Washington State Department of
Labor & Industries

Guideline for Prescribing Opioids to Treat Pain in Injured Workers

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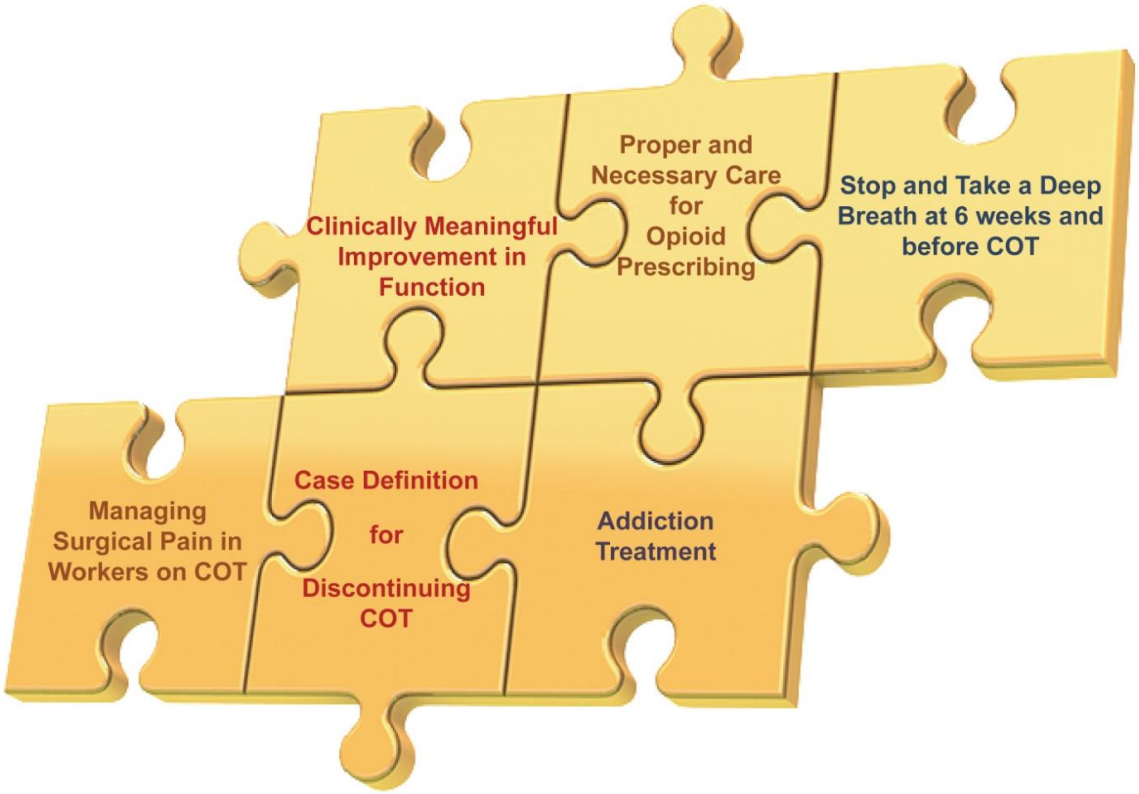

