

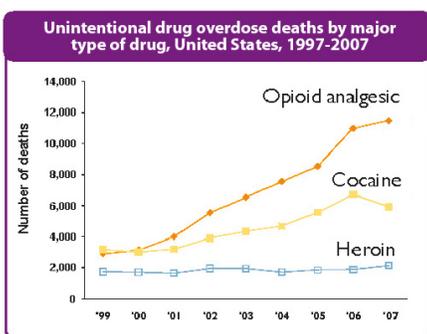
Opioids in the Treatment of Injured Workers: When and How to Maximize Effectiveness

A. Phillip Walls, R.Ph.
Matt Schreiber, MBA

Executive Summary

- Use of prescription painkillers has increased in staggering proportions compared with other medication classes, in terms of the number of prescriptions written, costs and incidence of overuse and abuse.
- Adherence to guidelines for instituting and monitoring opioid therapy can have a significant impact on cost control in managing the care of an injured worker.
- Access to information and warning signals is key in the judicious use of opioid therapy. The earlier in the claim that insurers are alerted to problems, even to the point of predicting cases in which potential exists, the easier it is to ensure improved outcomes.

The skyrocketing use and cost of pain medications is well documented. According to Risk & Insurance, up to 20% of all doctor visits in 2007 included a prescription for an opioid medication. An analysis of prescribing patterns nationwide shows that approximately 56% of patients who received an opioid prescription in 2009 had filled another opioid prescription within the previous 30 days. This analysis comes on the heels of data showing that from 1991 to 2009, prescriptions for opioid analgesics increased almost threefold, to over 200 million. Overdoses attributed to prescription painkillers killed nearly 15,000 people in the U.S. in 2008, more than three times as many as in 1999.¹ And, according to the Centers for Disease Control and Prevention, prescription opioid overdose is now the second leading cause of accidental death in the U.S., killing more people than heroin and cocaine combined.²



Source: National Vital Statistics System

Specific to the workers' compensation arena, research indicates that temporary disability payments are 3.5 times higher when opioids are prescribed.³ A California Workers' Compensation Institute study indicated that a small number of physicians (around three percent)

“The abuse of prescription opioids has become a grave personal risk to injured workers, a disruptive force in the lives of those close to claimants harmed by abuse, and a cost concern to other stakeholders in the United States workers’ compensation system.”

*Joint statement of the
ACOEM and IAIABC,
Oct. 2011⁷*

were responsible for more than 65% of prescription payments for the most tightly controlled narcotics in the state. Over half of those instances were to treat minor back injuries.⁴ With little to no regulation to help control narcotic use within the system, injured workers are being harmed by medical practices that violate safe, conventional treatment guidelines and the direct economic cost to employers and insurers is very high.⁵ Lack of safe treatment is not isolated either. In a recently completed study of 17 states, the Workers Compensation Research Institute found that many physicians who prescribed narcotics to injured workers were not using recommended tools to monitor use, abuse and diversion.⁶

When Should Opioids Be Prescribed?

Knowing the most effective situations in which to safely prescribe opioid therapy is the first step in controlling its use. ACOEM'S 2008 guidelines offer a clear measure, suggesting that the key to prescribing is functionality, not pain.

Opioid therapy should be only part of a treatment plan and should always begin with a therapeutic trial. Prior to starting any opioid regimen, a number of questions should be addressed covering such concerns as: Are there reasonable alternatives to treatment and have they been tried? Is the patient likely to improve?

Screening for the risk of addiction is an essential step that should be the precursor to instituting any opioid treatment plan. Various screening tools attempt to identify individuals who have personal (addictive personality indicators) or family traits that may indicate a risk of addiction. Questionnaires, such as Opioid Risk Tool (ORT), CAGE Adapted to Include Drugs (CAGE-AID) and Patient Health Questionnaire 9 (PHQ-9) (see Appendix A) are recommended for their clinical utility in screening opioid therapy patients.⁸

The ODG clearly outlines “red flags” that, if revealed during the screening process or early stages of therapy, indicate that opioids may not be the right choice for the injured worker. These include:

- Little or no relief with opioid therapy in acute/sub-acute phases
- Diagnosis in a category identified as one that hasn't been shown to have good success using opioids, such as disorders which cause pain that cannot be identified with an apparent physical cause or pain disorders associated with physiological factors

- Patient request of an opioid medication for their pain, with inconsistencies identified in history, presentation, behaviors or physical findings⁹
- Inappropriate use of opioids within the first 30 days of therapy

Patients receiving 100 mg or more per day morphine equivalent dose (MED) had a 9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.

