New Year, New Ideas

What is influencing workers’ compensation in 2018?

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About the IAIABC

The IAIABC finds solutions to reduce harm and aid recovery from occupational injury and illness.

IAIABC is the largest trade association of workers’ compensation jurisdictional agencies in North America. Along with these government entities, various private organizations involved in the delivery of workers’ compensation coverage and benefits participate in the IAIABC.

Since it was founded in 1914, the International Association of Industrial Accident Boards and Commissions, or IAIABC, has been providing information and education on workers’ compensation policy, regulation, and administration.

Perspectives

The goal of this publication is to provide various perspectives on contemporary workers’ compensation topics and to promote discussion and sharing of ideas. The IAIABC’s Perspectives digital magazine is published quarterly.
As a child of the 1980’s (80’s) and a product of the 80’s culture, I gravitate toward most things of that era. I just can’t get rid of my 80’s playlist and I’m the first to sign up for that “Totally Rad 80’s” fun run for the opportunity to dress up in bright neon colors and wear leg warmers. What a sight!

Not unlike the significance of the 80’s and the influence it has in my world, there are several issues in the workers’ compensation world that have such impact and implication for 2018 and beyond. In our last issue of Perspectives, we asked our readers: “What issues/events/legislation will influence workers’ compensation in 2018?” Not surprising, the responses were topics that have been in the forefront of workers’ compensation news articles and seminars across the country. Issues concerning constitutional challenges to the workers’ compensation system as we’ve known it for the past 30+ years, as well as drug formularies, opioid abuse, and the gig economy.

In this issue we will revisit some of these very important topics. We will hear from the Honorable Wesley G. Marshall who provides insight into the current constitutional challenges and what events sparked recent lawsuits. Next, we’ll read about changes in opioid treatment guidelines in the state of California which focuses on combatting the chronic use of opioids. In his article, Dr. Raymond Meister explains the significance of the first three days of opioid use.

We’ll also hear from Peter Rousmaniere who writes on the inequities felt by the injured worker and illustrates the need for change in the current workers’ compensation system. Here we are reminded of the constitutional challenges to our world of workers’ compensation and the call for new legislation to address these concerns.

Also in this issue we visit with Michael Coupland who covers a genuine issue of concern for many injured workers: Post Traumatic Stress Disorder (PTSD). We hear about this condition more and more in current workers’ compensation claims most associated with first responders and some developed due to the advent of active violence in the workplace. Are some people more susceptible to PTSD than others?

Lastly, we have a conversation with Dr. Christopher Grubb, a pain management specialist who answers our questions on current changes to treatment for patients in need of pain relief and the prescription of opioid-based medication. Dr. Grubb answers a question on opioid public policy/legislation and offers his insight on the 3-day limit placed on opioid prescriptions in those states that have enacted such legislation. Also addressed in this conversation is Dr. Grubb’s take on addiction and misuse by injured workers and why this group may be more susceptible to developing an addiction or engage in misuse.

These topics have showered the headlines as different states tackle issues one by one and our workers’ compensation community has kept track with great interest. As you read this issue, we invite you to respond to any of the articles at perspectives@iaiabc.org and give us your perspective.

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Modern Constitutional Challenges to Workers’ Compensation Systems

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In accordance with Canon 2B of the Canons of Judicial Conduct for the State of Virginia, any opinions in this presentation are those of the author, they are personal, and they are not official opinions of the Virginia Workers’ Compensation Commission or any other court or governmental agency.

Over the past three years, state workers’ compensation systems in the United States have faced constitutional challenges that are unprecedented in recent times. These challenges ran parallel to other dialogues: critical attention from the federal government and serious criticism from the media. They occurred in an environment of experimentation, change and introspection by legislators, regulators, and stakeholders. The trend of constitutional challenges reflects strains and imbalances in America’s state workers’ compensation systems.

A Quick Look Backwards

Workers’ compensation laws were a product of industrialization in the Gilded Age. America’s founding fathers, raised in an agrarian economy, could hardly have anticipated the need for a social welfare Grand Bargain that traded unpredictable tort liability for fast and fixed, but limited wage replacement and medical benefits. In a discussion of property rights, Thomas Jefferson commented, “our ancestors . . . were labourers, not lawyers.” Adoption of workers’ compensation systems tweaked the tort system. The new laws granted employers immunity from liability and removed fault from the test for compensability. Swift and sure, but limited, compensation for injured workers counterbalanced these concessions.

The first workers compensation statutes enacted in the United States failed to pass constitutional muster. Many believed the United States Supreme Court’s narrow interpretation of the Commerce Clause of the United States Constitution would foreclose comprehensive workers’ compensation laws. Attempts to enact laws in New York and Maryland failed. But in New York Central Railroad v. White, the United States Supreme Court gave a green light, holding New York’s workers’ compensation law did not violate due process or equal protection of the laws. Most states had begun enacting comprehensive workers’ compensation laws, and White both validated and accelerated that trend.

In 1925, the United States Supreme Court decided Yeiser v. Dysart. That case challenged the regulation of claimants’ attorney fees under the Nebraska workers’ compensation act. The appellant, an attorney, argued the state’s limitation on fees unreasonably restricted his right of contract and deprived him of due process of law under the Fourteenth Amendment. Justice Holmes, writing for the Court, flatly rejected that notion, indicating the state’s regulation of attorney’s fees bore a rational relation to its exercise of police power.

Similarly, State laws were challenged constitutionally on various grounds in the first couple of decades of the twentieth century, but generally were upheld. After interest grew in a predictable system to address the uncertainties of workplace injuries, the constitutional problems dissipated. In his seminal workers’ compensation treatise, Professor Larson states:

At the present time, with the constitutionality of all types of compensation acts firmly established, there is no practical purpose to be served by tracing out the elaborate and violent constitutional law arguments provoked by the early acts. This is not to say that there has been a lack of constitutional issues raised since then; indeed, the Index will show over 150 entries under the heading of “Constitutionality.” But, with rare
exceptions, these have involved the constitutionality not of the basic system, but of detailed amendments or specific features. Here again, with rare exceptions, the constitutional attacks have been unsuccessful.

Recent Constitutional Challenges

Courts in several states have considered challenges to the bedrock concepts of state workers’ compensation systems. These include the “Grand Bargain” of limited but prompt benefits for injured workers in exchange for employer immunity from tort liability.

