100 paid for medical services, $17 is for RX.

C: Chronic Injuries whose effects last more than 10 years, RX average $45 to $50 for every $100 of Medical Service.

D: 7% of prescriptions in a service year are for narcotic drugs accounting for 24% of all Drug costs.

E: Thirteen of the top 25 workers' compensation medications were opioids. **Express Scripts (4-4-17).**

F: In 2016, opioids remained the most expensive therapy class at $391.35 per user per year (PUPY).

To Paraphrase the Rolling Stones

"Don't you know the price of drugs are going, up, up, up!"

Narcotic Medicine	2013 Cost	2014 Cost	2017 Estimate?
Percocet (Brand)	$7.15	$9.18	$12.25
OXYCODONE ACETAM. (Gen)	$1.19	$1.61	$2.11
OXYCODONE HCL Gen	$0.63	$1.01	$1.36
MORPHINE SULFATE	$2.35	$2.94	$3.96
OXYCONTIN (Brand)	$6.73	$7.27	$9.76.

2. CARRIERS:

Premiums are Calculated

Payroll/$100 x Rate X Experience Modification Rating = Premium paid so, more workers/ more injuries = higher premiums

A: Constant Pool of Claims Means More Business 32K new Customers

(Source: Bureau of Labor Statistics 2014)

Connecticut Labor Force: (2014 Statistics)

Labor Force:	1,898,752
Employed:	1,776,115
Unemployment:	122,637
2014 Non-Fatal Injuries:	58,924
Recordable time Loss	32,100/year (or 1.7% of Labor Force OOW on WC)

B. **Connecticut is higher than the National Averages**

Higher Rates CT is Second in Nation ($2.87/ $100/ wages earned)

$ 879,363.45 for Opioid in new Claims alone

(Based on Express Scripts statistics)

3. INJURED WORKER

1: Tremendous Pain Relief

2: 100% paid by carrier/ employer

3: Gain Mobility and Function

II. PROBLEMS FROM OPIOIDS:

1. **EMPLOYER/CARRIER PROBLEMS:**
   - A: Lost Productivity
   - B: Loss of Work Force
   - C: Detoxification Programs
   - D: Loss of Ability to Control Costs
2. **PHYSICAN PROBLEMS:**
   - A: Loss of Ability to Control Treatment Options
   - B: Malpractice Liability
   - C: Physician Dispensing Drugs
   - D: Licensing Issues (Several CT Doctors/ Nurse Practitioners have been suspended from Dispersing Medicines

3. **EMPLOYEE PROBLEMS:**

   - A: Addiction
   - B: Overdose
   - C: Financial Devastation
   - D: Additional Medical Complications:
   - F: Teeth Loss
   - G: Weight Issues
   - H: Mental/ Depression
   - I: Invasion of Privacy: Urine Test/ DNA squabs
   - J: Loss of Control of Medical Care
   - K: Costly Litigation

4. **WORKERS COMPENSATION COMMISSION PROBLEMS:**

   - A. Increase Litigation on authorization of Prescriptions
     - a. Too Expensive to Fight for Medication
     - b. Too Expensive to Stop Medication
   - B. Commissioner Dilemma as Adjudicator:
     - -Increase Pain vs. Increase Costs
   - C. No Control over Decisions from Managed Care Plans

CONNECTICUT WORKERS COMPENSATION RESPONSE

I What is the Legal Standard that Justifies entitlement to Opioids?

Conn. Gen. Stat. Sec. 31-294d. Medical and surgical aid. Hospital, ambulatory surgical center and nursing service. (a)(1) The employer… shall provide a prescription drugs, as the physician or surgeon deems reasonable or necessary. The employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the

employer or insurer shall be responsible for paying the cost of such prescription drugs directly to the provider.

Case Law:

Question: What Can Commissioners Do?

Answer: Whatever They Want.

A: Commissioners can order or deny new treatment Options

Petrini v. Marcus Dairy, Inc. 6021 CRB-7-15-7 (5-12-16), appeal pending in Appellate Court AC 39256 (2016)

Commissioner decision affirmed where she found use of **medical marijuana** (MM) for pain management constitutes reasonable and necessary medical treatment.

Donaldson v. Continuum of Care, Inc. 4581 CRB-3-02-10 (10-6-04), aff'd, 94 Conn. App. 334, cert. denied, 267 Conn. 904 (2006)

The trial commissioner's determination that **Ketamine injections** was not reasonable and necessary when treatment not approved by FDA or administered by authorized doctor.