Office of the Medical Director

Washington State Department of Labor & Industries

Medical Treatment Guidelines

Guideline for Prescribing Opioids to Treat Pain in Injured Workers

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I. Executive Summary

- The DOH pain management rules, 2010 AMDG Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain, and this Supplement are reflective of the practice standard for prescribing opioids for a work-related injury or occupational disease.
- Effective use of opioids must result in clinically meaningful improvement in function. Continuing to prescribe opioids in the absence of clinically meaningful improvement in function or after the development of a severe adverse outcome is not proper and necessary care in the Washington State workers' compensation system (Section III. Opioid Use in Worker's Compensation).
- Chronic opioid therapy (COT) should not be prescribed in the presence of current substance use disorder (excluding nicotine) and cautiously if there is past substance use disorder (Section IV. Opioid Prescribing Precautions).
- The department or insurer will cover opioids for up to 6 weeks when prescribed to treat acute injury or after surgery (Section V. Prescribing Opioids for a Work-related Injury or Occupational Disease).
- Use of chronic opioid therapy requires regular monitoring and documentation, such as screening for risk of co-morbid conditions with validated tools, checking the Prescription Monitoring Program database, assessing clinically meaningful improvement in function and administering random urine drug tests (Section V. Prescribing Opioids for a Work-related Injury or Occupational Disease).
- Workers on chronic opioid therapy who are undergoing elective surgery are more likely to encounter difficulty with post-op pain control (Section VI. Managing Surgical Pain in Workers on COT):
  - Obtain an early consult with anesthesiologist to develop a coordinated pain management plan, including opioid taper after surgery and discuss expectations with the worker.
  - Avoid escalating opioid dose or adding new benzodiazepines or sedative-hypnotics before surgery.
  - Do not prescribe long-acting or extended-release opioids for post-op pain.
  - Most patients should be back to their pre-operative dose of opioids or lower by six weeks after surgery.
- Discontinue opioids if treatment has not resulted in clinically meaningful improvement in function, or the worker has experienced a severe adverse outcome or overdose event. In most cases, tapering can be done by the AP in a community setting. Workers with mental health or substance use disorder may require special care (Section VII. Discontinuing COT).

II. Introduction and Purpose

The Washington State Department of Labor & Industries (L&I, or the department) is officially adopting the *Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain* as developed by the Agency Medical Directors' Group (AMDG Guideline) and revised in June 2010 [1]. The AMDG Guideline represents the best practices and universal precautions necessary to safely and effectively prescribe opioids to treat patients with chronic non-cancer pain [2].

This guideline is a supplement to both the AMDG Guideline and the Department of Health's (DOH) pain management rules, and provides information specific to treating injured workers covered by Washington State workers' compensation [3]. Both the AMDG Guideline and this guideline are intended for use by health care providers, the department, insurers, and utilization review staff.

This guideline was developed in 2011-2012 by the Industrial Insurance Medical Advisory Committee (IIMAC) and its subcommittee on chronic non-cancer pain. It is based on the best available clinical and scientific evidence from a systematic review of the literature and a consensus of expert opinion. The IIMAC's primary goal is to provide standards that ensure the highest quality of care for injured workers in Washington State.

III. Opioid Use in Workers' Compensation

Prevalence

Over the past decade, there has been a dramatic increase in the use of opioids to treat chronic non-cancer pain. Among the workers' compensation population nationally, the prevalence of opioid use is approximately 32% [4]. In Washington, 42% of workers with compensable back injuries received an opioid prescription in the first year after injury, most often at the first medical visit for the injury. Sixteen percent of those workers were still receiving opioids one year after injury [5].

Opioids are also being prescribed in stronger potencies and larger doses for musculoskeletal injuries [4, 6, 7]. The most potent class of opioids, Schedule II, accounted for 43% of all opioid prescriptions in WA workers' compensation in 2008, compared with 19% in 1996 [8]. During this same time frame, the average morphine equivalent dose (MED) of Schedule II long-acting opioids rose from 88 mg/day to 132 mg/day [6, 8]. The average dose remained relatively steady through 2008, then declined, likely related to the publication of the AMDG Guideline [9].

Impact on Recovery

In some cases, the use of opioids for work-related injuries may actually increase the likelihood of disability. Receiving more than a one week supply of opioids or two or more opioid prescriptions soon after an injury doubles a worker's risk of disability at one year post-injury, compared with workers who do not receive opioids [10]. Other states have seen similar outcomes, including correlation between large dose escalations and increasing duration of time loss [6, 11, 12]. Evidence-based guidelines on the management of acute low back pain recommend conservative initial therapies (e.g. acetaminophen or non-steroidal anti-inflammatory drugs), rather than opioids in almost all cases [13, 14].