Recently, regulations have been put in place to regulate opioid prescribing practices in some states. Perhaps the most aggressive control is in the State of Washington, where new rules compel physicians to follow evaluation protocols and treatment practices much like those described here when prescribing opioids to treat non-cancer pain. Texas has adopted a closed formulary, which restricts the use of certain drugs, such as Actiq®, by requiring approval via a prior authorization process involving a licensed Utilization Review Agent. The State Compensation Insurance Fund in California has set specific limits on the prescribing of opioids for doctors in its network.

A critical indicator in the use of opioid therapy is the level of medication as measured by average daily morphine equivalent dosage (MED). The MED total is computed utilizing dosages of all opioid and opioid-containing medication taken during a 24-hour period. A new study referenced in the *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain*¹⁰ and being recognized across the country, supports the 120 mg MED threshold as an indicator of risk. It “provides the first estimates that directly link receipt of medically prescribed opioids to overdose risk and suggests that overdose risk is elevated in chronic non-cancer pain patients receiving medically prescribed opioids, particularly in patients receiving higher doses.” Patients receiving 100 mg or more per day MED had a 9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.¹¹

The 120 mg MED threshold is considered somewhat controversial as a part of Washington State’s medical guidelines, which recommend that doctors not increase dosage beyond this threshold when a patient does not demonstrate improved functionality and decreased pain at lower doses or without first consulting with a pain management expert. Early data show that this guideline has played a part in reducing injured-worker deaths caused by the dramatic rise in opioid prescribing, according to the National Council of Self-Insurers.

Early data show the 120 mg MED guideline has played a part in reducing injured-worker deaths caused by the dramatic rise in opioid prescribing.

What Are Best Practices In Prescribing Opioids?

At the outset of any opioid therapy, a full evaluation of medical history and a physical examination should be done. This should include an assessment of physical and psychological function, as well as

underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of pain.

Determine the lowest effective dosage – The first step in prescribing is establish the lowest effective dosage utilizing a therapeutic trial.

Set and agree on goals - After obtaining baseline pain and functional assessments, goals should be set and the continued use of opioids should be contingent upon meeting these goals. Other than in certain states, a written Pain Treatment Agreement is not required, but can make treatment plans easier to document and can clarify the expectation of adherence. The CDC recently recommended the use of patient-provider agreements (sample in Appendix B) combined with urine drug tests for people using prescription painkillers long term.¹²

Use Step Therapy - A key strategy in pain management, Step Therapy offers benefits to both the injured patient and the workers' compensation industry. This step-wise approach drives good clinical choices, such as initiating therapy with a lower dose or short-acting opioids and only "stepping up" to agents like OxyContin if the injured patient does not experience relief from pain. This is only one example of thousands where this approach may improve care, deter abuse and avoid dangerous side effects.

Monitor with Urine Drug Screening - Actively monitor the patient using urine drug screening (UDS) and psychological evaluations. The purpose of screening is to reveal not only the *presence* of illicit substances, but also the *absence* of the prescribed medication. Start with a baseline UDS and, from preliminary screening using a tool such as the ORT, determine the patient's risk level. Random UDS monitoring should be repeated at a frequency based on this level.

