Opioid/narcotic medications and the injured worker

WorkSafeBC has developed a practice and process for the prescription of opioid/narcotic medications for injured workers—here's what you need to know

In 2007 in British Columbia, more than 1550 injured workers were taking prescribed opioid/narcotic medications—not including Tylenol 3—for longer than 12 weeks postinjury or postsurgery. WorkSafeBC policy limits reimbursement for opioid use to the first 8 weeks postinjury or postsurgery in the majority of cases. Clinical evidence suggests that long-term use of high-dose opioids may be associated with certain risks, including developing tolerance, dependence, and potential addiction, as well as accidental death and heightened pain sensitivity. In addition, long-term use of opioids may not improve physical function or pain management.

Following pain management principles and medical best practices adopted and approved by the College of Physicians and Surgeons of Ontario and adopted by the College of Physicians and Surgeons of BC (*Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain: Reference Guide for Clinicians*), WorkSafeBC has developed a practice and process for the prescription of opioid/narcotic medications for injured workers. One of the goals of the practice initiative is to ensure that WorkSafeBC applies its policy on opioids consistently across the entire province.

The process

In accordance with policy, WorkSafeBC covers the costs of opioid/narcotic medications for injured workers for up to 8 weeks postinjury or postsurgery. However, in special or extenuating circumstances, WorkSafeBC may cover the costs beyond this acute period.

For injured workers who require opioids beyond the 8-week acute period, the process for WorkSafeBC to continue paying for prescribed medications involves both the injured worker and his or her physician.

If your injured worker patient is on opioids 7 weeks postinjury or postsurgery, you will receive two documents:

- D.I.R.E. score reference form—for your use only. This form does not need to be returned to WorkSafeBC, but the actual D.I.R.E. score is required on the form described below. This scoring instrument provides insight as to whether your patient is likely to receive benefit/harm from a trial of opioid treatment for chronic nonmalignant pain.
- Physician Request for Opioid/Narcotic Funding Extension Form (68D80)—for completion and return to WorkSafeBC within 4 weeks.

Payment for the completion and timely return of the Opioid/Narcotic Funding Extension Form (68D80) is under Code 19909, Standardized Assessment Form, and is $75.

If you would like to discuss your patient's condition and treatment, the possible use of therapeutic alternatives, or your concerns that your patient may not be a good candidate for continued use of opioids, please contact the medical advisor listed on the covering letter.

At the same time that you receive the scoring instrument and form, your injured worker patient will receive a letter from WorkSafeBC, enclosing a Worker Opioid/Narcotic Agreement to be signed and returned within 4 weeks if ongoing medication is required. This agreement is between your patient and WorkSafeBC and does not involve you.

If WorkSafeBC has not received the completed forms 4 weeks after they are sent to you and your patient—particularly Form 68D80, which must come from you—the medical advisor will contact you to verify your decision that further opioid medication is not required.

If the signed forms are returned, the medical advisor will contact you to develop an action plan to:

- Continue the medication with a follow-up review at a specified time.
- Wean the worker off the opioids.
- Help the worker make the transition to alternate medication or treatment.
- Discontinue the prescription.

If the agreement between you and the medical advisor is to continue the opioid medication for your injured worker patient, another review will be scheduled for 6 months after the initial prescription. At that time WorkSafeBC's Opioid Team may become involved to develop a further action plan with you, the treating physician, and your injured worker/patient.

The intent of WorkSafeBC's new practice and process for prescription of opioid/narcotic medications is to support physicians in following evidence-based medical best practices to achieve optimum outcomes for injured workers and to ensure that

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Season's Greetings

Season's greetings from all of us to all of you. Have a safe holiday season and a happy, healthy 2009.

