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Workers' Compensation: Staying Ahead in 2019

Burns White and Marsh

About Marsh

The Global Leader of Insurance Brokerage & Risk Management

30,000 Employees who:

- Quantify & Manage Risk
- Uncover Opportunities for Growth

100 Pittsburgh Office Employees provide industry-focused:

- Claims Advocacy
- Consulting & Brokerage

Leverage:

- Data & Analytics
- Technology

Reduce:

- Clients' Total Cost of Risk

Local Specialties:

- Manufacturing, Healthcare, Construction, Energy & Tech

About Burns White

Big Law Performance with a Personal Touch

- 140 attorneys
- 29 Practice Areas
- 7 locations across the Mid-Atlantic Region
- Broad range of industries
  - Banking
  - Commercial Litigation
  - Transportation and Logistics
  - Real Estate
  - Construction
  - Healthcare
  - Energy
  - Retail and Hospitality

Recognized consistently, regionally and nationally

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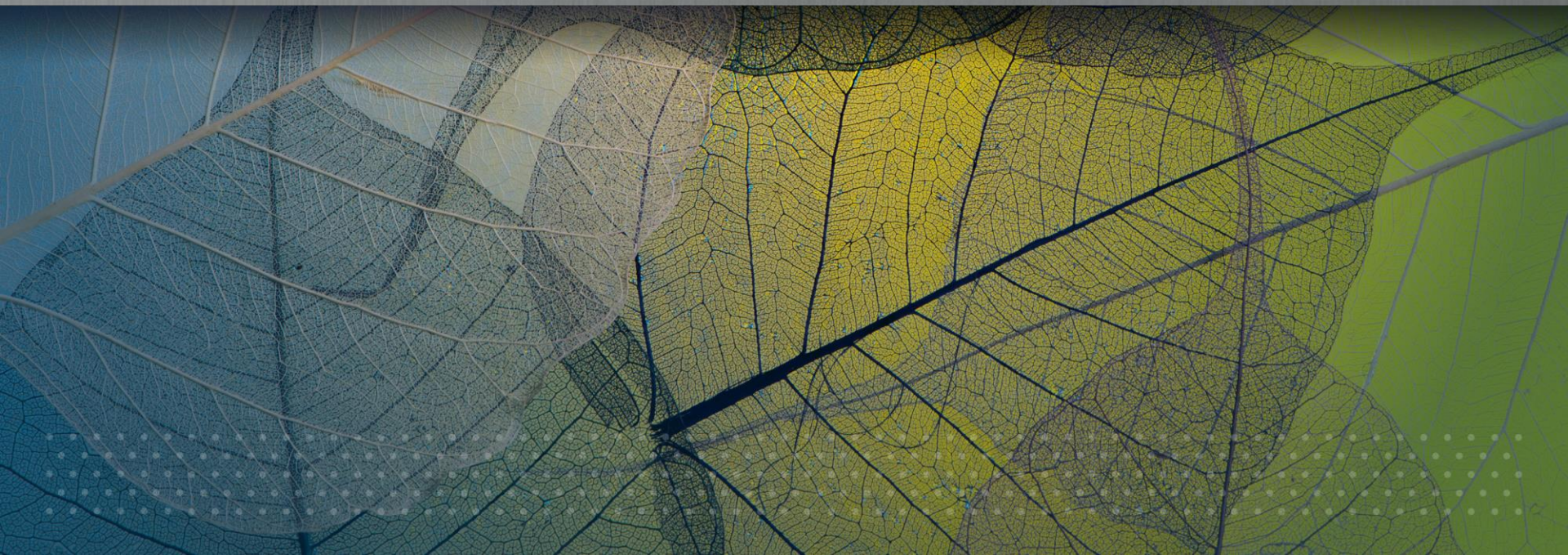
Pennsylvania Legislative Updates