Risk Category	UDT Frequency	Drugs or Drug Classes to Test
Low Risk by ORT	Periodic (e.g. up to 1/year)	<ul style="list-style-type: none"> • Drug you are prescribing if not listed • Amphetamines • Opiates
Moderate Risk by ORT	Regular (e.g. up to 2/year)	<ul style="list-style-type: none"> • Cocaine • Benzodiazepines
High Risk by ORT or opioid doses >120 mg MED/d	Frequent (e.g. up to 3-4/year)	<ul style="list-style-type: none"> • Alcohol • Barbiturates • Oxycodone • Methadone
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)	<ul style="list-style-type: none"> • Fentanyl • Marijuana <p>Testing for all drug classes may not be necessary, depending on clinical situation.</p>

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain

misuse. A survey of primary care physicians (PCP) sponsored by the National Centers for Addiction and Substance Abuse showed that over of 90% of PCPs missed substance abuse and few (17%) felt even capable of detecting it.¹³ An algorithm for the use of UDS in monitoring opioid treatment for chronic non-cancer pain can be found in Appendix D.

- Use of objective information, such as that from family members and caregivers, should be considered. This is a specific recommendation included in opioid prescribing policies in multiple states.

In treating chronic pain, reasonable efforts should periodically be made to stop the use of the controlled substance, decrease the dosage and try other drugs, such as nonsteroidal anti-inflammatory drugs, or other treatments. This is an effort to reduce the potential for abuse or the development of physical or psychological dependence.¹⁴

Evaluating the Continued Use of Opioid Therapy

Careful monitoring and analysis by the prescribing physician is essential in determining if opioid therapy is effective and if it should continue to be used. For chronic pain patients taking opioids, monitoring and evaluation is best described with the four A's for ongoing monitoring:

- Analgesia – Is there documented pain relief?
- Activities of daily living – Is functioning returning to normal? Cases in which there is documented improvement in pain and functioning, not just a patient-reported decrease in pain, indicate that opioid therapy can be continued.¹⁵
- Adverse side effects – Are they minimal and tolerable?
- Aberrant drug-taking behaviors – Are there any “red flags”?

The outcome of such monitoring should influence ongoing therapeutic decisions made in the context of ACOEM guidelines for pain management, which include the use of non-opioid analgesics, psychological support and active treatments (e.g., exercise). Other factors that must be taken into consideration include: if the injured worker has been able to return to work, if prescriptions are being obtained from a single practitioner and if all prescriptions are filled by a single pharmacy. The use of a pain diary, continuing UDS and documentation of misuse are other standards to maintain with continued opioid treatment.

The image shows two pages of a 'DAILY PAIN CHART' form. The top page is a grid for recording pain levels from 0 to 10 over a 24-hour period. The bottom page is a 'DAILY PAIN SUMMARY' form with various questions about pain management, medication use, and patient satisfaction, including a body diagram for marking pain locations.

Knowing When It's Time to Stop Treatment

Clearly, there are situations in which treatment is ineffective and/or the injured worker is displaying aberrant behavior. A number of indicators that treatment should be discontinued, all of which should be well documented, include:

- Level of function - Unless there are extenuating circumstances, if the patient is experiencing no overall improvement or a decrease in functioning, opioid therapy should be discontinued.
- Continuing pain with intolerable adverse effects – Side effects experienced along with opioids can require so many additional medications as to outweigh the benefit of this type of treatment.
- Serious non-adherence – This can involve the way the patient is taking their medication or the manner in which they are obtaining prescriptions.
- Evidence of illegal activity – Indications of diversion, forgery or stealing, or if the patient is involved in a motor vehicle accident related to opioids or other illicit drugs should all be considered “red flags”.
- Repeated violations of medication contract or any other evidence of abuse, addiction or possible diversion.

Risk Reduction is Key to Positive Outcomes in Treatment Utilizing Opioids

The use of opioid therapy in the workers' compensation arena requires a careful balancing of the benefits and risks for the injured worker. The FDA's recently-enacted action plan addressing long-acting and extended-release opioids takes a significant step toward reducing overall risk. Because of the potency and potential for diversion and abuse of opioids, the FDA has instituted a Risk Evaluation and Mitigation Strategies (REMS) to address the unique risk-benefit profile of this class of prescription medications.