Opioid-related Adverse Outcomes

In addition to the risk of mortality, chronic opioid therapy (COT) is associated with significant risk of non-fatal adverse outcomes. Chronic opioid therapy may result in tolerance to its analgesic effects. The traditional prescribing practice was to use escalating doses to overcome this effect. However, evidence is accumulating that chronic, high-dose opioid use may lead to the development of abnormal pain sensitivity (opioid-induced hyperalgesia) [15]. Dose escalation that does not improve pain and function can lead to increased risk for severe adverse outcomes. These include inhibition of endogenous sex hormone production, neonatal abstinence syndrome, central sleep apnea, opioid use disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders V or DSM-V at **www.dsm5.org/Pages/Default.aspx**), overdose and death.

Measuring the Impact of Opioid Use

Beyond the acute phase, effective use of opioids should result in **clinically meaningful improvement in function (CMIF)**. Providers should track function and pain on a regular basis, using the same validated instruments at each visit, to consistently determine the effect of opioid therapy. The department endorses the Two Item Graded Chronic Pain Scale [16] as a quick, two-question tool to track both function and pain when opioids are prescribed (see AMDG Guideline, Appendix C at **http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf**).

CMIF is defined as an improvement in function of at least 30% as compared to the start of treatment or in response to a dose change [17, 18]. **A decrease in pain intensity in the absence of improved function is not considered CMIF.**

Other validated instruments may also be used to measure functional improvement (see AMDG Guideline, Tools for Assessing Function and Pain at **http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf**. The American Chronic Pain Association has created a 10-item Quality of Life Scale for people with pain, which helps correlate the Graded Chronic Pain Scale with actual daily activities [19]. Use of the PROMIS web-based tool (**www.nihpromis.org/**) may also be helpful in determining the effectiveness of COT. **Ultimately, effective COT should result in improved work capacity or the ability to progress in vocational retraining.**

Evaluation of clinically meaningful improvement should occur at three critical decision-making phases:

1. At the end of the acute phase (about 6 weeks following injury or surgery), to determine whether continued opioid therapy is warranted in the subacute phase.
2. At the end of the subacute phase (3 months following injury), to determine whether to prescribe COT.
3. Periodically during COT, to assess impact on function and risk of therapy.

Continuing to prescribe opioids in the absence of clinically meaningful improvement in function or after the development of a severe adverse outcome is not considered proper and necessary care in the Washington State workers' compensation system. In addition, the use of escalating doses to the point of developing opioid use disorder is not proper and necessary care.

IV. Opioid Prescribing Precautions

Opioid Use with Co-morbid Substance Use or Mental Health Disorders

Managing pain in workers with complex medical conditions such as substance use disorder or a mental health condition can be a challenge. Research has shown that patients with substance use or psychiatric disorders, or both, are actually more likely than patients without these disorders to receive COT [20]. They are also more likely to have complications such as misuse, abuse or overdose [21, 22]. Adults with a history of depression, alcohol or other non-opioid drug abuse or dependence are three to five times more likely to receive COT [23]. In addition, nicotine dependence is associated with a greater likelihood of using opioids and at higher doses [24].

Among adults with chronic pain, COT use is increasing more rapidly in those with mental health and substance use disorders than in those without these diagnoses. These patients are also more likely to receive Schedule II opioids, to receive opioids at higher dosage levels, and to be prescribed sedative-hypnotic medications on a chronic basis, than those without mental health or substance use disorders [25].

High-risk COT prescribing practices (high opioid dose, extended COT duration, concurrent use of sedatives/hypnotics) are associated with increased risks of opioid overdose and serious fractures [26, 27]. Unfortunately, patients who receive high-risk COT are also more likely to have high-risk characteristics, including younger age, history of substance abuse and mental disorder and presence of opioid misuse [28].