B: Commissioners can Order Claimant to be Enrolled in Detoxification and Mandate Physician Compliance

Nails v. Freddie's U.S. Mail, Inc. 5982 CRB-7-15-1 (12-8-15)

The trial commissioner is the ultimate judge of medical recommendations and can mandate the claimant enroll in a detoxification program as a condition of receiving weekly benefits. The trial commissioner can mandate treating doctor to produce a written Opioid Agreement to the Commission or be withdraw as an approved treating physician.

Micale v. State of Connecticut Dept. of Emergency Serv. 5910 CRB-6-14-2(1-8-15)

Commissioner found death was compensable where Claimant was treating for a compensable injury died from a Fentanyl overdose and Fentanyl was a natural sequalae of the compensable injury.

C: Commissioners Can Award or Deny Benefits w/ Opioids

Brey v. State of Connecticut/Department of Correction 5833 CRB-2-13-4 (4-2-14)

Commissioner decision to deny total disability benefits even though claimant hired by the U.S. Postal Service was prevented from taking the position because of a positive drug test for opiates.

Marandino v. Prometheus Pharmacy 4986 CRB-1-05-8 (9-29-06), rev'd in part, 105 Conn. App. 669 (2008), cert. granted, 286 Conn. 916 (2008), aff'd in part; rev'd in part, 294 Conn. 564 (2010)

Trial Commissioner can consider increased use in pain medication to further justify a continuation of total disability benefits.

Strona v. Textron Lycoming Division 4398 CRB-4-01-5 (8-6-02)

Commissioner did not abuse discretion in awarding prescription and award penalties for failure to administer this claim reasonably

Agosto v. City of Bridgeport 3967 CRB-04-99-01 (4-12-00)

The Commissioner can consider the claimant is on narcotic pain medication when determine that the claimant continued to be temporarily totally disabled.

D: Commissioners Can Award or Deny Medical Based on Opioids

Brassard v. The Erectors, LLC 5790 CRB-2-12-10(10-18-13)

Commissioner have the power to reject Claimant's testimony as to the need of high levels of narcotic medication which had been "prescribed largely based upon his subjective complaints and the lack of any other effective modality when the complaints of extreme pain are disproportionate to any objective findings relative to his spine,

Chimblo v. Connecticut Light & Power 5574 CRB-7-10-7 (7-21-11)

Trial Commissioner can condition surgery that the claimant must first undergo the successful completion of a detoxification program and the successful completion of a weight loss program.

Cotugno v. Lexington Caterers, Inc. 4390 CRB-2-01-5 (6-21-02)

Commissioner had discretion to deny pain medication **BUT** the Commissioner is duty bound to explore what options are available as to a detoxification procedure and medication reduction regimen before she could safely stop using those drugs.

III. WHERE ARE WE NOW WITH OPIOIDS IN THE WORKERS COMPENSATION ARENA?

According to the Workers Compensation Research Institute WCRI the use of Opioid in CT WC has been decreasing....

BUT DO WE KNOW WHY?

Not Because Injured Workers Are Getting Better

1: Approved Managed Care Plan allow Employees More Control

Sec. 31-279. Employer-sponsored plan for medical care and treatment.

(c)(1) Any employer or any insurer acting on behalf of an employer, may establish a plan, subject to the approval of the chairman of the Workers' Compensation Commission under subsection (d) of this section, for the provision of medical care that the employer provides for treatment of any injury or illness under this chapter.

--employee's choice of physician is restricted to Doctors that are part of the plan.

--Utilization review allows employer to determine the medically necessity and appropriateness of treatment for an injury independent of the WCC (See **Byrd v. Bechtel/ Fusco 90 Conn. App. 641 (2005).**

--Nurse Case Manager is to coordinate services aimed at ensuring quality medical care. --Drug Utilization Review formulary management, and brand-to-generic conversions with comprehensive narcotics management, physician-dispensing discouragement.