REMS requires manufacturers to ensure that training is provided to prescribers of these medications and that they develop informational materials for patient counseling to cover use, risks of misuse and potential for abuse and addiction. REMS goes beyond a drug's written prescribing information and can include a Medication Guide, communication plan and other elements to assure safe use of a drug. Additionally, in support of REMS and to curb diversion and misuse, pharmaceutical companies are seeking ways to create abuse

deterrent formulations of extended-release opioids. In addition to impeding abuse, the goal is to make these formulations more difficult to alter in the attempt to gain immediate release of the opioid.

As a leader in Pharmacy Benefit Management (PBM) for injured workers, myMatrixx has discovered that the key to balancing the benefits and risks of opioid treatment is managing it from the onset. Our clients can do this via a system of comprehensive monitoring developed to work seamlessly with our continuously evolving technologies and information analysis capabilities. Using a multifaceted approach, we focus on educating claims professionals, developing advanced technologies and emphasizing open lines of communication between our clinical staff and physicians.

Our robust Alert, Review and Manage (ARM)[™] program provides an automated system of clinical oversight that is highly flexible and customizable for each client, delivering real-time data directly to the claims professional's desktop. Not limited to clinical concerns, ARM's focus is from the perspective of injury state management, including such areas as: relatedness, appropriateness, fiscal responsibility and excessive dose or duration of therapy. Opioid management involves a special subset of ARM that triggers a review of prescribing patterns and alerts everyone in the process as soon as an opioid is dispensed. Each ARM is tied to one or more measurable actions, reviewed by and communicated to the physician by our pharmacists. The clinical information provided by the ARM program has enabled us to build a strong pharmacist-physician link aimed at optimizing patient care.

After only 90 days utilizing myRisk Predictor[™], clients have experienced as much as a 30% reduction in prescription drug utilization.

As an extension of the ARM program, myMatrixx has introduced a fully integrated risk assessment tool that is highly unique in the industry. By combining, analyzing and stratifying patient information kept in diverse places, myRisk Predictor[™] couples our predictive modeling capabilities with algorithms developed by our clinical team to identify cases in need of intervention. This patent-pending, real-time technology utilizes continuously updated data points to assess the appropriateness or potential misuse/abuse of opioid therapy, identifying patients that have poor chances of returning to work or who appear to be headed toward abuse/addiction.

myRisk Predictor's algorithms are customizable, adapting to risk levels identified in a specific client's injured worker population. Once a risk score identifies an individual, our clinical team can provide a complete Drug Regimen Review, peer-to-peer intervention with the treating

physician and assistance with the development of an alternative treatment plan. After the first 90 days using assessments provided by myRisk Predictor, some clients have experienced as much as a 30% reduction in prescription drug utilization. The result: lower cost of care and improved outcomes for their injured workers.

Urine Drug Screening (UDS) is an essential component of any risk reduction strategy. To be effective in the workers' compensation arena, UDS needs to cover more substances than standard workplace drug testing. Additionally, the interpretation of UDS results is complex and requires an analysis of expected results, such as pharmaceutical impurities, to flag what is unexpected. myMatrixx partners with diagnostic laboratories that use sophisticated data analysis in order to provide summary reports that are easy to interpret and clearly flag unexpected results.

Our commitment to help clients optimize the care of their injured workers does not stop with prediction and alert systems. An effective clinical staff/physician link is of utmost importance, so myMatrixx pharmacists take a lead role in communicating with the physician. Utilizing information from our technology driven programs along with evidence-based pain management guidelines, such as ODG, our clinical staff develops patient-specific recommendations and treatment plans. With these, our pharmacists make personal contact with physicians to clarify and reach consensus on recommendations. Physicians can depend on myMatrixx pharmacists for an in-depth understanding of opioid treatment guidelines versus information provided by pharmaceutical companies, which may or may not be accurate.

A Drug Regimen Review (DRR) gives our pharmacists yet another opportunity to interact with the physician. This comprehensive assessment provides detailed information for making improvements in treatment specific to individual patients. Our clinical staff can provide guidance specific to opioid therapy, such as conversion dosages for alternative opioids with better therapeutic profiles or detailed weaning guides when a decision is made to stop treatment.