Miami Heat: Constitutional Challenges in Florida

Florida has been a hotbed of constitutional challenges to workers’ compensation laws in recent years. In Castellanos v. Next Door Company, the Florida Supreme Court in April 2016 held the state’s mandatory fee schedule provision for workers’ compensation cases was unconstitutional under the Florida and United States Constitutions. By creating an irrebuttable presumption which declared statutory fee amounts were reasonable, and by omitting any mechanism to refute them, the statute denied due process. The Court noted while workers’ compensation systems were intended to be prompt and efficient, “in reality, the system has become increasingly complex to the detriment of the claimant, who depends on the assistance of a competent attorney to navigate the thicket.” It is interesting to contrast the Florida Supreme Court’s decision in Castellanos with Yeiser, where the U.S. Supreme Court, practically speaking, reached the opposite result in the early years of workers’ compensation.

Florida has considered other challenges. On April 30, 2015, the Florida Court of Appeal, First District, in Stahl v. Haleah Hospital, rejected a challenge alleging the Workers’ Compensation Law was an inadequate exclusive replacement remedy for a tort action. The opinion found the legislature’s 1994 addition of a $10 copay for medical visits after a claimant reached maximum medical improvement and the 2003 elimination of permanent partial disability benefits, supplanted by impairment income benefits, withstood rational basis review. The Florida Supreme Court initially accepted jurisdiction to review, but after further consideration and oral argument, dismissed the lawsuit. The United States Supreme Court denied without comment a petition for certiorari seeking review of the lower court decision in an October 31, 2016 opinion.

In Westphal v. City of St. Petersburg, the Florida Supreme Court in June 2016 declared another provision of Florida’s workers’ compensation statute unconstitutional. It struck down a statutory provision terminating temporary wage benefits after 104 weeks for workers who were totally disabled but who had not reached maximum medical improvement. The Court held, “Applying the statute’s plain meaning, we conclude that the 104-week limitation on temporary total disability benefits results in a statutory gap in benefits, in violation of the constitutional right of access to courts.” The Court employed a remedy of “statutory revival” to validate a previously enacted 260 week limitation which had passed constitutional muster.

In Miles v. City of Edgewater Police Department, Florida’s First District Court of Appeal ruled that the attorney’s fee provisions of Florida’s workers compensation law violated injured workers “rights to free speech, free association, and petition.” The Court reversed a Judge of Compensation Claims decision denying approval of two attorney’s fee contracts.

In 2015, the Florida Third District Court of Appeal reversed a lower court decision that would have permitted a direct cause of action against an employer. The Dade County Circuit Court held Florida’s exclusive remedy provision was unconstitutional because the grand bargain envisioned by the workers’ compensation act was devalued to the point it was unjust. In State v. Florida Workers’ Advocates, the Court of Appeal held that mootness and lack of standing prevented the plaintiffs from receiving the relief granted below. In December 2015, the Florida Supreme Court declined to exercise jurisdiction over the case.

In a May 18, 2016 opinion, the Utah Supreme Court in Injured Workers Association of Utah v. State of Utah, invalidated a state statute delegating the authority to regulate attorney fees to the Utah Labor Commission. The plaintiffs alleged that under the Utah Constitution, the exclusive authority to regulate attorney fees rested with the Utah Supreme Court. The Court agreed and struck down the fee regulation statute. The Court noted it had plenary authority to govern the practice of law, derived from both inherent power and, since 1985, explicit and exclusive constitutional power. It found the regulation of attorney fees, “falls squarely within the practice of law.” Because the court could not delegate the authority to regulate fees to the legislature or the Labor Commission, the statute and fee schedule were unconstitutional.

Pennsylvania Permanent Partial

In Protz v. Workers’ Compensation Appeal Board (Derry Area School District), the Supreme Court of Pennsylvania declared a portion of the Pennsylvania Workers’ Compensation Act unconstitutional. The workers’ compensation statute required physicians to use “the most recent edition” of the American Medical Association’s Guides to the Evaluation of Permanent Impairment when assessing the degree of impairment from a compensable injury. The Court relied on the Pennsylvania Constitution’s “non-delegation” clause requiring all legislative power to “be vested in a General Assembly” to find the statute unconstitutional. The legislature could not delegate its responsibility to make laws.

Following Protz, the Commonwealth Court of Pennsylvania held it was error for the Workers’ Compensation Board to grant a reduction of benefits from full to partial disability, because the impairment rating evaluation system was invalid. Thompson v. Workers’ Comp. Appeal Bd. (Exelon Corp.) Following these cases, the Pennsylvania legislature has considered amendments, including one which would adopt the Sixth edition of the AMA guides. As of this writing, no bill has been passed.

Changes Come Sooner In Oklahoma

In 2013, Oklahoma enacted a series of workers’ compensation reforms. These changed administration of workers’ compensation from a court-based system to one run by an administrative commission. The law also included the “Oklahoma Employee Injury Benefit Act.” Involving known as “Opt-out,” it afforded employers the option of providing their own system of benefits for workplace injuries as a substitute for traditional mandatory workers’ compensation. The legislature expected employer opt-out plans would be subject to the Employee Retirement Income Security Act (ERISA), subject to exclusive jurisdiction of the federal courts. A series of legal challenges ensued.

In Vasquez v. Dillards, Inc., the Oklahoma Supreme Court considered a challenge to the Opt out statute. The claimant suffered injuries lifting shoe boxes at work. He filed a claim with Dillards, which was denied. The claimant appealed to the Workers’ Compensation
Modern Constitutional Challenges to Workers’ Compensation Systems

In a September 2016 Opinion, the Oklahoma Supreme Court affirmed the Commission. It held that the opt-out statute was unconstitutional under the Oklahoma Constitution, because it created an impermissible select group of employees seeking compensation for work-related injuries for disparate treatment. The Court held that the opt-out Act did not guarantee all employees the same rights; rather, it singled out employees under specific plans who suffered inequitable treatment as compared to those who enjoyed the benefit of the Oklahoma Workers’ Compensation Act.

The Oklahoma Supreme Court addressed other constitutional challenges. In Torres v. Seaboard Foods, LLC, the Court considered changes to the Oklahoma Workers’ Compensation Act. One provision excluded cumulative trauma claims where a claimant had not worked a continuous 180-day period for the employer. The Supreme Court reversed the 180-day work requirement for cumulative trauma claims as unconstitutional. Under a rational basis analysis, the statute was over inclusive and under inclusive as it related to the state’s interest in avoiding fraudulent claims. By excluding workers who truly suffered cumulative trauma within 180 days even though they committed no fraud, the law was over inclusive. At the same time, if a purpose of the law was to provide compensation to legitimately injured workers, denying benefits was under inclusive.