2. Other Medical Options

A: Abuse-Deterrent Opioids

Xtampza
(Coated with Wax prevents it from being injected)

Probuphine
(Ssubdermal implant provides non-fluctuating blood levels for 6 months)

Troxyca
(Slow release opioid if crushed loses all euphoric effect)

B: Medical Marijuana

3: Removing the Bad Apple Keeps the Doctor Away

Sec. 31-280-1. List of approved physicians, surgeons, podiatrists, optometrists and dentists; standards for approval and removal from the list

(b)The chairman of the Workers' Compensation Commission may, after notice and an opportunity to be heard, remove a practitioner from the list of approved physicians, surgeons, podiatrists, optometrists or dentists if such practitioner fails to meet one or more of the standards in subsection (a) of this section.

(See **Wang v. Frankl** No. CV 960391493. (10-18-99) (WCC Chairman is empowered to order a hearing to show cause on removing a physician right to provide medical treatment)

4: Workers Compensation Commission Medical Protocols for Opioid (rev. 3-27-17) (See Attached)

5: Cost Shifting Behind the Scenes

Compensation carriers deny every case to preserve their right to challenge a future claim so Costs get shifted to Other Payors:

---Group Insurance/ Union Health Plans
--Medicare
--Medicaid
--State Exchanges

OBSERVATIONS:

--Let the Claimant and the doctor decide what Prescription is reasonable
--The Opioid Crisis should not be placed on the Injured Backs of Injured Workers
--Allow alternative treatment options: Medical Marijuana/ Ketamine

One alternative that works is that when an injured employee is faced with competing medical opinions about the best way to treat his work-related injury, each of them medically reasonable, it is for the employee, not the employer or the administrative law judge (ALJ), to decide what is best for the employee.

Amos v. Director, Office of Workers' Compensation Programs ,153 F.3d 1051 (1998)

MEDICAL PROTOCOLS: OPIOIDS – PAGE 1 of 5

OPIOID MANAGEMENT OF THE INJURED PATIENT

OVERVIEW

Proper opioid management is essential for the safe and efficient care of injured patients. The WCC recognizes that some injured patients may require opioids for the management of their acute and chronic pain. It is not the intention of the WCC to restrict the proper medical use of this class of medications, however responsible prescribing is mandatory. Additionally, studies have shown that injured workers placed on high dose opioids early in the post-injury period may experience a slower recovery, more difficulty with returning to work, more difficulty with weaning, and more frequently end up on long term opioids.

During the first two weeks post injury, low dose, short acting opioids may be appropriate for those with more severe injuries. Even during the acute phase it is preferred that the injured worker avoid opioid medications when possible. During the remaining portion of the acute and subacute period, attempts should be made to wean and discontinue opioid medications as appropriate (i.e., as symptoms improve) and as soon as possible. Dose escalation during these periods should be avoided, as the injury should be stabilized and healing. Medications that are deemed to be inappropriate for the vast majority of injured patients include immediate release, ultra-short acting sublingual and nasal opioid preparations. Long acting opioids are not recommended in the acute and sub-acute phases of treatment. In addition, following major surgical interventions, as acute postoperative pain resolves attempts should be made to wean medications as soon as possible, again avoiding dose escalation beyond the acute post-operative period.

Opioids are not meant to completely eliminate pain, but to ease symptoms and improve function (i.e., improvement of work capacity, ADLs, sleep and sexual function). Any continuation of medications beyond the first two week period must include proper documentation of improvement in pain level (VAS or other screening tool) and improvement in function or work capacity. At each visit history should be obtained to ensure medications are providing the desired pain reducing effect and looking specifically for side effects such as over sedation, cognitive impairment, or inappropriate medication usage. Any patient maintained beyond a four week period on chronic medications should have appropriate compliance monitoring documented. This should occur through history, screening questionnaires, prescription monitoring programs queries, urine drug tests (up to 2x / yr. for a stable, low risk patient and more frequently as indicated for high risk patients), and/or pill counts, as deemed appropriate by the physician. Patients continuing on opioids longer than 4 weeks should be managed under a narcotic agreement as recommended by the Federation of State Medical Boards. Medical necessity should be documented as to the need for all opioid prescriptions in terms of measured improvement in pain, function or work capacity.

If an injured patient requires opioid maintenance longer than 12 weeks, evaluation / consultation and treatment by a physician with appropriate specialty training in pain management should be considered. Documentation of medical necessity, including gains in pain, function or work capacity, is mandatory for prescribing beyond what is described within these guidelines.

The total daily dose of opioids should not be increased or maintained above 90mg oral MED (Morphine Equivalent Dose), unless the patient demonstrates measured improvement in function, pain and/or work capacity. A second opinion from an expert in pain management is recommended, if contemplating raising/maintaining the dose above 90 MED.

