Document Review Report: Evaluation of the Massachusetts Department of Industrial Accidents' Opioid Alternative Treatment Pathway Program

A report to the Occupational Health Surveillance Program
Massachusetts Department of Public Health

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The recommendations expressed in this report are those of the authors and do not necessarily reflect the official policy or position of the Massachusetts Department of Public Health or the Centers for Disease Control and Prevention.

Summary

This report describes a content analysis of filed Massachusetts Department of Industrial Accidents' forms related to mediation around medical care for injured workers on long-term opioid therapy. These documents (2016 to April 2022) include insurers' and employees' request for mediation as well as the mediation agreements. Insurers filed 59 requests for mediation regarding 55 employees' opioid medication and employees filed 17. Twenty-nine mediation agreements were filed concerning 27 employees who were presumed to participate in the Opioid Alternative Treatment Pathway program (OATP). Employees were generally in their late 50's and more men than women were represented by these forms. Most forms were filed more than 10 years after the employee's injury. It is not known, but may be assumed, that most employees represented by these forms had sustained opioid therapy for many years.

The requests for mediation generally followed an Independent Medical Review that recommended tapering of opioid medications and non-opioid pain management. Mediation agreements have no standard content and, as a result, varied widely with some only a sentence and others including extensive provisions. Common elements included goals of improved employee health and reduction of employee dependence on opioid medications, employee commitment to cooperate in good faith with a Care Coordinator who would facilitate the taper and necessary medical care, insurer commitment to pay for necessary treatment, and agreement to release medical records and pay the employee's attorney. Virtually absent were specific tapering and pain management plans, timelines and milestones of success, and reporting requirements.

The report recommends the adoption of a checklist to guide the development of mediation agreements related to the OATP. The checklist includes several elements that are recommended but generally absent from most mediation agreements, including affirmation of participation in the OATP, statement of concrete goals, tapering and pain management plans, agreement to pay for medical services and support related to alternative pain management and reduction of opioid dependence, and timelines and reporting schedules. A draft of this checklist is included as an appendix to this report.

Introduction

Background and Project Goals

This project grew out of a previous one sponsored by the Massachusetts Department of Public Health (DPH) Occupational Health Surveillance Program to document issues related to workers and the opioid crisis. The purpose of that report was to help guide opioid hazard awareness educational interventions for working people. The full report can be accessed here.[1] The report also discussed medical and legal issues related to opioids for injured workers who file claims through the Commonwealth's Department of Industrial Accidents (DIA), the workers' compensation system for Massachusetts. Senior Judge Omar Hernandez has led an effort to introduce reforms at the DIA to assist injured workers overcome obstacles to reducing their dependence on opioids. That work coalesced in the Opioid Alternative Treatment Pathway Program (OATP) which began as a pilot in 2016 and which became a full-fledged program at the DIA in 2018. At the time of his interview for the prior report mentioned above, Judge Hernandez expressed an interest in assistance in evaluating and improving the OATP.

In 2019, the evaluation of the OATP was submitted as proposed component of the Commonwealth's Opioid Assistance for States proposal to the CDC and was funded as a cooperative agreement, *Overdose Data to Action (OD2A)*. The rationale for this work as part of the Commonwealth's response to the opioid crisis includes that this program represents a cutting-edge state-sponsored initiative to prevent opioid overdose by intervening to reduce opioid dependence in a high-risk population: injured workers.

This report on a review of the relevant DIA legal documents related to the OATP was conducted during the second year of the three-year project. It supports the second goal of the project which is to conduct qualitative research to evaluate the OATP process at the DIA to inform directions for program improvements. This document review describes the documentation of the OATP process for injured workers. It evaluates whether those documents reflect program goals and **provides recommendations for enhancement of the OATP program via a guidance checklist for mediation agreements.**

Summary of the Opioid Alternative Treatment Pathway Program

The OATP was initiated by the DIA to provide an expedited process for injured workers to reduce or eliminate their opioid use and improve their pain management. The program is overseen by Judge Hernandez and does not have dedicated staff. The program is viewed as an integrated "pathway" in the processes and operations of the DIA. DIA staff have previously reported that there are 24 current program participants and 70 who are "in process." It was not clear how many have begun and either dropped out or "finished."