Other constitutional challenges are pending in Oklahoma. In January 2017, a suit was filed to examine a 2013 amendment to the workers compensation act narrowing the scope of coverage for aggravation of pre-existing conditions. Prior law provided coverage for aggravations, but the new law required “an identifiable and significant aggravation incurred in the course and scope of employment.” In October 2017, the Oklahoma Supreme Court declared unconstitutional a provision providing for forfeiture of workers’ compensation benefits if an injured worker missed two medical appointments without a valid excuse or notice to his employer. The divided Court held the forfeiture provision violated the adequate remedy provision of the state constitution.

Alabama


In Clower v. CVS Caremark Corp., the judge declared the $220 PPD cap failed to meet the rational relation test to satisfy the requirement for equal protection of the laws under the Alabama Constitution. The Judge held equal protection was violated where injured workers received the same amount of permanent partial disability benefits though they earned different amounts prior to an accident. “There cannot conceivably be any more arbitrary, capricious, irrational, or attenuated idea than telling both workers that ‘equal protection of the laws’ means that they each get the identical amount under those circumstances.”

Because of a non-severability statute inserted into the Workers’ Compensation Act in 1984, the Alabama judge’s holding created much uncertainty. Shortly after the decision, the judge issued a stay on the Order for 120 days, given the “magnitude” of the ruling’s implications. The case ultimately settled.

Colorado Fine System

Not all constitutionality challenges are pursued by injured workers. In Dami Hospitality v. Industrial Claims Appeal Office, an employer challenged an $841,200 fine for failure to maintain mandatory workers’ compensation insurance. The Colorado Court of Appeals held the fine was unconstitutional under the Eighth Amendment of the United States Constitution and a parallel state provision. Under an “as applied” constitutional challenge, the Court found uniform application of a penalty schedule adopted by the state failed to consider required factors: (1) the defendant’s reprehensibility and culpability; (2) the relationship between the penalty and the harm caused by the defendant’s action; and (3) the sanctions imposed in other cases for comparable conduct.” The Court noted the schedule did not consider the employer’s ignorance of the lapse of its insurance coverage, the state’s failure to notify the employer of the lapse for almost half a decade, and the employer’s ability to pay. The case remains pending before the Colorado Supreme Court, which granted a partial writ of appeal.

Equal Protection in Kentucky

In Parker v. Webster County Coal, the Kentucky Supreme Court held a state law was unconstitutional. The statute declared that all workers’ compensation wage benefits terminated on the date an injured worker qualified for social security benefits. A claimant appealed on the grounds that the statute violated his right to due process. The parties focused on statute’s unequal treatment of younger versus older workers. A young injured worker who remained disabled could receive wage benefits for 425 (or in some cases 520) weeks, whereas an older worker who was injured might be able to receive them for a much shorter time, due to his qualifying for social security.

The Kentucky Supreme Court adopted a different approach. It noted one class of employees—Kentucky teachers—never qualified for social security because they participated in a totally separate retirement system. The Court reasoned the statute was unconstitutional under a “rational basis” analysis because it treated older injured workers who qualified for social security differently from teachers who did not. The Court held the statute failed to provide equal protection of the laws and was unconstitutional.

Pending Cases

There are other cases pending in a number of states. Following Protz in Pennsylvania, there are several Oklahoma cases that are challenging use of the 6th edition of the AMA Guides to determine permanent partial disability awards. Similar challenges to use of the Guides are pending in Kansas. Another Kansas case challenges the offset of social security retirement against a workers’ compensation award as violating equal protection of the laws.

Why Is This Happening?

After eight decades of relative stability, what happened in the last few years to bring constitutionality to the forefront? Several factors seem likely to contribute. Others have been raised by scholars and bloggers.
Federal Attention to State Workers’ Compensation Systems: The last time the federal government took a hard look at workers compensation was in 1972. President Richard Nixon created a National Commission for the Study of Workers’ Compensation laws that gathered data and issued a report. It identified 19 key provisions which were fundamental to effective workers’ compensation systems. It posited that if states did not move towards implementing these systems, federal regulation might be appropriate. For this reason, it recommended that the federal government might again consider minimum benefit standards. After the 2016 elections, federal interest in the workers’ compensation system faded. But the national attention may have caused some lawyers and judges to examine laws with closer scrutiny.

Many recent constitutional challenges address the adequacy of benefits. Some cases suggest the Grand Bargain is not so grand and is no longer a bargain. One aspect of federal intervention has affected benefit adequacy. For the past ten years, the federal government has increased scrutiny of workers’ compensation cases. The Centers for Medicare Services has encouraged the use of set-aside arrangements to avoid shifting workers’ compensation medical costs to Medicare. Virtually all stakeholders agree this has created instability and difficulty with resolving claims in ways which directly and indirectly impact benefit adequacy.

Media Critiques: In 2015, the workers’ compensation system received criticism from the news media. In a series of news releases, ProPublica and National Public Radio interpreted system performance. They highlighted shortcomings in the workers compensation systems including benefit adequacy. The articles covered a broad spectrum, but focused on several themes, including the efforts of state governments to dismantle benefit programs, deny benefits to injured workers, and transfer the cost of workplace accidents to taxpayers and society. Some have posited that the media’s analysis and a fresh round of public attention to system shortcomings may have raised awareness about an unbalancing of the system. Fairness of state systems has been a key theme in the foregoing constitutional challenges. And, some courts have found a constitutional challenge to a particular statute section opens the door to examining a state’s entire system.

Fundamental Challenges to Systems: In an impromptu interview at the National Association of Workers’ Compensation Judiciary (NAWCJ) College in August 2017, I asked Professor Michael Duff of the University of Wyoming College of Law why we have seen so many constitutional challenges – and so many successful ones – in the past few years. Citing Oklahoma’s Opt-out legislation and the move to have similar laws adopted in other states, he commented: “when you have legal changes which challenge the fundamental aspects of the whole legal system, then anything is fair game.” This was a poignant observation. Until the past few years, state workers’ compensation systems appeared relatively stable, even though many states enacted incremental limitations which devalued benefits over time.