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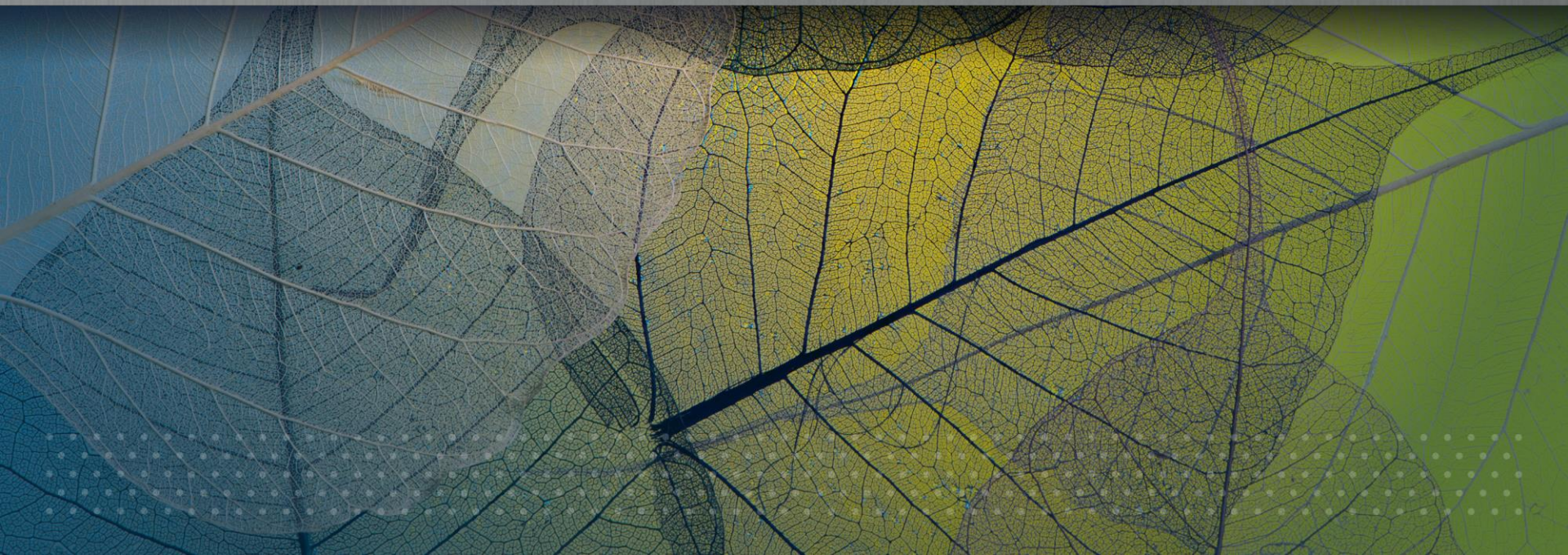
Employment Law Issues and the Impact on Claimant Outcomes



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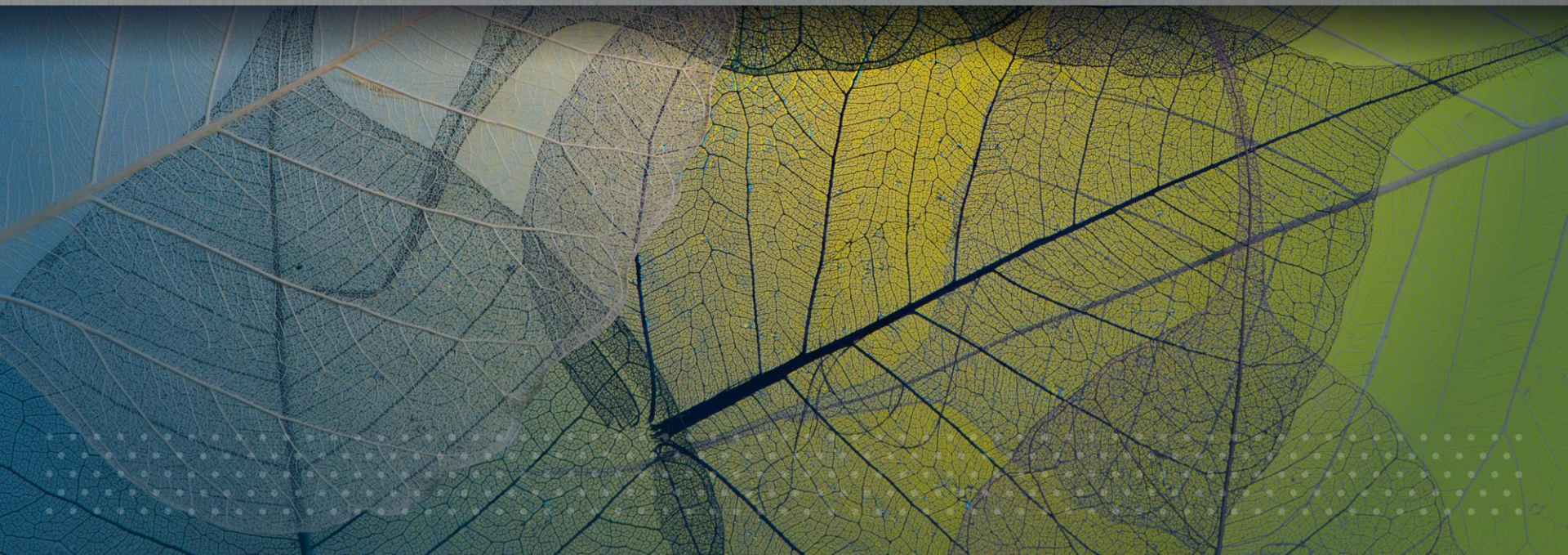
Medicare Set-Asides