Advanced systems and customizable technology developed in partnership with our clinical team has put myMatrixx in a unique position to react to the risks and benefits associated with opioid therapy for our clients' injured workers. Our ongoing commitment is to help our clients manage opioid treatment from the start, by

providing real-time data, expert clinical oversight, individualized clinical treatment plans and open communication with physicians. At myMatrixx, the focus is on helping control the cost of care for our clients, while providing improved outcomes for their injured workers.

Our Position

We believe the three most significant factors in successful opioid management are:

- Identify appropriate patients - Consider the outcome of alternative treatment as well as trial doses of an opioid
- Establish a treatment plan - Employ Step Therapy and include a written Pain Treatment Agreement
- Pre-determine endpoints to indicate when it's time to discontinue opioid therapy

What we will do on behalf of our clients:

- Monitor our extensive prescription database and provide information to prescribers of opioids regarding the implementation of opioid treatment plans
- Monitor the dose of opioids in opioid-naïve patients and alert the prescribing physician if daily MED exceeds 120mg
- Prepare a custom weaning schedule for any of our patients that we identify should be weaned or if the physician requests assistance in preparing a compassionate weaning schedule
- Report to our clients on the outcome of this program

Appendix A

Date _____

Patient Name _____

OPIOID RISK TOOL

	Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol <input type="checkbox"/>	1	3
	Illegal Drugs <input type="checkbox"/>	2	3
	Prescription Drugs <input type="checkbox"/>	4	4
2. Personal History of Substance Abuse	Alcohol <input type="checkbox"/>	3	3
	Illegal Drugs <input type="checkbox"/>	4	4
	Prescription Drugs <input type="checkbox"/>	5	5
3. Age (Mark box if 16 – 45)	<input type="checkbox"/>	1	1
4. History of Preadolescent Sexual Abuse	<input type="checkbox"/>	3	0
5. Psychological Disease	Attention Deficit Disorder <input type="checkbox"/>	2	2
	Obsessive Compulsive Disorder Bipolar Schizophrenia		
	Depression <input type="checkbox"/>	1	1
TOTAL	<input type="checkbox"/>		
Total Score Risk Category	Low Risk 0 – 3	Moderate Risk 4 – 7	High Risk ≥ 8

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain

Appendix A

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

(Brown 1995)

Appendix A

PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

a. Little interest or pleasure in doing things

Not at all **Several days** **More than half the days** **Nearly every day**

b. Feeling down, depressed, or hopeless

Not at all **Several days** **More than half the days** **Nearly every day**

c. Trouble falling asleep, staying asleep, or sleeping too much

Not at all **Several days** **More than half the days** **Nearly every day**

d. Feeling tired or having little energy

Not at all **Several days** **More than half the days** **Nearly every day**

e. Poor appetite or overeating

Not at all **Several days** **More than half the days** **Nearly every day**

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

Not at all **Several days** **More than half the days** **Nearly every day**

g. Trouble concentrating on things such as reading the newspaper or watching television

Not at all **Several days** **More than half the days** **Nearly every day**

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

Not at all **Several days** **More than half the days** **Nearly every day**

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Copyright held by Pfizer Inc, but may be photocopied ad libitum

Appendix B

Chronic Pain Agreement

I, _____ (patient receiving chronic pain medications), have agreed to correctly use pain medications as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase my level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____ will be my pain management provider and the only provider who will be ordering my pain medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

- I will only take the medications at the amount and frequency as ordered.
- I will not increase or change how I take my medications without the approval of my pain management provider.
- I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours.
- I will make the necessary arrangements before holidays and weekends.
- I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy: _____ Phone Number: _____

- I will allow my pain management provider to provide a copy of this agreement to my pharmacy.
- I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.
- I understand that other physicians should not change doses of my pain medications without first talking to my pain management provider.
- I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.
- I will let my other health care providers know that I am taking these pain medications and that I have a pain management contract.
- In event of an emergency, I will give this same information to emergency department providers.
- I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.
- I will inform my pain management provider of any new medications or medical conditions.
- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- In addition, I will do the following (Initial each box):