Good Lawyering: At the 2017 IAIBC annual convention, I posed the same question to conference attendees. One group attributed the trend of increasing constitutional challenges to good lawyering. They postulated injured workers’ advocates, through groups such as the Workers Injury Law Group, developed a collaborative approach to identify vulnerable system features and the best venues in which to pursue them. Zealous advocacy is apparent in some jurisdictions. Advocacy organizations historically have undertaken such an approach in other areas of the law and the workers’ compensation bar is well organized.

Money: Another group at the IAIBC meeting said it really is all about money. Many of the successful challenges have been premised upon benefit adequacy, which really makes it about dollars and cents. This applies to attorneys as well as injured workers. Recent cases in West Virginia and Maryland upheld the constitutionality of attorney fee regulation in workers’ compensation. But a surprisingly large number – Castellanos in Florida, Injured Workers Association in Utah, and Clower in Alabama – declared attorney fee provisions unconstitutional. Those obviously have a direct impact on attorney compensation. So it seems undeniable that the pursuit of compensation is one key consideration.

Conclusion

The beauty of the United States Constitution is that it has survived more than two-hundred years of societal and economic changes, whether interpreted strictly or as a living document. Most state Constitutions are younger, less tested and more frequently amended.
The long-term impact of constitutional challenges on workers’ compensation systems is likely a story still being written. But cases over the past four years have shown many courts are willing to examine the essential elements of the “Grand Bargain” and to weigh against the fundamental fairness ensured by our state and federal constitutions.

References
3. Thomas Jefferson, Memoirs, Correspondence and Private Papers of Thomas Jefferson, Late President of the United States, Vol. 117 (1825-1829).
9. The Employee Retirement Income Security Act of 1974, 29 U.S.C. Ch. 11, is a federal law which sets minimum standards for most private industry pension and health insurance plans. The law gives employers the right to establish an internal review system for claims administration which is generally subject to exclusive federal court jurisdiction, 29 U.S.C. § 1132(b)(1). Under general workplace law, especially OSHA and FLSA, workers who believe their rights are being violated may file complaints with federal agencies, boards and commissions. Under the federal law, workers may also file complaints with state agencies. Injured Workers?
10. Id. at 314.
12. Id. at 343.
15. Id. at 314.
16. Id. at 327.
17. Miles v. City of Edgewater Police Dep’t/Preferred Governmental Claims Solutions, 190 So.3d 171 (Fla. 1st DCA 2016), with den. Miles v. City of Edgewater Police, 2016 Fla. App. LEXIS 8441 (Fla. 1st DCA, May 13, 2016).
22. Id. at 14-15, 374 P3d at 18.
23. Id. at 43, 374 P3d at 24.
25. Id. at 161 A.3d at 841.
27. Id. at 854.
31. 31 Ohio Const., Article V, § 59 provides, “laws of a general nature shall have a uniform operation throughout the State, and where a general law can be made applicable, no special law shall be enacted.”
32. Vanegas, 381 P.3d at 174-175.
34. 85A O.S. Supp. 2013 § 2(14).
35. Torres, 373 P.3d at 1078.
37. Does the Workers Compensation System Fulfill Its Obligations to Injured Workers? at p. 28
38. Id. at 6-7.
40. 85B S.R 2016 states in pertinent part: All income benefits payable pursuant to this chapter shall terminate as of the date upon which the employee qualifies for normal old age Social Security retirement benefits under the United States Social Security Act, 42 U.S.C. §§ 401 to 1370EE or two (2) years after the employee’s injury of last exposure, whichever last occurs.
41. Id. at 770. The court also invalidated the law as unconstitutional special legislation under the Kentucky Constitution.
42. 50 Parker v. Webster Cty. Coal, LLC, 529 S.W.3d at 768 (Ky. 2017).
47. 49 Id at ¶ 28.
48. Id. at ¶ 67.
49. 32 Id. at 161 A.3d at 343.
50. 17 Id. at 161 A.3d at 343.
52. 11 Castellanos v. Next Door Co., 192 So.3d 43 (Fla. 2016).
53. Id. 39 Id. at 6-7.
54. 39 Id. at 6-7.
55. 39 Id. at 6-7.
56. Id. at 161 A.3d at 841.
Ray Meister has served as executive medical director for DWC since June 2016 and was an associate medical director since 2014. Prior to joining DWC, Dr. Meister served as public health medical officer at the California Department of Public Health, Occupational Health Branch, from 2000 to 2014.

Ray is boarded in Occupational Medicine having done his residency at UCSF. He earned a Master of Public Health degree from the University of California, Berkeley School of Public Health and a Doctor of Medicine degree from the University of Southern California, School of Medicine. He has been a faculty member at the University of California, San Francisco since 1998 and is currently an associate clinical professor.

Opioid misuse is a significant concern in California, as it is almost everywhere else in the country. California’s workers’ compensation system aims to provide the best care for injured workers, based on the principles of evidence-based medicine (EBM), the use of medical treatment guidelines, and a corresponding evidence-based formulary. Much attention has been focused on the dangers of the chronic use of opioids, but we now understand that the potential for problems can start in the first few days of the initial use of these drugs.

The advice given in guidelines on the appropriate use of opioids has evolved rapidly over the past several years. The Centers for Disease Control and Prevention (CDC) offers evidence-based guidance in the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. One recommendation in this guideline regarding the use of opioids to treat acute pain is the following.

“When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.”

For many health-care providers, the use of an opioid pain reliever for only three days or less may be a change, but it could be key in avoiding the needless risk of creating unintended opioid dependence. Some might ask, “What is the risk of a few extra days of providing opioid medication when it is not really needed to treat an acutely painful condition?” This question is answered at least in part in a CDC Morbidity and Mortality Weekly Report (MMWR) report released March 17, 2017, which states: “Transitions from acute to long-term therapy can begin to occur quickly: the chances of chronic use begin to increase after the third day supplied and rise rapidly thereafter.”

The California Division of Workers’ Compensation (DWC) recently updated all its evidence-based medical treatment guidelines and incorporated an evidence-based formulary based on those treatment guidelines. The DWC formulary relies largely on this information from the CDC and the recommendations in its opioids guideline, including a provision that allows physicians to offer those initial few days of an opioid that may be needed for a severely painful acute condition while requiring an additional level of utilization review for opioid use beyond that time, when it may be more appropriate to transition to less-problematic forms of pain relief.