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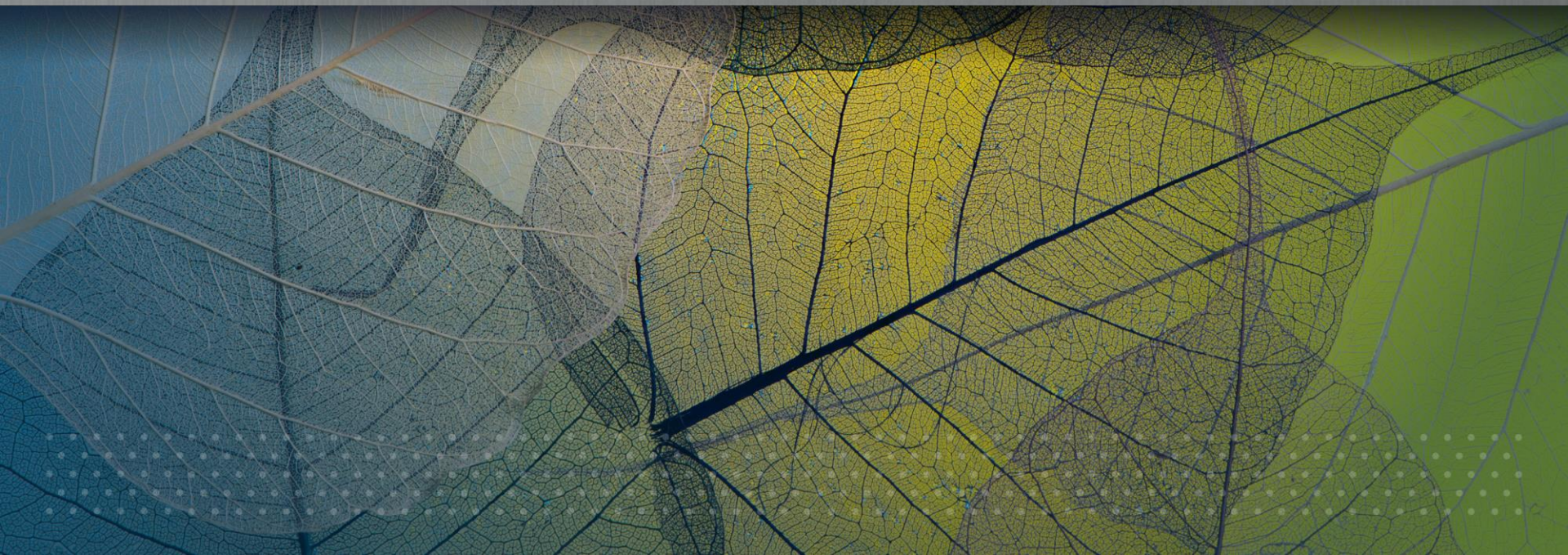
Break