Because of the increased risk for adverse outcomes from the use of COT in patients with mental health disorders, such as borderline personality disorder, mood disorders (e.g. depression, bipolar disorder, anxiety, post traumatic stress disorder or PTSD) or psychotic disorders, providers should be cautious when prescribing COT for workers with these co-morbid conditions. Furthermore, workers with current substance use disorders as defined by DSM (excluding nicotine) should not receive COT. Workers with a history of opioid use disorder should only receive COT under exceptional circumstances.

Drugs and Drug Combinations to Avoid

DO NOT USE:

- Parenteral opioids in an outpatient setting.
- Meperidine for chronic pain.
- Methadone for acute or break-through pain.
- Long-acting or extended-release opioids (e.g. Oxycontin®) for acute pain or post-operative pain in an opioid-naive worker.

Use is NOT RECOMMENDED:

- Carisoprodol (Soma®)
- Any combination of opioids with benzodiazepines, sedative-hypnotics or barbiturates. *There may be specific indications for such combinations, such as the co-existence of spasticity. In such cases, a pain specialist consultation is strongly recommended. Consider alternatives such as tricyclic antidepressants or antihistamines to manage insomnia.*

Use with CAUTION:

- Over-the-counter acetaminophen with acetaminophen combination opioids (e.g. Vicodin®, Norco®, Percocet®, Endocet®, Ultracet®).
- Tramadol or meperidine in patients at risk for seizures or who are taking drugs which can cause seizures (e.g. bupropion, serotonin reuptake inhibitors, tricyclic antidepressants).
- Methadone for pain (see box warning below). Due to methadone's nonlinear pharmacokinetics, unpredictable clearance and multiple drug-drug interactions, providers should use extreme caution when prescribing this drug for pain. Additional information is available at **www.agencymeddirectors.wa.gov/**.

Prescribing methadone is complex. To prevent serious complications from methadone, prescribers should read and carefully follow the methadone (Dolophine®) prescribing information at www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm.

Deaths, cardiac and respiratory, have been reported during initiation and conversion of pain patients to methadone treatment from treatment with other opioid agonists. It is critical to understand the pharmacokinetics of methadone when converting patients from other opioids.

Respiratory depression is the chief hazard associated with methadone administration. Methadone's peak respiratory depressant effects typically occur later, and persist longer than its peak analgesic effects, particularly in the early dosing period. These characteristics can contribute to cases of iatrogenic overdose, particularly during treatment initiation and dose titration.

In addition, cases of QT interval prolongation and serious arrhythmia (torsades de pointes) have been observed during treatment with methadone. Most cases involve patients being treated for pain with large, multiple daily doses of methadone, although cases have been reported in patients receiving doses commonly used for maintenance treatment of opioid addiction.

Methadone treatment for analgesic therapy in patients with acute or chronic pain should only be initiated if the potential analgesic or palliative care benefit of treatment with methadone is considered and outweighs the risks.

V. Prescribing Opioids for a Work-related Injury or Occupational Disease

Opioids in the Acute Phase (0 to 6 weeks after injury or surgery)

In general, opioid use for acute pain should be reserved for post surgery, for the most severe pain (e.g. pain scores ≥ 7), or when alternative treatments such as NSAIDs and non-pharmacological therapies are ineffective**. Evidence does not support the use of opioids as initial treatment for back sprain or other strains, but if they are prescribed, use should be limited to short-term (e.g. ≤ 14 days).**

Pain intensity and pain interference should decrease during the acute phase as part of the natural course of recovery following surgery or most injuries. Resumption of pre-injury activities, such as return to work, should be expected during this period. **If use in the acute phase (0-6 weeks) does not lead to improvements in pain and function of at least 30%, or to pain interference levels of 4 or less, continued opioid use is not warranted.**

L&I or insurer may cover opioids for up to 6 weeks when prescribed to treat pain from the acute injury or after surgery.