Before prescribing opioids for chronic pain, potential comorbidities should be evaluated. These include opioid addiction, drug or alcohol problems and depression. A baseline urine test for drugs of abuse and assessment of function and pain should be performed prior to institution of opioids for chronic pain.

GUIDELINES FOR PRESCRIBING

Connecticut law limits initial prescriptions to a 7-day supply for adults; exceptions are allowed for patients with chronic pain or acute pain that will last beyond 7 days with appropriate chart documentation.

Associated risks of addiction and overdose must be explained to the patient before prescribing controlled substances for the first time.

State law requires the PDMP be checked prior to the first prescription.

Single prescriber

Single pharmacy

Opioid agreement

Caution should be used with:

- combination therapy
- barbiturates
- sedative-hypnotics
- muscle relaxants
- benzodiazepines

Routine assessment of pain and function, if there is no improvement

Weaning of opioid

General:

- Whenever a prescribing practitioner prescribes controlled substances for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent who is also a licensed health care professional, shall review, not less than once every ninety (90) days, the patient's records in the Connecticut Prescription Monitoring and Reporting System (CPMRS) at *www.ctpmp.com*

Post-Op:

- Prior to any surgery that will require more than a 72-hour supply of any controlled substance (Schedule II-V), the prescribing practitioner or such practitioner's authorized agent who is also a licensed health care professional shall review the patient's records in the Connecticut Prescription Monitoring and Reporting System (CPMRS) at *www.ctpmp.com*

REASONS TO DISCONTINUE OPIOIDS OR REFER FOR ADDICTION MANAGEMENT

No measured improvement in function and / or pain,

or

Opioid therapy produces significant adverse effects,

or

Patient exhibits drug-seeking behaviors or diversions such as:

- selling prescription drugs
- forging prescriptions
- stealing or borrowing drugs
- frequently losing prescriptions
- aggressive demand for opioids
- injecting oral / topical opioids
- unsanctioned use of opioids
- unsanctioned dose escalation
- concurrent use of illicit drugs
- failing a drug screen
- getting opioids from multiple prescribers
- recurring emergency department visits for chronic pain management

If there is no measured improvement in pain, function, ADLs or work capacity after three (3) months of opioid medication, the prescribing physician must justify the continued use of opioids and should consider weaning of the opioid.

Opioids may allow the patient to return to work safely and more expeditiously and therefore may be indicated; nevertheless, attempts to wean these medications and avoidance of dose escalation should be the goal of treatment.

This document is meant as a guideline for the practitioner and should not supplant proper medical judgment.

SAMPLE OPIOID EQUIVALENCY TABLE

OPIOID	MED
Codeine	0.15
Fentanyl Transdermal	2.4
Hydrocodone	1
Hydromorphone	4
Methadone up to 20mg	4
Methadone 21-40mg	8
Methadone 41-60mg	10
Methadone >60mg	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

OPIOID DRUG MONITORING

INTRODUCTION

Use of chronic controlled substances in chronic pain management is acceptable in appropriate clinical situations. However, there are a number of risks associated with these medications, which have been well documented and include addiction, overdose, and death. Careful monitoring is required to maximize safety when prescribing opioid medications.

In addition to other risks, opioid medications can also interact with many medications, including:

- other prescribed controlled substances (i.e., benzodiazepines)
- anti-depressants
- medical marijuana
- other common medications

Prescribing providers must ensure the safe use of this form of potentially risky medical treatment, including its interaction with other prescribed medications.

Chronic opioid management requires careful, ongoing monitoring to ensure that each patient complies with directions given for the proper use of all prescribed medications. Such monitoring provides objective information that can help identify the presence or absence of drugs or drug classes in the body, assisting clinicians in making appropriate treatment decisions for patients requiring chronic controlled substances as part of their medical care.

In addition, each patient must be screened to assess his or her risk status (see "PATIENT RISK ASSESSMENT" on page 5 of these Opioid Protocols), by means of:

- a full medical and personal history
- administration of a risk assessment interview or questionnaire
- review of any documented evidence that may exist of any type of aberrant behavior known to indicate a potentially increased risk to the patient, if chronic opioid management is utilized as part of that patient's treatment plan

NOTE: the Commission's previously-published opioid guidelines encourage clinicians to avoid high-dose long-term prescribing, given the lack of medical evidence supporting such practice.