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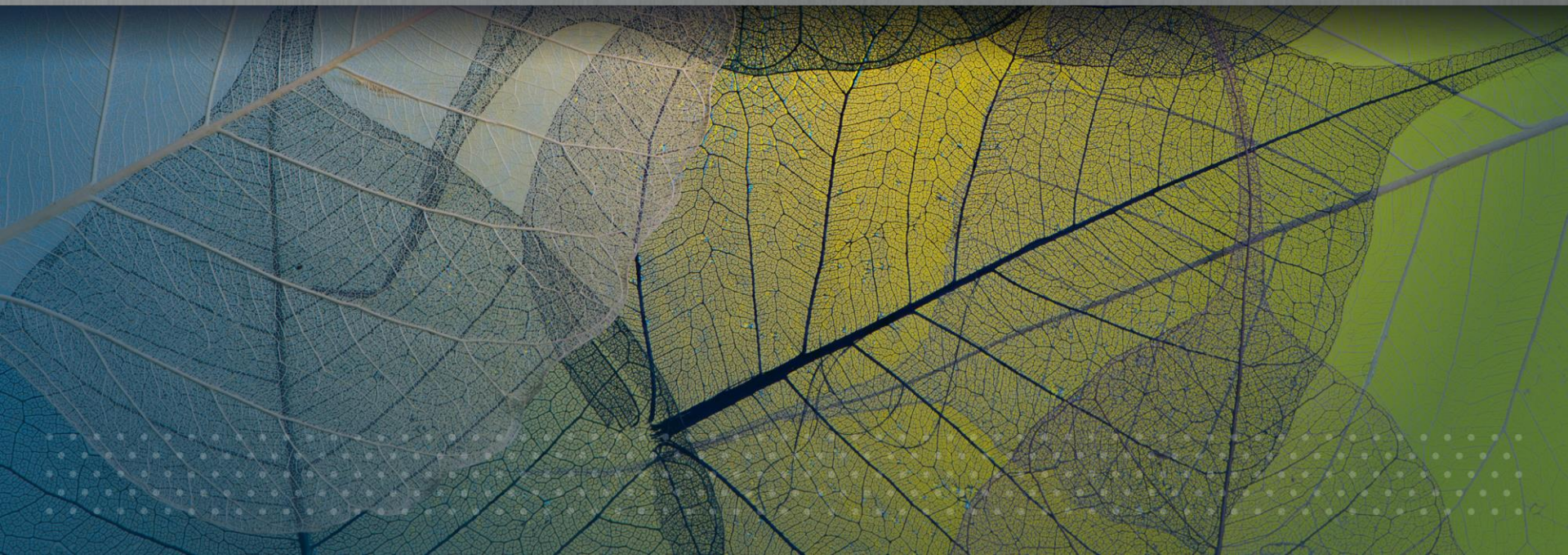
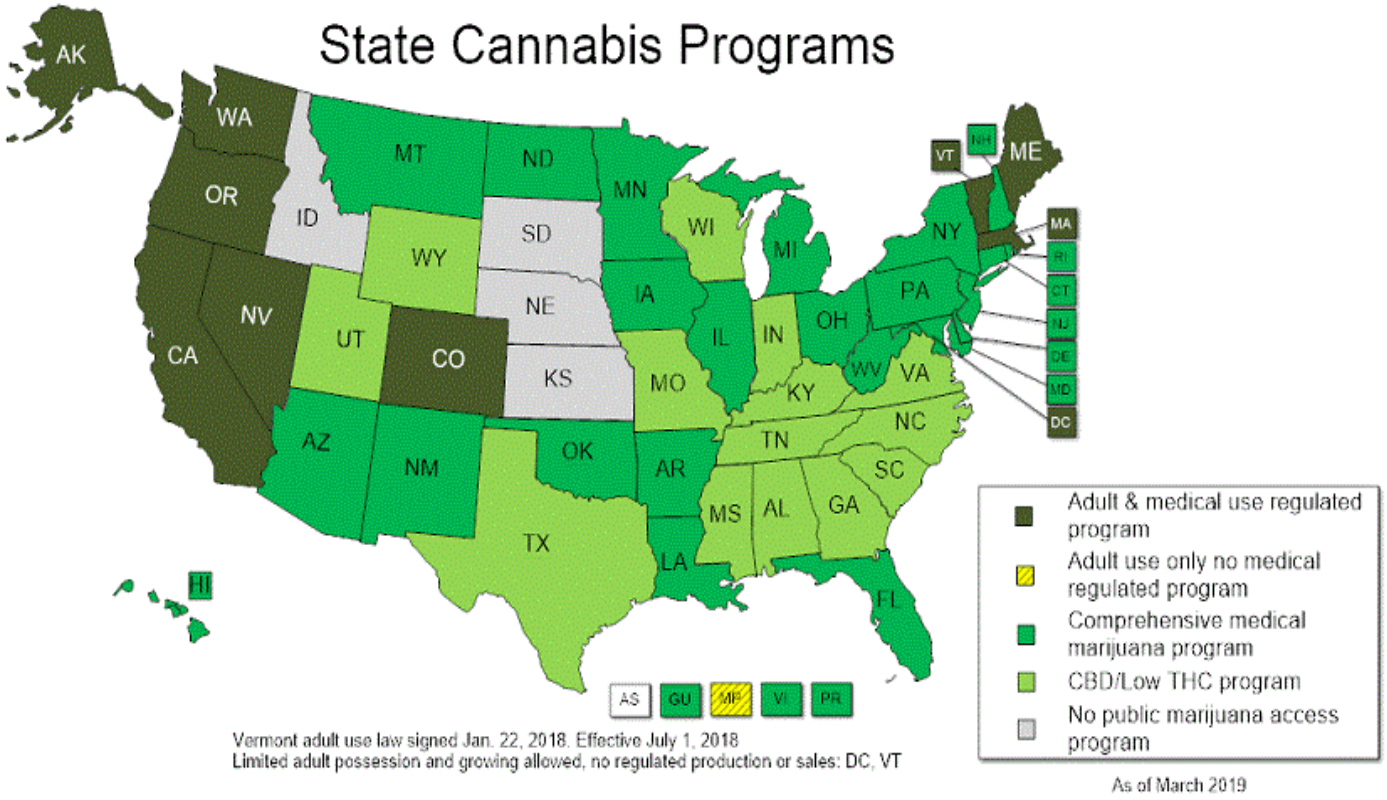
The Current State of Medical Marijuana