Preliminary data from the Prescription Monitoring Program (PMP) has suggested that substantial numbers of newly injured workers received opioids or other controlled substances in the 60 days prior to injury. For this reason, providers should check the PMP prior to prescribing opioids for new injuries or occupational diseases.

Providers should:

- **Obtain baseline measures of pain and pain interference (function) within 2 weeks of filing a claim.**
- **Inform the worker that L&I or insurer will not pay for opioids beyond 6 weeks in the absence of clinically meaningful improvement in function.**
- Help the worker set reasonable expectations about their recovery and return to work.
- Talk to the worker about safe storage and disposal of opioids and other controlled substances.
- Prescribe opioid(s) in multiples of 7-day supply to reduce the incidence of supply ending on a weekend.
- Document clinically meaningful improvement in function and pain with treatment.
- Explore non-opioid strategies to treat pain, including early activation.
- Use urine drug tests, the state's PMP and other screening tools in the AMDG Guideline to ensure controlled substances history is consistent with prescribing record and worker's report.
- Determine pre-injury use of controlled substances and help the worker understand that L&I or insurer is not responsible for non-work-related treatment and conditions.
- **Taper the worker off of opioids by 6 weeks.**
- Request opioid authorization no later than 4 weeks post injury if continued opioid use is anticipated beyond 6 weeks to avoid abrupt cessation. See "subacute phase" below for authorization procedures.

Opioids in the Subacute Phase (between 6 and 12 weeks)

With some exceptions, resumption of pre-injury activities such as return to work should be expected during this period. Use of activity diaries is encouraged as a means of improving patient participation and investment in recovery. Non-pharmacological treatments such as cognitive-behavioral therapy, activity coaching, and graded exercise are also encouraged [13, 29]. If the injury is a sprain or strain, opioid use beyond the acute phase is rarely indicated.

If opioids are to be prescribed for longer than 6 weeks, the provider must seek authorization. With the exception of catastrophic injuries, the provider must perform the following best practices before L&I or insurer can authorize payment for opioids beyond the acute phase:

- Access the state's PMP to ensure that the controlled substance history is consistent with the prescribing record and worker's report.
- Document clinically meaningful improvement in function and pain with acute use.
- Screen worker for depression (e.g. PHQ-9 or other validated tools) to identify potential comorbid conditions which may impact response to opioid treatment. If the worker's history suggests PTSD, administer the 4-item PC-PTSD screen (**www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf**).
- Screen for opioid risk (e.g. Opioid Risk Tool, SOAPP-R, DIRE, or CAGE-AID). If the worker has current substance use disorder (excluding nicotine) or a history of opioid use disorder, opioid use beyond the acute phase is rarely indicated.
- Administer a baseline urine drug test (UDT). If results reveal "red flags" such as the *confirmed* presence of cocaine, amphetamines or alcohol, opioid use beyond the acute phase is not indicated (see AMDG Guideline, Appendix D at **http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf**). Unless cannabis use disorder is diagnosed, the presence of cannabis on a UDT does not preclude the use of opioids.
- Re-examine and consider discontinuation or taper of concurrent sedative-hypnotics and/or benzodiazepines.

During the subacute phase, providers should review the effects of opioid therapy on pain and function to determine whether opioid therapy should continue. Opioids should be discontinued during this phase if:

- There is no clinically meaningful improvement in function when compared to function measured during the acute phase.
- Treatment resulted in a severe adverse outcome.
- Worker has a current substance use disorder (excluding nicotine).
- Worker has a history of opioid use disorder (with rare exceptions).