The goal of focusing on the initial opioid prescription for acute pain is to reduce the incidence of unnecessary chronic opioid use among California’s injured workers.
Walking in the Shoes of the Injured Worker

The workers’ compensation industry is discovering anew the injured worker. Using the term “claims advocacy,” claims professionals say they want to be on the side of the injured worker as he or she tries to navigate the medical system, keep her home life in order, and return to work. This is a welcome shift from a reactive to a proactive approach in managing claims. Let’s bring the claims advocacy concept from daily practice of thousands of claims and medical professionals to the doorsteps of legislators in fifty states. Politicians set the rules for workers’ compensation. Is there a state that has reviewed them to consider how they impact the injured worker? A “worker advocacy” approach to legal review of some basic and easy to understand provisions is likely to uncover unexamined, outmoded, sometimes indefensible laws.

Choice of Medical Provider

Most states allow the injured worker complete or near-complete freedom to select her medical provider. Twenty-six states, including California, Florida, and New Jersey, assign to the employer complete or partial control over the selection of medical provider. Surveys over many years show that injured workers want freedom to choose. Two recent studies have seriously challenged the justification for employer control. (At the end of the article is a list of source materials.)

In 2017, Workers’ Compensation Research Institute compared choice of provider laws to claims experience. Contrary to conventional wisdom, when given the power to pick their doctors, workers do not cause medical and indemnity costs to soar. The idea of masses of knowing, self-maximizing injured workers who pull the levers to stay out and run up costs is a figment of the imagination.

Now an article in the Journal of Occupational and Environmental Medicine by respected experts in workers’ comp concludes that “States that permit employer selection of treating physician have slightly higher cost due to the higher prevalence of attorney involvement in the claims process.” In other words, employer choice laws may increase claims costs.

An argument for employer choice can be made by showing that claims payers use their prerogative to improve medical care. There’s ample evidence that quality of care varies significantly within a medical community. Can research show that employer choice laws are particularly needed to make sure that quality improves? Or do claims payers use employer choice laws mainly, or even only, to drive down medical reimbursement?

Has the asserted value of employer choice laws been eclipsed by advances in claims practices? Take patient and provider education. It cannot be quantified well, but it appears that some claims payers and some state agencies have sharply improved their coaching of injured workers about treatment options. And, utilization review, drug formularies, and other mandated programs may be better ways to improve the quality of care than employer choice laws. These are researchable issues.

Waiting Periods

All state workers’ compensation systems hold off replacing wage loss for a few days. States are roughly evenly divided between holding benefits until the fourth day and until the eighth day. The waiting period is paid to the worker if she stays on disability for a period of time, typically for seven or fourteen days. It’s worth noting that Texas opt-out benefit plans often do not have waiting periods.

Assume Mary, a full-time worker, is disabled from work for six workdays (say, from Monday through the following Monday). The table below shows how for how many of these days she will receive wage replacement. In only eight states she will receive complete benefits. For twenty states, she will receive benefits for either zero or one day.

Waiting periods were justified on two grounds — apparently, because there is hardly any discussion about why they exist. First, they were a recognition of built-in delays in reporting and response. The second

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rationale for a waiting period is that immediately awarding indemnity benefits is supposed to encourage workers to file frivolous claims. For these rationales, time has not been gracious.

A supervisor’s smartphone can, within minutes of the incident, take and transmit a video of the site of an injury to the claims organization. Immediate triage by phone or telepresence tells the claims payer much of what it needs to know about the injury.

Pretty much every well-run employer today uses a process to get accurate same-day medical care for its injured workers and used modified duty to curb days off. I suspect with these advances, claims payers can make compensability decisions on at least 80% of injuries within 48 hours.

The National Commission on State Workmen’s Compensation Laws wrote in 1972 that waiting periods of over three days were “inequitable.” It urged that retroactive payment commence no later than two days after the close of the waiting period.

**Wage Replacement**

Being on wage replacement for many is a form of torture to prove you are really disabled.

Disability insurance, both occupational and non-occupational, almost always calculates the beneficiary’s income replacement check by using a formula. Almost all states set the wage replacement rate as a tax-free percentage, usually 66 2/3% of the injured worker’s gross pre-injury wage.

The 1972 Commission discovered replacement rates as low as 30%. It recommended that states set the benefit as a percentage, at least 80%, of the worker’s disposable income, that is, income after taxes. But the current rules cause many injured workers to suffer a decline in take home pay of more than 15%, which may be a threshold for hardship. Many will experience a shortfall of over $500 a month in take home, another signal for hardship.

But there is another problem. Employees participate through wage deductions in valuable, even essential benefits, such as health, dental, and short-term disability insurance. When they go on work disability, they still have to keep paying their premium obligations to remain eligible for benefits. The employer has no obligation to waive or permit a postponement of these payments. Household financial risks go up.

It appears that many workers can’t afford to be injured. It is not surprising that many claimant bar attorneys say they know of situations where their clients have had their phones cut off and vehicles repossessed. The table below captures the financial distress that grips many injured workers. Assume a couple both earning the median wage in their state and living in the largest city in their state. If one goes on work disability, in 28 states the couple cannot afford the area’s basic household budget.

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<th>States’ Compensation for 10 Lost Work Days</th>
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<td>Paid &lt; 5 Days</td>
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<th>States’ Take-Home Pay as % of Basic Budget</th>
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<td>Paid &lt; 5 Days</td>
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Source: Rousmaniere, P. (2016, January). *The Uncompensated Worker: Workcompcentral SPECIAL REPORT.*
in 2014, the cap effective in that year would have limited wage replacement in seven states. At 120% of the median wage, the caps in sixteen states would have been enforced. At 133% of the median wage, twenty-two states would cap the benefit. A well-compensated electrician, especially one earning much overtime pay, would likely hit the cap in many states.

The rationale for a cap may seem a mystery. Terry Bogyo, former Director of Corporate Planning and Development for WorkSafeBC (British Columbia), says that when workers’ compensation systems were created, law drafters wanted a system focused exclusively on-line workers, the ones who predictably were in harm’s way of injury, day after day. One way to effectively remove higher level managers from the beneficiary pool was to put a weekly cap on benefits.

Again, we have a benefit design out of sync for our time. The 1972 commission recommended that states put the cap at 200% of the state’s average weekly wage, far above current laws. Bogyo says they should be based, not on average wage, but on a percentile of wages in a state. A 90th percentile cap would mean that weekly wage replacement could not exceed the gross wages of the 90th highest paid worker in the state. Bogyo notes that labor economists figured out how to calculate wage percentiles 40 years ago, but no state has converted to this method of designing a cap.