The Development of Legalization



To date, 33 states, District of Columbia, Guam, Puerto Rico and US Virgin Islands have approved medical marijuana/cannabis programs

Controlled Substance Act

Under the Federal Controlled Substance Act marijuana is a Schedule 1 controlled substance

- It is illegal for physicians to prescribe Schedule 1 controlled substances (21 U.S.C. § 802(16))

- In states where medicinal marijuana is legal, doctors may write a *recommendation* (not a prescription) after determining and certifying that the patient suffers from one of the approved enumerated conditions

Pennsylvania Law

Pennsylvania passed its Medical Marijuana Act ("MMA") in 2016

35 Pa.C.S.A. 10231.101.

- The act provides a way for qualified individuals diagnosed with one of seventeen medical conditions to obtain medical marijuana as part of treatment

- Doctors may provide a recommendation, but not a prescription, for patients who qualify

Patients with the following conditions may be able to receive medical marijuana as treatment:

- Amyotrophic Lateral Sclerosis
- Autism
- Cancer
- Crohn's Disease
- Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity
- Epilepsy
- Glaucoma
- HIV/AIDS
- Huntington's Disease
- Inflammatory Bowel Syndrome
- Intractable Seizures
- Multiple Sclerosis
- Neuropathies
- Parkinson's Disease
- Post-traumatic Stress Disorder
- Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective
- Sickle Cell Anemia

Medical Marijuana's Impact on Employers

How does an employer's business model coexist with the new legislation?

Considerations:

Federal Contracts

To be eligible for federal contracts, federal employees and contractors are subject to the Drug Free Workplace Act

Applies to:

- Any company that receives a federal contract of at least $100,000
- Any organization that receives a federal grant of any amount
- Employees who are directly engaged in the performance of contract work throughout the life of the contract

Companies and contractors face serious consequences for failing to conform to the Act's requirements

Drug Testing

- PA's MMA does not prohibit an employer from conducting drug testing in the workplace

- Employers may still discipline an employee for being under the influence of medical marijuana at work or when the employee's performance fails to meet the normally accepted standard of care § 2103(2)

Hiring/Firing

Anti-Discrimination Provision

- Section 2103(b)(1) of the MMA provides that employers may not:

  discharge, threaten, refuse to hire or otherwise discriminate or retaliate against an employee regarding an employee's compensation, terms, conditions, location or privileges solely on the basis of such employee's status as an individual who is certified to use medical marijuana

- The provision essentially makes qualified individuals a protected class

ADA and Accommodations

- PA employers are not required to accommodate medical marijuana use, but must accommodate conditions that fall under the Americans with Disabilities Act ("ADA") and/or the Pennsylvania Human Relations Act ("PHRA")
  - Notably, the ADA excludes an individual who is engaged in current illegal drug use from its scope
  - PA case law suggests exclusion of medical marijuana from its purview
- A critical step in the reasonable accommodation analysis under the ADA is ascertaining what is, and is not, the essential job functions of a position

Workers' Compensation

- While the MMA ensures that workers' compensation carriers would never have to pay medical marijuana dispensaries directly, reimbursing workers is not excluded

- An injured worker must demonstrate the use of medical marijuana is for a covered condition and that it is reasonable and necessary treatment

Workers' Compensation

Reimbursement Process

- Determination if the use of medical marijuana is reasonable and necessary

- In order for the out-of-pocket cost of medical marijuana to be potentially reimbursable, it must be provided by a healthcare provider, as defined in § 127.3 of the Workers' Compensation Medical Cost Containment Regulations ("WCMCCR")

- Determination of rates, given that there is no price schedule for medical cannabis