- I must make an appointment with a drug and alcohol counselor and bring proof on working with my treatment plan. (contact number 1 800 562 1240)
- I must take a drug test at (frequency of) _____
- I agree to pill counts to prove I am using my medications correctly
- If I fail a drug test I will take the drug test more often at _____
- If I fail a drug testing I will be referred to the Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (<http://maa.dshs.wa.gov/PRR>)
- If I sell my narcotics my name will be referred to the DSHS fraud unit
- If I fail all of the above I will be discharged from your care with no notice

Should any of the above not show good faith efforts and your provider's feel they can no longer order your pain medications in a safe and effective way you may be notified of discharge from our care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and / or changes in my providers.

Provider: _____ Clinic: _____ Phone Number: _____
Provider: _____ Clinic: _____ Phone Number: _____

Patient Signature _____

Appendix C

COMM™

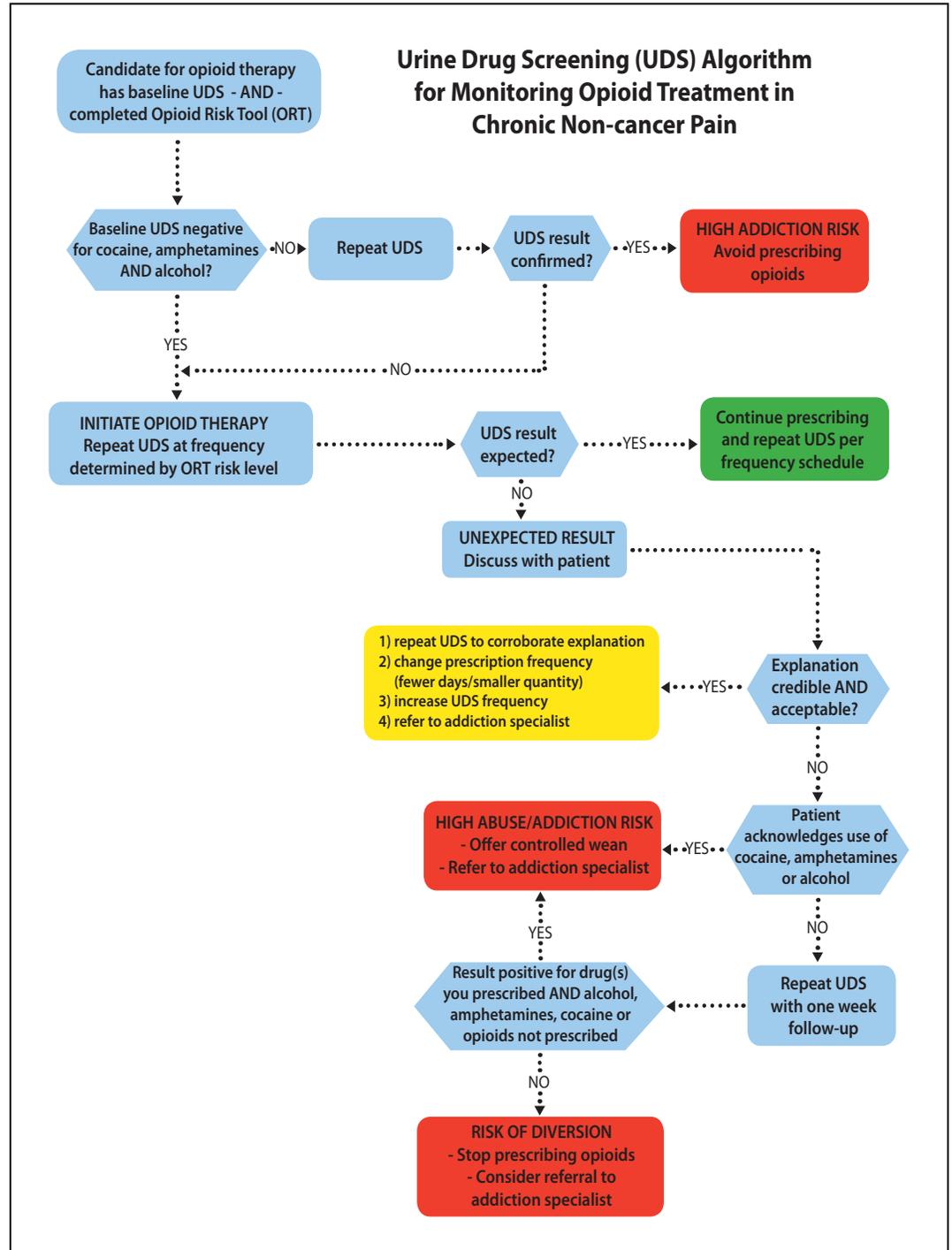
Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	<input type="radio"/>				
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	<input type="radio"/>				
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	<input type="radio"/>				
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	<input type="radio"/>				
5. In the past 30 days, how often have you seriously thought about hurting yourself?	<input type="radio"/>				
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	<input type="radio"/>				
7. In the past 30 days, how often have you been in an argument?	<input type="radio"/>				
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	<input type="radio"/>				
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	<input type="radio"/>				