This article calls on these organizations to walk in the shoes of the injured worker. That’s what the claims advocacy movement is about. Perhaps legislators are unlikely to step forward until a multistate review is done. Which states might take the initiative?

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What To Do

This article shows that some basic worker benefit provisions are outdated. They deserve fresh review. Some benefit provisions are quite complicated such as permanent partial disability benefits. But the provisions examined here are straightforward to understand. Legislative language is relatively simple. An individual state can conduct a review or a group of states can commission the WCRI or the International Association of Industrial Accident Boards and Commissions. This article calls on these organizations to walk in the shoes of the injured worker. That’s what the claims advocacy movement is about. Perhaps legislators are unlikely to step forward until a multistate review is done. Which states might take the initiative?
Post-Traumatic Stress Disorder and Achieving the Best Outcomes for Injured Workers

The recent tragedy at a Florida high school was a tipping point to a drive to bring forward legislation that would provide indemnity benefits to first responders who suffer from work-related Post-Traumatic Stress Disorder (PTSD). Gov. Rick Scott was expected to sign the measure, which would provide coverage even in the absence of an associated physical injury.

Florida is the latest of a handful of states to adopt proposals that would allow firefighters, police officers, paramedics, and emergency medical technicians to receive treatment for PTSD through the workers’ compensation system. Such legislation has drawn criticism about the potential costs involved. However, exorbitant costs need not be incurred. Producing the best outcomes for injured workers and saving money for payers is dependent on providing appropriate treatment as soon as possible after an incident. Additionally, preventive measures can go a long way in mitigating PTSD symptoms.

PTSD Defined

PTSD is a reaction to a traumatic event the victim has experienced, witnessed or been confronted with that involves actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. Even the death of a loved one can trigger it. But not everyone exposed to a horrific event develops PTSD, especially with the right treatment. It is important to understand what it is and how it manifests in certain people.

PTSD is characterized as persistent avoidance behavior to stimuli associated with the incident, along with a general numbing of reactions. The affected person may constantly relive the trauma and experience a significant deterioration in his ability to function. He or she may also have a variety of physical symptoms, such as headaches, high blood pressure or gastrointestinal problems. Typically there is a decrease in work performance and an increase in absenteeism. Depression, anxiety disorder, and drug abuse are common symptoms. At its worst, suicide can result.

Experiencing or witnessing a horrific event impacts most people in negative ways. But the vast majority of people recover. Even people with certain biopsychosocial risk factors that predispose them to symptoms can avoid long-term suffering, given the proper help.

PTSD and First Responders

The incidence rate of PTSD for most people exposed to a traumatic event is approximately 12 percent and the lifetime prevalence rate of PTSD for groups with a high risk of experiencing traumatic events is estimated to be between 30 percent and 40 percent. But a Canadian study showed the rate for police officers studied was between 3 percent and 9 percent, for either clinical PTSD or partial PTSD, meaning they had some but not all symptoms. That may have been due to a higher resiliency of those officers, or some preventive measures undertaken.

Florida is one of the states that have performed over 250,000 evaluations. He is the developer of the AssessAbility Functional Medicine Evaluation and Disability Evaluations companies that have performed over 250,000 evaluations. He is the developer of the AssessAbility Functional Medicine Evaluation and

Michael Coupland is a Charter Psychologist, Registered Psychologist, a former Emergency Services Psychologist, and was a Certified Rehabilitation Counselor (inactive as of 3/31/16). He co-founded three national Disability Evaluations companies that have performed over 250,000 evaluations. He is the developer of the AssessAbility Functional Medicine Evaluation and SWOP programs. He also oversees IMCS’ Post-Traumatic Stress Disorder (PTSD) assessments and treatments for first responders throughout the nation. He is a chapter author of the AMA 6th Ed. Guidelines companion text Guides to the Evaluation of Functional Ability and author of Psychosocial Interventions for Chronic Pain Management, The International Journal of Industrial Accident Boards and Commissions; Fall 2009. He was honored in 2014 with the Top 50 People in Workers Compensation award from the SEAK organization.

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Re-experiencing the event through flashbacks, frightening thoughts or bad dreams that may be triggered by words, situations or the person’s own thoughts and feelings.

Avoidance behavior by staying away from anything that is a reminder of the event, or even avoiding thoughts and feelings related to it.

Arousal and reactivity symptoms, such as being easily startled, or having sudden angry outbursts.

Cognition/mood symptoms including memory loss of aspects of the event, negative feelings about oneself, or a loss of interest in activities.
Risk Factors

Psychosocial

Research shows there are myriad reasons some people develop PTSD after a traumatic incident while others don't. In addition to characteristics that make some people more susceptible, events that occur before, during, and after the event play a significant role.

Certain biopsychosocial factors influence how a person responds to various life challenges, such as an injury and a traumatic event. Some of the most prevalent ones include

1. Catastrophic thinking — thinking worst case scenario.
2. Fear avoidance
3. External locus of control — giving up one's power to others, such as medical providers.
4. Depression
5. Anxiety
6. Past trauma
7. Childhood trauma
8. Low self-efficacy

A person's hardness, personal resilience, and the ability to manage emotional stress are also key factors that may determine whether someone develops PTSD or not.

During

A person's reactions during a traumatic event can play a significant role in how well he adjusts afterward. The person typically feels intense fear, helplessness, or horror.

A recent study of police officers in Quebec looked specifically for risk factors among police officers who were exposed to tragedies. It found that the circumstances during and immediately after the event impact the person's handling after the event.

Those most affected had experienced negative reactions during the incident. Among the emotional reactions cited were fear, guilt, shame, anger, disgust or sadness. Physical reactions included palpitations, trembling, dizziness, sweating, hot flashes and shivering.

The loss of control, of ones emotions and/or bodily functions during the traumatic event was key, along with the officer's perception of social support of colleagues during and immediately following.

A major factor impacting whether and to what extent the officers suffered from PTSD was feeling disassociated, or a lack of emotional reactivity during the event. It is described as feeling disconnected from one's thoughts, feelings, memories or sense of identity.

While it's fairly common to experience a sense of detachment or other worldliness — as if watching it on television — during a trauma, it typically resolves itself soon after the event. But for some people that sense persists and can lead to memory problems, cognitive issues, sudden and unexpected mood shifts, or feeling as if the world is distorted.