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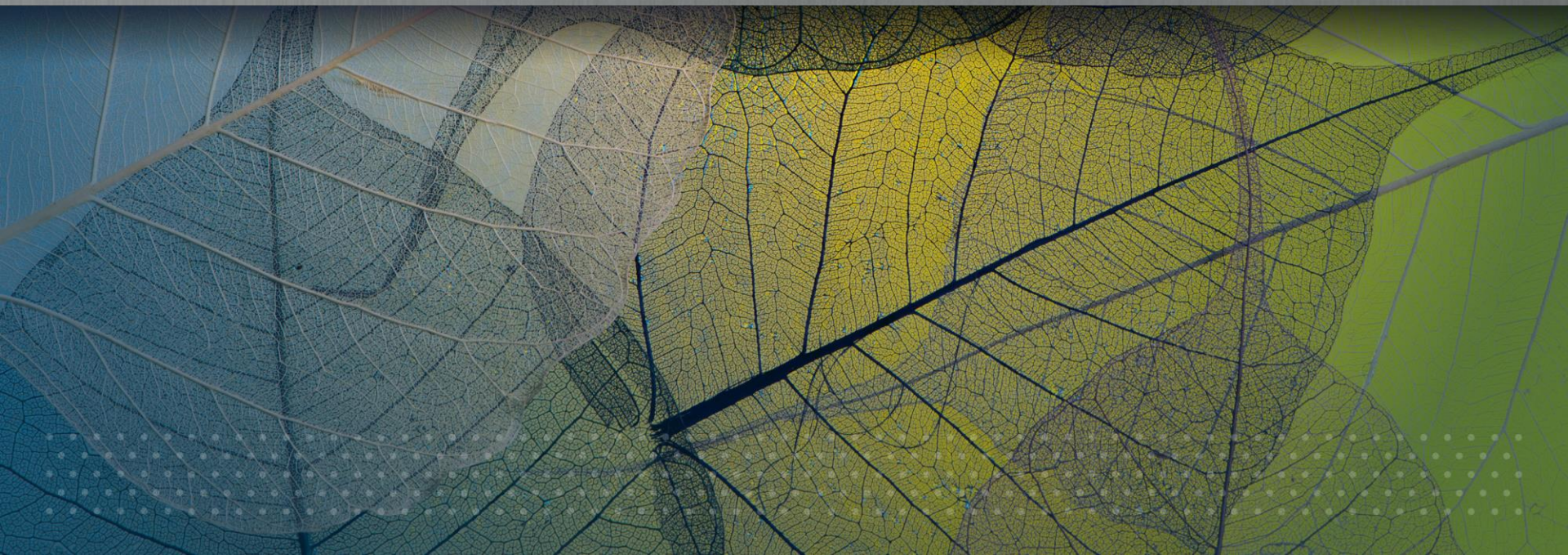
The Opioid Crisis



CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN – UNITED STATES, 2016

Truth, Reconciliation and Cross Examination

Burns White Seminar, April 25, 2019

ME, ME, ME…ME

Pain & Disability Management Consultants, P.C.

Stephen M. Thomas, M.D., MBA
7240 McKnight Rd.
Pittsburgh, PA 15237

sthomas@pdmconsultants.info

Objectives

- Become intimately familiar with the content of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
- Highlight the content of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
- Provide cross examination pearls for those of you who might want to roast a doctor of two

Impetus for this talk

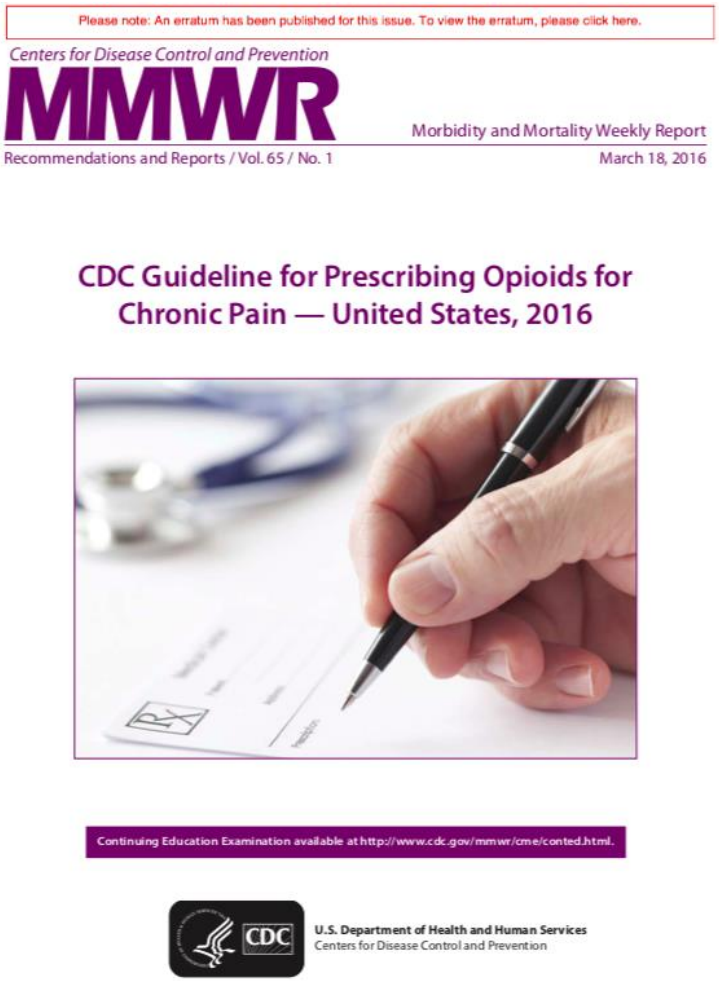
- **Utilization Review # 1:** Patient PB– 65 year-old, DOI 04/02/90. LBP, microdiscectomy 1992. Prescribed Methadone 80 mg per day, Oxycodone 120 mg per day, Clonazepam 3 mg per day. Pain 8. Max activity, “shower.” MME = 1,140 mg per day.