Opioids in the Chronic Phase

If opioids are to be prescribed beyond 12 weeks post-injury or post-surgery, the provider **must** have received prior authorization from the department. With the exception of catastrophic injuries, the provider must document the following before L&I or insurer can authorize payment for opioids during the chronic phase:

- Clinically meaningful improvement in function (≥ 30%) has been established with opioid use in the acute or subacute phase.
- Failure of trials of reasonable alternatives to opioids.
- Signed treatment agreement (pain contract).
- A time-limited treatment plan, addressing whether chronic opioid therapy is likely to improve the worker's vocational recovery (e.g. work hardening, vocational services).
- Consultation with a pain management specialist if the worker's dose is above 120mg/d morphine equivalent dose (MED) and there is no CMIF. Additional appropriate consultations are recommended if the worker has a co-morbid substance use or poorly controlled mental health disorder.
- Worker has no contraindication to the use of opioids.
- No evidence or likelihood of having serious adverse outcomes from opioid use.

During the chronic phase, providers should routinely review the effects of opioid therapy on function to determine whether opioid therapy should continue. COT focused only on reducing pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life. Prescribers should also continue to check the PMP and administer UDTs based on risk, in accordance with AMDG recommendations and DOH regulations. Because COT is associated with substantial risk for harm, opioid prescribing or dose increases that do not result in CMIF is considered not proper and necessary in the Washington State workers' compensation system.

Continued coverage of COT will depend on the prescriber documenting the following:

- CMIF is maintained, or pain interference with function score is ≤ 4 with stable dosing. If COT dose is increased, CMIF must be demonstrated in response to the dose change.
- A current signed treatment agreement.
- Worker has no relative contraindication to the use of opioids.
- No evidence of serious adverse outcomes from opioid use.
- Consultation with a pain management specialist if the worker's dose is above 120mg/d MED and there is no CMIF. Additional appropriate consultations are recommended if the worker has a co-morbid substance use or poorly controlled mental health disorder.
- No aberrant behavior is identified by PMP or UDT.

Prescribers should discontinue opioids and L&I or insurer will not pay for opioids if all the above criteria are not met. Please see Section VII for discontinuing opioids.

Opioids for Catastrophic Injuries

Catastrophic injuries such as severe burns, crush or spinal cord injury in which significant recovery of physical function is not expected are exempt from the above coverage criteria. For catastrophic injuries, the department or insurer may cover COT when the prescriber has documented the following:

- A current signed treatment agreement.
- Stable opioid dose at or below 120mg/d MED.
- When opioid dose is above 120mg/d MED, a consultation with a pain specialist before further dose escalation.
- Worker has no relative contraindication to the use of opioids.
- No evidence of serious adverse outcomes from opioid use.
- No aberrant behavior identified by PMP or UDT.

VI. Managing Surgical Pain in Workers on COT

Managing pain in workers on COT who are undergoing elective surgeries presents unique challenges and requires a coordinated treatment plan for pain management prior to surgery. This requires a collaborative effort involving the surgeon, anesthesiologist, pain management specialist, attending provider (AP) and the worker.

In general, patients on COT will report higher pain scores and manifest more anxiety than other patients [30, 31]. They will also likely require higher opioid doses in the intra and post-operative period. COT patients undergoing surgery have more frequent and more deadly respiratory depressive episodes than opioid-naïve patients [30].

Based on the lack of evidence, there is no consensus on whether or not to taper chronic opioids before elective surgery.

A pre-operative evaluation is recommended, preferably by an anesthesiologist, one to two weeks prior to surgery. This should include the worker's current opioid dose (both prescribed and actually taken) and a thorough medical history that includes mental health and substance use disorder information. Accurate dosage information is especially important for planning peri-operative pain management, yet only 9% of patients taking opioids preoperatively have dosage information in the chart [30]. The evaluator should also check the opioid prescribing history in the PMP. The following recommendations will help manage the workers' pain and minimize their risk associated with surgery.

Before Surgery (pre-operatively), the surgeon and AP should:

- Have a coordinated treatment plan for managing surgical pain, including identifying the post-operative opioid prescriber.
- Obtain a pre-operative anesthesia consult, as above. Workers on buprenorphine need special anesthesia care and should have a consult at least 2 weeks before surgery.