Post-event

A perception of negative social interactions after the trauma is identified as a risk factor for developing PTSD. This is why more PTSD is seen in a workplace that has a stressful, non-supportive culture.

Whereas, getting appropriate social support during or immediately after the event can help prevent the development of PTSD. Intensity of depressive symptoms and the number of ASD symptoms also contribute to the likelihood of having PTSD.

Treatment/Prevention

PTSD can be mitigated after a traumatic event by getting immediate treatment to the person. The key is to identify those most at risk and intervene as early as possible.

Between 24 and 72 hours of the incident a peer counselor trauma specialist should be in contact with the first responder and a face-to-face meeting should be set up. In addition to assessing the worker's psychological and physical states, the trained person will also help the person feel more secure, by informing them of the possible psychological symptoms they may experience and giving them tangible emotional support.

Most cases require just a handful of trauma recovery sessions that help the worker return to work and normal activities. If symptoms are severe during the first month or continue for more than one month, a trained professional should perform a criterion based PTSD diagnostic assessment to rule out other conditions.

Those red-flagged as having PTSD should undergo trauma interventions that have been shown to reduce symptoms and promote recovery. There are a variety of treatments that can help those suffering from PTSD.

Exposure/desensitization therapy, for example, may involve exposing the worker to the traumatic event through mental imagery. In vivo therapy, in which the worker confronts the actual scene or similar events associated with the trauma, is another.

Our practice uses cognitive behavioral therapy (CBT), which utilizes principles of learning and conditioning and includes components from behavioral and cognitive therapy. The idea is to focus on eliminating the person's negative beliefs about himself and gradually expose him to the thoughts and situations he fears.

When provided to the worker in a timely manner, CBT does not need to be long-term or expensive. In fact, several CBT sessions within two weeks of the event helps most people who have ASD symptoms. Those who need further follow up generally recover within a few months. Workers who have delayed recoveries following a traumatic event may have comorbid issues that need additional attention.

In addition to the post-event interventions, preventive measures given to first responders can go a long way in helping to prevent PTSD from developing. Training programs can help develop protective measures and reduce risk factors.

For example, first responders can be taught effective coping strategies to a particular work environment, such as problem solving, applied relaxation, or breathing training to use during a traumatic incident. Strategies can also help them to better manage intense emotions, or prevent dissociative reactions during the trauma. Simulation exercises can also help.

Legislation

The idea of including PTSD for first responders in workers' compensation coverage started catching on several years ago. The killings of 17 people in Florida's Marjory Stoneman Douglas High School at the hands of a 19-year-old former student on Valentine's Day prompted that state's Legislature to add that state to the list.
The legislation is a positive step, in that it acknowledges that PTSD is not dependent on having a physical injury. But it has some factors that will need to be monitored to see if the regulations bring forward the intended treatment and outcomes.

For example, coverage would be provided based on the first responder having symptoms for more than one month. This will pose some difficulty for early intervention in avoiding PTSD, which should begin as soon as symptoms are causing significant distress or impairment in social or occupational settings.

It also requires mental health training to first responders, including mental health awareness, prevention, mitigation and treatment. A first responder who has PTSD symptoms before the one-month mark, or ASD symptoms, would need treatment from an employee assistance program or critical incident response team initially, until the PTSD diagnosis could meet the definition of the law.

On the plus side, the PTSD diagnosis is not subject to apportionment for a previous PTSD diagnosis, but does not limit apportionment to other mental health diagnoses that impact on the persistence and severity of PTSD, such as substance abuse disorder, depression, anxiety, and panic attacks. That means first responders who are treated for PTSD would also be covered for mental health diagnoses.

Finally, impairment ratings will become an especially important step in resolving workers’ compensation cases. The Florida impairment ratings guide does not clearly require testing and leaves it to the “best clinical judgment of the evaluator” to determine the degree of impairment.

Lawmakers in Washington State approved a measure to create a presumption that PTSD is compensable for first responders. At press time, that bill was awaiting action by the governor. A fiscal analysis has projected it would result in new claims between $3 million and $8 million.

Both Vermont and Maine passed PTSD legislation last year. New Hampshire considered a proposal to provide PTSD treatment through workers’ compensation to first responders who were diagnosed with PTSD within three years of the last date of employment. That measure stalled in committee, however.

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Perspectives Magazine: Tell us about your background in the field of pain management and why you chose it as your specialty.

Dr. Christopher Grubb: In the field of pain management, people come from a number of different medical specialties. My background is probably the most common, starting as an anesthesiologist. After that, I pursued board certification with the American Board of Pain Medicine to become qualified to practice pain management and currently, I do both. I spend half of my time in the operating room and the other half in our pain clinic taking care of patients with chronic pain. But there are other avenues that certain types of doctors will take to get to the point where they consider themselves pain specialists.
PM: How did you first get engaged in the discussion on opioid public policy in North Carolina?

CG: My start was on the education side. In North Carolina, we have a program called Project Lazarus which started about three years ago. I was one of the faculty which aimed to improve prescribing practices state-wide for opioids. From there it developed into more of a direct involvement with a couple of state agencies, as well as working closely with one of the state representatives, when the issue of designing a law related to opioids arose about a year ago.

PM: There are a number of states that have adopted or are considering legislation which would place limitations on opioid prescribing either through supply limits or daily morphine equivalents (MED). Congress is also considering legislation which would place a three day limit on initial fills of opioids nationwide. What are your thoughts on this approach?

CG: I would be very supportive of it because I do believe that initial prescription is very important when it comes to the risk of developing an opioid use disorder. It is also important with regard to how much of that fill or supply would be left over. In my experience, most patients who are opioid naïve generally do not like some of the side effects of opioids and tend to leave over half the bottle in a medicine cabinet; that leaves the possibility for pills to get in the wrong hands.

PM: Is three days the right number?

CG: It depends on the context. I don't know that three days would be the right number for, say, a major joint replacement operation. Certain types of major surgery warrant a little bit longer than a three day supply. In North Carolina, the STOP Act, gave an exception to that the rule for post-surgical pain, where the limit would be seven days instead of five days.

PM: Many states have adopted or are considering adopting workers’ compensation formularies and evidence based medical treatment guidelines. Some physicians have been vocal in opposing these as cookie cutter medicine. What is your opinion? Are these tools or impediments to proper treatment and why?