ROUTINE DRUG TESTING

Routine testing of patients:

- is "best practice" when providing pain management and opiate therapy – such testing can help to identify:
  - drugs of adherence
  - drugs of abuse
- may detect the presence of prescribed medication, helping to:
  - verify patient compliance
  - reinforce therapeutic compliance
  - provide documentation demonstrating compliance
- may detect the absence of prescribed medication, indicating possible:
  - non-compliance
  - abuse
  - misuse
  - diversion
- may detect the use of substances that could result in:
  - adverse events
  - drug-drug interactions
- may detect the use of undisclosed substances:
  - alcohol
  - unsanctioned prescription medications
  - illicit substances

FREQUENCY OF TESTING

It is neither medically indicated, nor appropriate, to test every single patient at every single visit.

To ensure patient compliance, the Connecticut workers' compensation system considers it medically appropriate to randomly perform Point-of-Care (POC) urine drug testing (UDT) for patients receiving chronic opioid treatment:

- 2x / year (minimum)
- up to 4x / year (maximum)
- more frequently (if medical indications dictate)

Additional testing – above and beyond 4x / year – will only be covered for specific, documented medical indications, including:

- following up on abnormal urine drug test results (to confirm patient compliance)
- an aberrant PMP report
- a patient at high risk for abuse
- a patient with a known history of substance abuse (based on an "outside" report of potential abuse, i.e., from the carrier, another physician, a family member, or other source)

Medical indications requiring more frequent testing must be documented in the patient's medical records.

DRUG TESTS – DEFINED

Point-of-Care (POC) Drug Testing

- qualitative testing which provides immediate results
- used when medically necessary by clinicians for immediate patient management
- available when the patient and physician are in the same location
- testing is performed by office staff
- read by the human eye
- immunoassay (IA) test method that primarily identifies drug classes and a few specific drugs
- platform consists of cups, dipsticks, cassettes, or strips
- limited accuracy, requiring confirmatory testing for unexpected or unexplained results

Qualitative Drug Testing

- when medically necessary, determines presence or absence of drugs or drug classes in urine sample
- results expressed as negative, positive, or as a numerical result
- includes competitive immunoassays (IA) and thin layer chromatography
- performed by licensed laboratorian (MT / MLT- ASCP)

Definitive / Quantitative / Confirmation

- used when medically necessary to identify specific medications, illicit substances, and metabolites
- reports the results of drugs absent or present in concentrations of ng / ml
- limited to GC-MS and LC-MS / MS testing methods only
- performed by licensed laboratorian (MT / MLT- ASCP)

Specimen Validity Testing

- ensures urine specimen is consistent with normal human urine and has not been adulterated or substituted
- may include pH, specific gravity, oxidants, temperature, and creatinine

Immunoassay (IA)

- qualitative / semi-quantitative testing
- ordered by clinicians primarily to identify presence or absence of drug classes and some specific drugs
- biochemical test to measure the presence of a substance (drug) – above a cutoff level – using an antibody
- read by photometric technology
- chemistry analyzers with IA UDT technology are used in office and clinical laboratory settings
- may be used when less immediate test results are required
- at no time is IA technology by chemistry analyzer analysis considered confirmatory testing
- performed by licensed laboratorian (MT / MLT- ASCP)

POINT-OF-CARE (POC) DRUG TESTING

POINT-OF-CARE (POC) DRUG TESTING

Point-of-Care (POC) or "in-office" (enzyme immunoassay) drug testing is that which is done in the office using any number of types of immunoassay testing.

POC testing should be the primary route of routine urine drug screening, and is encouraged, because:

- it has the advantage of providing the clinician with immediate feedback
- it assists the clinician in making appropriate clinical decisions at the same time that a prescription is provided

Basic POC dip stick / cup / card / cartridge testing is expressly allowed under these protocols.

Initial testing should be with basic immunoassay drug panels (usually 10-12 drugs).

Confirmatory testing should only be performed as described in "CONFIRMATORY DRUG TESTING" on page 4 of these Opioid Protocols.

TESTING FACILITIES – LABS

Physician Office Labs (POLs) must meet all of the same standards as those that third-party labs must meet.

Some offices, however, are not equipped to perform routine POC urine drug testing.