©2008 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.



Appendix D



Adapted from Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain

- 1 CDC Vital Signs, November 2011, Centers for Disease Control, <http://www.cdc.gov/vitalsigns>
- 2 Analysis of opioid prescription practices finds areas of concern, NIH News, April 5, 2011, <http://www.drugabuse.gov/newsroom/11/NR4-05.html>
- 3 Workers' Compensation on Drugs: Ending the Inappropriate Use of Opioids ©2011 International Association of Industrial Accident Boards and Commissions, <http://www.iaiabc.org/i4a/headlines/headlinedetails.cfm?id=216&pageid=1&archive=0>
- 4 Workers' Compensation on Drugs: Ending the Inappropriate Use of Opioids ©2011 International Association of Industrial Accident Boards and Commissions, <http://www.iaiabc.org/i4a/headlines/headlinedetails.cfm?id=216&pageid=1&archive=0>
- 5 Resources for Understanding and Responding to Opioid Abuse in Workers' Compensation, September 29, 2011, International Association of Industrial Accident Boards and Commissions, <http://www.iaiabc.org/i4a/pages/index.cfm?pageid=3897>
- 6 WCRI Report: Interstate Variations in Use of Narcotics, as reported in Workers Compensation Research Institute Research Bulletin, July 2011
- 7 ACOEM/IAIABC Comment to State WC Officials on Prescription Opioid Abuse in the U.S. , September, 2011, http://www.acoem.org/Comments_PrescriptionOpioidAbuse.aspx
- 8 Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain, 2010 Update, sponsored by the Washington State Agency Medical Directors' Group (AMDG), <http://www.agencymeddirectors.wa.gov/>
- 9 Work Loss Data Institute, Official Disability Guidelines, 2009, <http://www.disabilitydurations.com/>
- 10 Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain, 2010 Update, sponsored by the Washington State Agency Medical Directors' Group (AMDG), <http://www.agencymeddirectors.wa.gov/>
- 11 Dunn KM, Saunders KW, Rutter CM, et.al; Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92.
- 12 CDC Vital Signs, November 2011, Centers for Disease Control, <http://www.cdc.gov/vitalsigns>
- 13 McCarberg B; A Critical Assessment of Opioid Treatment Adherence Using Urine Drug Testing In Chronic Pain Management. Postgraduate Medicine, Vol 123, Issue 6, November 2011.
- 14 Bolen J.; State Opioid Prescribing Policy: New Jersey. Medscape Pharmacists. Accessed 6/10/11. Available at: <http://www.medscape.com/resource/opioid/opioid-newjersey>
- 15 Chronic Pain. Occupational medicine practice guidelines: evaluation and management of common health problems and functional recovery in workers. 2nd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2007.