- Access the PMP and review the worker's controlled substance history to get accurate information on opioid dose and concurrent medication use. Provider should discuss any apparent discrepancies with the worker.
- Prepare the worker for elective surgery by setting appropriate expectations for pain management. Workers need reassurance that their pain management needs will be met, and they need to know that their opioid use is expected to return to the pre-operative dose, or less, following surgery.
- Consider an opioid taper, but this is not required. Avoid escalating opioid dose before surgery.
- Avoid prescribing new benzodiazepines or sedative-hypnotics.
- Consider a consult with a pain management specialist before surgery for workers on high dose opioids or who have co-morbid mental health or substance use disorder.

Day of Surgery (intra-operatively), the anesthesiologist should:

- Use anti-inflammatories, acetaminophen or both, if not contraindicated.
- Continue pre-operative opioids to decrease the risk of withdrawal symptoms and use regional blocks, if appropriate.
- Consider the use of other non-opioid analgesic adjuncts (e.g. gabapentin, ketamine or lidocaine) for opioid sparing effects.

After Surgery (post-operatively), the surgeon or hospitalist and AP should:

- Continue pre-operative opioids, with extra analgesia for acute pain via patient-controlled analgesia (PCA) while hospitalized.
- Use care when transitioning from PCA to oral opioids. DO NOT perform a "straight" conversion from IV to oral opioid because of a lack of complete cross-tolerance.
- Expect the worker to need more time than other patients to stabilize pain control after transitioning to oral opioids.
- **Discharge the worker on the same pre-operative opioid regimen and only supplement with short-acting (not extended-release) opioids for post-operative pain.**
- Do not prescribe long-acting or extended-release opioids for post-operative pain unless the worker was previously maintained on these drugs.
- Avoid new sedative-hypnotics and benzodiazepines.
- Taper total opioids to pre-operative dose or lower by 6 weeks.
- A specialist may be needed for workers on high dose opioids or who have co-morbid mental health or substance use disorder.

VII. Discontinuing COT

Safety and efficacy of long-term opioid use, particularly in the injured worker population, have not been established. Discontinuation of opioids frequently improves function and quality of life and usually does not lead to increased pain levels [32]. **In most cases, it is best to taper opioids off completely**.

Case Definition – When to Discontinue COT

- Worker or AP requests opioid taper OR
- Worker is maintained on opioids for at least 3 months and there is no sustained CMIF, as measured by validated instruments OR
- Worker's risk from continued treatment outweighs benefit OR
- Worker has experienced a severe adverse outcome or overdose event OR
- Evidence of aberrant behavior (inconsistent urine drug test result, lost prescriptions, multiple requests for early refills, multiple prescribers, unauthorized dose escalation, apparent intoxication, etc.) OR
- Use of opioids is not in compliance with DOH's pain management rules, L&I's rules, AMDG Guideline or L&I's Guideline for Prescribing Opioids to Treat Pain in Injured Workers**.**

STEP 1: Discontinuing Opioids in a Community Care Setting

In most cases, workers who are not on chronic high dose opioids or who do not have comorbid substance use disorder or a significant mental health disorder, may be tapered in a straightforward manner. A gradual taper of approximately 10% per week (see AMDG Guideline, Tapering or Discontinuing Opioids and Appendix H at **http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf**) can be carried out by the attending provider. Adjuvant agents like clonidine and psychological support such as cognitive behavioral therapy can be provided to assist with the taper process. The department or insurer may also authorize temporary coverage of buprenorphine or buprenorphine/naloxone to assist with the tapering process (see L&I coverage policy) [33]. The AP may also seek consultative assistance from a pain management specialist.