CG: Opioid-specific policies that have been discussed are unique as compared to other treatment protocols that might otherwise be criticized as “cookie-cutter.” This is mostly because of the epidemic that has occurred over the past 10-20 years with regard to opioid abuse and other drug abuse in general that seems to be connected to the prescribing or over-prescribing of opioids. Providers everywhere, should acknowledge that desperate times call for desperate measures. In general, I am opposed to “cookie cutter” medicine, but there does seem to a problem with opioid prescriptions getting into the wrong hands and the possibility that patients could develop an opioid-use disorder arriving out of their treatment of pain. In workers’ compensation, it would make sense that injured workers would want the highest level of care. In the case of opioids, following well-established guidelines such of those from the CDC constitute the standard of care. It would be substandard care to allow providers to prescribe opioids in a manner that is not consistent with those guidelines.

PM: Where do you think is the greatest need to increase education for the public on abuse prevention?

CG: The most important opportunity for public education would be where people are receiving their health care. Some local doctors have educational materials about opioids, addiction and diversion in their office waiting rooms or exam rooms. Some post their policy in regard to expectations for patients who do get prescribed a controlled substance. Those are very effective ways for practices to educate their patients.

PM: What are some of the early indicators of addiction or dependence that you have seen in your practice which perhaps may be overlooked by primary care physicians or occupational health specialist if they are not as skilled in pain management?

CG: The general concept behind addiction is that there is inherently dysfunctional behavior that underlies the addiction, and part of that behavior will be manipulative. Most people that develop an addiction have shown sophisticated signs of drug seeking behavior. The most common manifestation would be a perceived or reported increase in pain. It is common to hear a patient say that their pain is getting worse, and therefore, they need more of the opioid. This is a subtle indicator that maybe a primary care provider, when they are busy with all aspects of patient care throughout the day, may not pick up on. Primary care providers may have a knee-jerk reaction to increase the dose or the number of pills prescribed because the patient is saying they have more pain.

PM: Where do you see the greatest need for improvements in our prevention?

CG: I do think that the older the patient group would be, the more tolerant of having pain be a normal part of life. Elderly patients or patients over the age of 55 most likely have some sort of chronic pain that they are dealing with (e.g. arthritis, neuropathic pain from diabetes or vascular disease). Those patients maybe have already realized that they will never be to a point of zero pain. I find myself talking about that concept with the younger patients - that pain is a part of life and is not something that has to be removed. It should not be so severe that it is debilitating and prevents people from doing normal activities and operating normally at work. Younger populations tend to have a higher expectation of what their doctor can accomplish with treatment of pain. They tend to have the expectation that, if an opioid pill can take their pain away, they should be able to feel like that 24/7. This is partly why there is such a large proportion of patients that are on a chronic, daily, maybe even a long-acting opioids like OxyContin. That is why we are seeing so many younger people being put on a daily opioid, while someone is older is expecting some degree of pain every day.
PM: What can pain management physicians do to help injured workers realize they can return to gainful employment, even when they are treating for chronic pain?

CG: The standard of care in pain management is to use as many modalities as necessary to treat the pain. There are at least five or six different drug categories separate from opioids and many non-pharmacologic therapies like physical, aquatic and massage therapy. Some people are interested in new research coming out about acupuncture. For an injured worker that may be developing a chronic pain condition, they need to know that there are many modalities out there that can help them to function normally on a daily basis.

PM: What immediate solutions do you think the workers’ compensation community could consider to address the opioid crisis, that would be high value to improve patient care, without adding a lot of administrative burden to the physician?

CG: I would be more specific and say “clinical burden” instead of “administrative burden.” In order to properly treat pain, especially when opioids are involved, there are so many aspects of the patients’ life that have to be considered as part of the clinic decision. A physician considering putting a patient on opioids, even for a short period of time, should do a risk assessment of the patient. Many doctors have not had training on how to do a risk assessment. It is not difficult and many tools are available. Some are administered by a nurse during the early part of the visit before the doctor even interacts with the patient. That could be limiting for physicians who already feel overburdened with administrative paperwork and overworked with the number of patients that are seen per day. I am afraid that physicians will see policies come out, including even the CDC guidelines, and will react in an unproductive way and never prescribe an opioid. It could limit the number of providers that will treat pain. On the flip side, fewer workers will be on an opioid for more than a few days because the provider will want to avoid a lot of the paperwork involved.

PM: Would that be a good thing or bad thing; would the ends justify the means?

CG: It depends on which expert you ask. In my opinion, even looking at the basic science level of the research out there, I have not been impressed with how opioids treat pain to begin with. Even if opioids were very safe or had no abuse potential, I would still consider them one of the therapies least likely to work, at least in the long-term, for chronic pain. Humans become tolerant to the effect of opioids over time. Tolerance includes a tolerance to the pain relieving effects of an opioid. If someone stays on an opioid for weeks into months, that same dose will not take care of the pain the way it did in the first few days. I can see the usefulness for opioids for short term, acute pain. I do not see a downside, if fewer workers will be on an opioid. It could limit the number of providers that will react in an unproductive way and never prescribe an opioid. It could limit the number of providers that will treat pain. On the flip side, fewer workers will be on an opioid for more than a few days because the provider will want to avoid a lot of the paperwork involved.

PM: What immediate solutions do you think the workers’ compensation community could consider to address the opioid crisis, that would be high value to improve patient care, without adding a lot of administrative burden to the physician?

CG: I would have to give a warning to any agency that regulates the care of injured workers. The population of workers’ between 20-50 years old is at a higher risk of opioid abuse. If states want to hone in on where the problem could develop, injured workers are a logical place to start when you look into the factors that go into someone who develops a drug addiction problem. It is more than just age; there are things that are psychosocial that play into it. When someone gets injured at work, that causes stress in other areas of their lives (marriage, homes, families, relationships). It is more common for an injured worker to develop a drug addiction problem. It is more than just age; there are things that are psychosocial that play into it. When someone gets injured at work, that causes stress in other areas of their lives (marriage, homes, families, relationships). It is more common for an injured worker to develop a drug addiction problem.

PM: Any last thoughts on this topic of opioid policies and patient care?

CG: A presidential commission in Washington recently looked at this very issue in terms of speeding up the approval of certain technologies through the FDA. One of the technological advances in wearables would be the capability of patients to communicate information to their doctor within a few days of starting opioids. Technology could help us pick up signs of non-compliant behaviors. If there were a way for prescriber to pick up on signs earlier, then it would be easier to address a burgeoning drug abuse problem than if someone had been on an opioid for a month or longer.