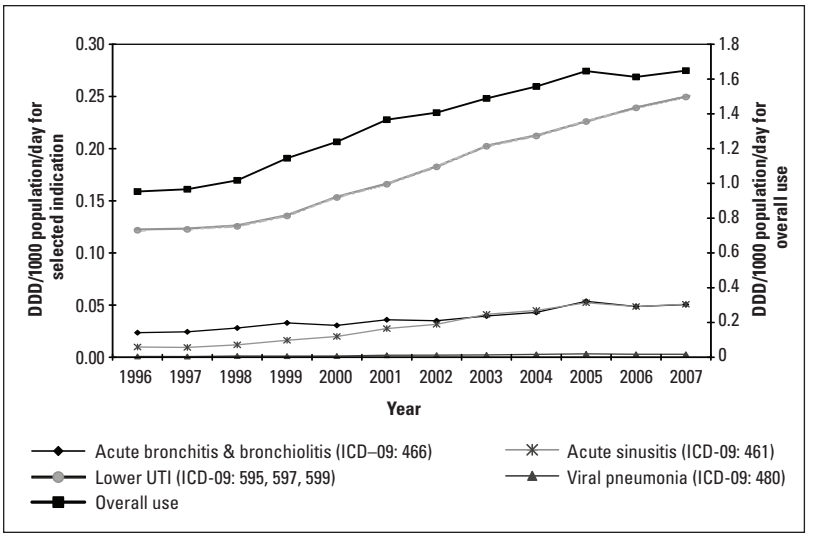

Figure 3. BC consumption of fluoroquinolones for selected indications, 1996–2007.

fluoroquinolones are used for urinary tract infections (**Figure 2** and **Figure 3**).

Although we have shown that overall antimicrobial use has decreased, it is apparent that there is a substantial increase in use of broad spectrum agents, particularly the macrolides and newer fluoroquinolones (levofloxacin and moxifloxacin). As such, we need to focus our efforts to reduce inappropriate use of these agents, in particular through:

- Public education about how certain infections do not require antibiotics.
- Reinforcement of basic infection control practices in the community, such as hand washing.
- Reinforcement among physicians and pharmacists that many classes of infection do not require antibiotics to resolve and that first line (e.g., simple beta-lactam) antibiotics are an appropriate first step in managing many community-acquired infections.

References

1. Wise R, Hart T, Cars O, et al. Antimicrobial resistance. BMJ 1998;317:609-610.
2. Bergman H, Huikko S, Pihlajamaki M, et al. Effect of macrolide consumption on erythromycin resistance in *Streptococcus pyogenes* in Finland in 1997–2001. Clin Infect Dis 2004;38:1251-1256.
3. Bronzwaer SL, Cars O, Buchholz U, et al. A European study on the relationship between antimicrobial use and antimicrobial resistance. Emerg Infect Dis 2002;8:278-282.
4. Goossens H, Ferech M, Vander Stichele R, et al. The ESAC Project Group. Outpatient antibiotic use in Europe and the association with resistance: A cross-national database study. Lancet 2005; 365:579-587.

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in-law are expecting their first baby in early December—this first Christmas as a grandparent is a long-awaited milestone. So I am both thankful and grateful for all that I have. And I hope all of you find the opportunity to reflect and realize all that you have to be thankful for. From my family to yours, I wish you all a happy and safe holiday season.

—Bill Mackie, MD
BCMA President

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an EMR through the PITO program receive assistance through the Implementation and Transition Support Program and one-on-one support from a local relationship manager and a local physician champion to capitalize on their experience to help make their EMR implementation successful.

Most of all, as Drs Wong and Simkus found, physicians can increase the probability for a successful EMR transition by including all of the stakeholders—MOAs, office managers, receptionists, even patients. Threats from change can be quickly turned into opportunities with a collaborative approach from the start.

—Jeremy Smith
PITO Program Director

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12. Safe Kids Canada. Safe Kids Canada's Position Statement on Bike Helmet Legislation. 2005. www.sickkids.ca/SKCPublicPolicyAdvocacy/custom/BikeLegislationPositionStatement.pdf (accessed 6 November 2008).
13. Fewer kids died in bike accidents after law enacted. The Canadian Press/CTV 2 September 2008. www.ctv.ca/servlet/ArticleNews/story/CTVNews/20080902/bike_deaths_080902/20080902?hub=Health (accessed 6 November 2008).

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injured workers throughout British Columbia receive consistent service from WorkSafeBC.

If you have any questions or concerns regarding opioid/narcotic prescriptions for your injured worker patient, please call your local WorkSafeBC office and speak to a medical advisor.

—Peter Rothfels, BEd, MD, ASAM
WorkSafeBC Director of Clinical Services
Chief Medical Officer