STEP 2: Discontinuing Opioids in an Intensive Setting

For those workers who have failed step 1 or who are at high risk for failure due to high dose, concurrent benzodiazepine use, or co-morbid substance use or mental health disorder, the prescriber should consider seeking consultative assistance from a pain management specialist, a structured intensive multidisciplinary program (SIMP) provider or addiction medicine specialist. Adjuvant agents and psychological support can be provided to assist with the taper process. The department or insurer may also authorize temporary coverage of buprenorphine or buprenorphine/naloxone to assist with the tapering process (see L&I coverage policy). In these situations, formal inpatient detoxification and/or a 4-week SIMP treatment program may be required.

Due to the lack of high quality evidence of safety and comparative efficacy, ultra rapid detoxification (e.g. within three days), using antagonist drugs with or without sedation, will not be covered.

Additional Services

If a worker has failed Steps 1 and 2, **AND** meets the DSM-V criteria for opioid use disorder, the department or insurer may cover up to six months of addiction treatment through a licensed chemical dependency treatment center as an aid to recovery. A list of treatment centers certified by the Division of Behavior Health and Recovery is available at **www.dshs.wa.gov/dbhr/dadirectory.shtml**.

L&I may authorize payment for addiction management as an aid to recovery if the following conditions are met:

- Steps 1 and 2 above have failed.
- Opioid use disorder is diagnosed and identified as a barrier to recovery.
- Provider has documented how temporary treatment of condition will allow significantly improved work capacity and/or the ability to progress in vocational retraining.
- Provider has submitted a time-limited treatment plan.

There are several treatment options available for opioid use disorder. A combination of medication and behavioral therapies has been found to be most successful (SAMSHA Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Program **www.kap.samhsa.gov/products/trainingcurriculums/pdfs/tip43_curriculum.pdf**). The department or insurer may temporarily pay for medication to treat opioid use disorder only if the worker is enrolled in a state-certified chemical dependency treatment program and maintains compliance with treatment recommendations and department requirements.

Treatment Options for Opioid Use Disorder:

- Medication assisted treatment
  - Buprenorphine (Subutex®, Suboxone®)
  - Methadone
  - Naltrexone (Depade®, Revia®, Vivitrol®)
- Drug-free outpatient treatment
- Residential treatment

VIII. Summary

Over the past decade, there has been a dramatic increase in the use of opioids to treat chronic non-cancer pain. Opioids are also being prescribed in stronger potencies and larger doses for musculoskeletal injuries. In some cases, the use of opioids for work-related injuries may actually increase the likelihood of disability. Chronic use of opioids is strongly associated with the occurrence of dependence, particularly in the presence of co-morbid mental health conditions. In addition to the risk of mortality, chronic opioid therapy is associated with significant risk of non-fatal adverse outcomes. Because of all these potential risks, this guideline focuses on carefully assessing the risk/benefit of prescribing opioids for injured workers, particularly if they are being considered for chronic (> 3 months) use. In addition, this guideline provides guidance on peri-operative use of opioids, an algorithm for tapering chronic opioid therapy, and a clear definition of meaningful improvement in function.

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IIMAC Committee Members	Subcommittee Clinical Experts	Consultants
David Tauben MD – Chair	Jane Ballantyne MD	Mario DePinto MD
Andrew Friedman MD	Daniel Brzusek DO	Joseph Merrill MD
Mark Sullivan MD PhD	Heather Kroll MD	Andrew Saxon MD
Gerald Yorioka MD	Niriksha Malladi MD	Wyndam Strodtbeck MD
	Linina Ragan ARNP	Greg Terman MD
	Jim Robinson MD PhD	Dennis Turk MD
		Michael Von Korff ScD

Department staff that helped develop and prepare this guideline include:

Teresa Cooper BSN, Occupational Nurse Consultant
Gary M. Franklin MD MPH, Medical Director
Lee Glass MD JD, Associate Medical Director
Simone P. Javaher BSN MPA, Occupational Nurse Consultant
Reshma N. Kearney MPH, Epidemiologist
Jaymie Mai PharmD, Pharmacy Manager
Marie Manteuffel PharmD MPH, Medical Program Specialist
Hal Stockbridge MD MPH, Associate Medical Director

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