- **Utilization Review # 2:** Patient JW– 54 year-old, DOI 04/14/94. Two lumbar spine operations. SCS. Methadone 60 mg per day. Monthly UDS. Pain 8. Max activity, part-time sedentary level of physical demand. MME = 600 mg per day.

Utilization Review

A formalized
mechanism
for back scratching

What is in it?


Please note: An erratum has been published for this issue. To view the erratum, please click here.

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 65 / No. 1

March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

34 pages of text
9 pages of references
5 pages of data grading tables
1-½ pages of acknowledgements

5 clinical questions
12 recommendations in 3 categories

Why was it necessary?

- **Dual Epidemics**
  - "Epidemic" of undertreated chronic pain
  - Epidemic of drug abuse, overdose, and addiction
  - **Deaths**: 1 in 550 at median 2.6 years from 1st prescription

Lies, Damn Lies, and Pain

- If one in three people has a condition, is it a bug or a feature, a problem or a normal state?

- If the provision of a “treatment” increased by 300% would the rate of the condition be expected to decrease? (1999-2015)

Scope and Audience

- The *Guideline* explicitly targets primary care physicians *(let's poo-poo that—"poo-poo")*

- Exclusions:
  - *Active* cancer treatment
  - Palliative and end-of-life care

  - Special populations
    - Elderly
    - Pregnant women
    - Adolescents

The Empire Strikes Back!

RESOLVED that our AMA affirms that some patients with acute or chronic pain can benefit from taking opioids at greater dosages than recommended by the CDC Guidelines for Prescribing Opioids for chronic pain and that such care may be medically necessary and appropriate.

RESOLVED that our AMA advocate against the misapplication of the CDC Guidelines for Prescribing Opioids by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit access to opioid analgesia.

The Empire Strikes Back!

- RESOLVED that our AMA advocate that no entity should use **MME thresholds as anything more than guidance,** and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations **solely** for prescribing opioids at a quantitative level above the MME thresholds found in the CDC Guidelines for Prescribing Opioids."

- *November 2018*
- *[Stupid is winning.]*

Key Clinical Questions

- KQ1: Effectiveness
- KQ2: Risks of harm
- KQ3: Comparative effectiveness of dosing strategies
- KQ4: Effectiveness of risk mitigation tools
- KQ5: Long term effects of acute opioids prescribing

CDC Recommendations

- Determining when to **initiate or continue** opioids for chronic pain
- Opioid **selection, dosage, duration**, follow-up and discontinuation
- Assessing **risks** and addressing **harms** of opioid use

CDC Recommendations

- Determining when to **initiate or continue**

1. Nonpharmacologic and nonopioid pharmacologic therapy are preferred. Consider opioids only if benefits for *both* pain and function outweigh risks. If used, opioids should be combined with other appropriate therapy.

2. Before starting opioids, establish realistic treatment goals for pain and function, and consider how to discontinue, if risks outweigh benefits. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweigh risks.

CDC Recommendations

- Determining when to **initiate or continue**

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.

CDC Recommendations

- Opioid **selection, dosage, duration**, follow-up and discontinuation

4. When starting opioid therapy for chronic pain, prescribe **immediate-release** opioids.
5. Clinicians should start with the lowest effective dosage, using caution at any dosage. Carefully reassess 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** dosage **≥90 MME/day.**

CDC Recommendations

- Opioid **selection, dosage, duration**, follow-up and discontinuation

6. Long-term opioid use often begins with **acute pain** treatment. When using opioids for acute pain, clinicians should prescribe the **lowest effective dose of immediate-release opioids** and should prescribe a quantity no greater than needed for expected duration of severe pain. Three (3) days or less will usually be sufficient.