Offices not equipped to perform such testing themselves may send their patients to outside testing labs, which can typically be found at:

- outpatient facilities
- hospitals

URINE DRUG TESTING (UDT)

Urine Drug Testing (UDT) is an important component of proper medical monitoring for patients on chronic controlled substances, along with:

- review of data in Connecticut's Prescription Drug Monitoring Program (CT PDMP)
- pill counts
- narcotic / opioid agreements

UDT provides objective information that can help identify the presence or absence of drugs or drug classes in the body, assisting clinicians in making appropriate treatment decisions for patients requiring chronic controlled substances as part of their medical care.

Baseline UDT (typically POC testing) should be performed – and documented in the medical record:

- when the clinician decides that medications are to be prescribed to a workers' compensation patient with chronic pain, on a long-term basis, for the management of that patient's pain symptoms

  or

- when a patient enters into a new practice with a change of providers

Thereafter, UDT should be used for monitoring patients according to the guidelines listed in "FREQUENCY OF TESTING" on page 2 of these Opioid Protocols:

- periodically and randomly

  or

- non-randomly, when indicated for other medical reasons

Urine drug tests that are abnormal may be sent for confirmation (Quantitative analysis) to an outside laboratory, for either:

- not showing the appropriate medications that the patient is supposed to be taking

  or

- showing medications that the patient is not supposed to be taking

UDT – BILLING AND PAYMENT

The reimbursement for this service is set within the Official Connecticut Practitioner Fee Schedule.

No pass-through / indirect billing will be allowed for UDT confirmation or quantitative testing.

Each physician's office location that performs point-of-care drug screen testing is required to have the necessary CLIA certification.

In-office immunoassay testing is only considered to be a qualitative test (by all standards) and is not considered to be a quantitative test.

DRUG TESTING OF HIGHER-RISK PATIENTS

PATIENT RISK ASSESSMENT

Before including controlled substances in patients' pain management treatment plans, clinicians should assess them for potential risks to which they may be susceptible.

Patient risk assessment is performed by:

- taking the patient's full medical and personal history, including:
  - a full accounting of any previously-prescribed medications
  - a history of substance abuse
  - a history of substance misuse
- administering a risk assessment interview or questionnaire:
  - Opioid Risk Tool (ORT)
  - Screener and Opioid Assessment for Patients with Pain (SOAPP)

    or
  - other form of written test
- reviewing any existing documentation containing evidence of any type of aberrant behavior known to indicate a potentially increased risk to the patient (if chronic opioid management is utilized as part of that patient's treatment plan)
- classifying the patient according to the Risk Group Stratification chart at the right

Each patient's risk assessment must be documented in his or her medical record.

FREQUENCY OF TESTING

Moderate and high-risk patients require more frequent monitoring and additional oversight to ensure compliance with their medication management.

Moderate and high-risk groups should receive more frequent UDT than low-risk patients:

- at least every 3-4 months

  instead of
- 2x / year

In high-risk patients, additional testing may be periodically indicated, if the clinician has a high suspicion and can document the need for more extensive confirmatory testing (including drugs that may not be tested on a basic POC screen).

Psychiatric co-morbidity may increase risk stratification and be an indication for more frequent testing (and lower-dose therapy).

More frequent testing may be indicated following abnormal test results in high-risk patients.

RISK GROUP STRATIFICATION

Risk Group Stratification can be categorized according to 3 different criteria:

- Opioid Risk Tool (ORT) / SOAPP / other form of written test
- Morphine Equivalent Dosage (MEQ or MED)

  and / or
- prior aberrant behavior

While increased practitioner vigilance is appropriate, not all patients in these categories – based on ORT / SOAPP or MEQ / MED – will ultimately go on to demonstrate aberrant behavior.

RISK GROUP	ORT Score / SOAPP Score	MEQ / MED*	ABERRANT BEHAVIOR
Low	0–3 / < 7	< 50	No
Moderate	4–7 / ≥ 7	50–90	No
High	≥ 8 / ≥ 7	> 90	Yes Suspicious behaviors, including: – self-escalation of dose – doctor-shopping, with documentation on Connecticut's Prescription Drug Monitoring Program (CT PDMP) – indications / symptoms of illegal drug use – evidence of diversion – other documented misuse or abuse or – a notable change in affect or behavior pattern

*MEQ / MED = daily dosage for patient (in morphine equivalents)