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State: CA
CWCI: Multiple Opioids Tied to Higher Claims Costs: Top [2013-10-29]

By John P. Kamin, Reporter

Claims featuring multiple opioid prescriptions are linked to higher rates of indemnity claims, more expensive medical benefits payments, a greater probability of attorney involvement and lower claim closure rates, according to a study by the California Workers' Compensation Institute.

CWCI and Axiomedics Research revisited and updated a 2008 study on the relationship between the number of opioid prescriptions and other claims characteristics titled, "Pain Management and the Use of Opioids in the Treatment of Back Conditions in the California Workers' Compensation System."

Dr. Laura Gardner, president of Axiomedics Research, told attendees of the California Workers' Comp Forum in San Diego on Friday that the latest data shows a correlation between the number of opioid prescriptions and the likelihood of indemnity claims among patients with "simple sprains and strains of the back." She noted that the American College of Occupational and Environmental Medicine guidelines do not recommend opioids for patients with simple back sprains and strains.

Gardner said 40% of applicants with one opioid prescription during their first post-injury year filed indemnity claims.

"This is what we see in general, in most studies, overall, the average is that 40% overall of claims are indemnity claims," she said. "What isn't in the normal limits is the likelihood of the claim becoming an indemnity claim goes up as the number of opioid prescriptions goes up."

According to the data Gardner presented, 67% of injured workers with three opioid prescriptions during their first post-injury year had filed indemnity claims. Claimants with six or more opioid prescriptions during their first post-injury year had the highest rate of indemnity claims, with 85% to 92% of their claims resulting in indemnity claims.

"By the time you get to eight or nine (opioid) prescriptions, you are at almost 90% of claims being indemnity claims," Gardner said. "The reason why ACOEM recommends that opioids not be prescribed for low back pain is they were never intended for this purpose. They are highly addictive. They are known to cause all sorts of side effects that inhibit recovery and return to work. They are associated with depression. They are associated with decreased physical activity. All of that can be seen in the likelihood of indemnity claims."

The study revealed a correlation between the number of opioid prescriptions and the likelihood of an applicants' attorney becoming involved in the claim, she said.

"We use 'attorney involvement' as our proxy (nickname) for litigation," Gardner said. "The percent of claims with attorney involvement goes up, as the number of prescriptions goes up. I am the first to admit that this is not a cause and effect relationship – this is an association that we see in the data."

However, she noted that the likelihood of attorney involvement is linked to the number of claimants who file indemnity claims. Because applicants with more opioid prescriptions are more likely to file an indemnity claim, they could also be more likely to hire an attorney to represent them, Gardner said.

The data also linked claim closure rates to the number of opioid prescriptions an injured worker has.

Gardner pointed out that applicants with only one opioid prescription had a claims closure rate of 87%, and noted that claims closure rate steadily decreased while the number of opioid prescriptions increased. For instance, applicants with three opioid prescriptions had a closure rate of 76%, workers with six opioid prescriptions had a closure rate of 67% and applicants with nine opioid prescriptions had a closure rate of 62%.

"Those claims that have greater than four or five prescriptions, they are approaching an almost one-third decrease in the likelihood of the claim being closed," Gardner said. "These are significant detrimental effects of a pattern of prescribing that is not even clinically justified. These are people who are getting addictive, life-destroying narcotics – when they probably do not even need one prescription. Let's just say that they definitely do not need 10 (opioid prescriptions), or seven (opioid prescriptions)."

The data also revealed a strong correlation between the amount of medical benefits paid on a claim, and the number of opioid prescriptions an applicant received, she said.

"The number of opioid prescriptions is directly related to increased spend on medical benefits," Gardner said.

Industry feedback to such data usually focuses on how injured the applicants in the study actually were, she noted. Gardner said she wanted to dispel attacks on the study's credibility, because critics typically allege that such studies only feature claimants with unusually severe side effects.

To help the study's credibility, Gardner used a technique called "case-mix adjustment" and limited the study's population to injured workers with diagnoses of simple back strains and sprains, who were not diagnosed with spinal cord injuries. Limiting the study to this particular segment of the population helps deflect critics' allegations that the study focused on an unusual subset of claims, she said.

"This is the first thing we controlled for, the most important thing to control for," Gardner said. "The first argument you want to shoot down is that these people are sicker and therefore need them (opioids), and that there is some other reason why these people need (opioids)."

The data does not clearly indicate why applicants with back sprains and strains are receiving multiple prescriptions for opioids, she said.

"The answer may lie in the involvement of the attorneys; it may lie in the patients themselves; it may lie in the culture," Gardner said. "It may have something to do with physician dispensing and drug

issues. We do not know specifically what the cause and effect is. But we do know that we see this association time and time again."

To purchase the 2008 study, click here.