CDC Recommendations

- Opioid **selection, dosage, duration**, follow-up and discontinuation

7. Evaluate benefits and harms within **1 to 4 weeks of starting** opioid therapy or **dose escalation**. Clinicians should evaluate benefits and harms of **continued therapy every 3 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.

CDC Recommendations

- Assessing **risks** and addressing **harms** of opioid use

8. Clinicians should periodically evaluate **risk factors** for opioid-related harms, incorporating strategies to mitigate risk, including offering **naloxone** with risks for overdose, such as **history of overdose**, history of **substance use disorder, higher opioid dosages** (≥50 MME/day), or concurrent **benzodiazepine** use.

9. Clinicians should review state prescription drug monitoring program (**PDMP**) data to determine whether the patient is at higher risk for overdose. Clinicians should review PDMP data [as required by state law.]

CDC Recommendations

- Assessing **risks** and addressing **harms** of opioid use

10. *When prescribing opioids, clinicians should use **urine drug testing before starting** opioid therapy and 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.

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.**

Defense of the Status Quo Ante

- “You can’t tell me what to do.”
- “The patient needs this.”
- “This [high-dose opioid] is the only thing that works.”
- “They are not dead yet.”
- “Those guidelines apply to new patients, not someone who has been on these drugs for years.”
- “People are committing suicide if they don’t get their opioids.”
- “Where’d you go to medical school?”

Cross Examination Questions

- What were you treatment goals for the claimant?
- Show me in your medical record where the claimant achieved clinically significant pain relief.
- What can the claimant do now that he/she could not do prior to this therapy?
- [High-dose opioid] What is the functional benefit of risking the claimant's life? [1 in 32 chance of death over 200 MME]
- Are you aware that the combination of [opioid] and [benzodiazepine] increases overdose risk by 1500%?

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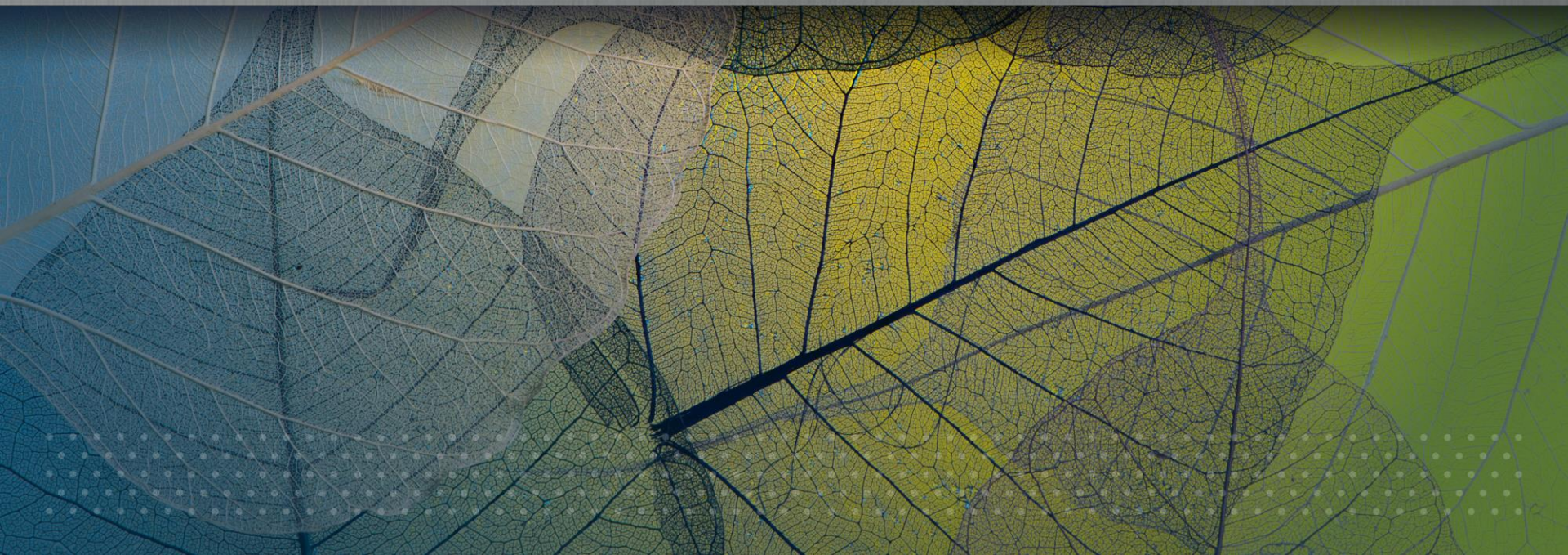
Questions?



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Thank you!