Only injured employees with settled indemnity claims can participate in the program. These employees have received a lump sum settlement, but continue to receive medical treatment with opioids that is paid for by the employer's insurer. Very often these patients are under the care of their primary care physician and are not receiving any additional treatments or clinical care from pain specialists. Employees whose cases are not yet settled, or who receive weekly income support from the DIA are not eligible to participate. The rationale for including only settled lump sum cases is to avoid the contentiousness of disability-related income support issues in the process of coming to agreement on medical care. Unfortunately, an employee may fear that their income support would be threatened if they became less opioid dependent, while still being uncertain about their ability to support themselves.

Eligible injured employees may volunteer to participate at any time, however, in most cases, a worker is encouraged to participate after the insurance company has filed a form to discontinue payment for opioid medications. At that point, the injured workers' attorney may recommend the mediation process, or the Judge may suggest it at the hearing on the matter. If the worker and the insurer agree to participate in the OATP, a mediating judge, who is not the judge who adjudicated the original case, supervises a "19A Medical Mediation" where the injured worker agrees to work with a Care Coordinator to reduce or eliminate their use of opioids, and the insurer agrees to pay for treatment (including opioids, pain management physician, primary care, and alternative treatments), the Care Coordinator fees, and a fee for the claimant's attorney.

The 19A form is not prescriptive – it is essentially a blank document for the parties to record their commitments and agreements. The 19A form agreement can be updated or renegotiated and is specific to the particulars of each situation. There are no time limits or guidelines for program participation. Each case's timeframe is determined on an individual basis.

When the injured worker and the insurance company agree to participate, they will agree to a Care Coordinator or other health care provider to facilitate the taper and improved pain management and to support the injured employee through the process. The supervising judge may request regular reports from the Care Coordinator to make sure that progress is being made and hearings may be held to check in with all parties. The goal is a non-adversarial process where the insurer's adjustor is open to approving the recommendations of the care coordinator. Because the process is generally to wean the injured worker, rather than eliminate opioids through a rapid detox, the insurer will continue to pay for opioids as well as pain management and other treatments. The injured worker or the insurance company can end the 19A agreement and revert to "traditional" litigation at any time. The Care Coordinator may report that a point of success has been achieved and the 19A agreement will be amended to sustain alternative treatments. It may also be the case that the Care Coordinator determines that further progress is unlikely and may suggest that the process be ended by the Judge.

The DIA has asked healthcare professionals (principally nurse case managers) to provide an application and credentials to be listed on the DIA site as a potential Care Coordinator. The goal is a geographically and otherwise diverse roster of professionals who can guide the patient through an opioid tapering process and help promote improved pain management through new therapies. Additionally, the Care Coordinator plays a critical support role for the injured worker, and liaison role for the other parties to communicate progress and challenges. Basic qualifications are reviewed, but specific experience with tapering injured workers is not required nor publicized. Many Care Coordinators work for insurers or companies that contract with them.

As described above, the OATP program differs from the "traditional" process in that it is a voluntary mediated agreement where all parties sit down together and agree to a plan, rather than an adversarial process resulting in a judge's order. In the "traditional" process, an injured worker continues the medical program agreed to at settlement of their case until either they or the insurance company requests a change. Because of the high cost, high risk of overdose, as well as the evolving literature documenting limited efficacy, insurance companies are generally challenging claimants' continued long-term opioid treatment. Insurers file Form 108-A - Insurer's Request for Post-Lump Sum Medical Mediation in order to initiate proceedings to get a court-ordered change in treatment. They may also directly deny claims and the injured worker may find that the pharmacy will not fill their prescription.

Because insurers are well aware of the risks of abruptly cutting off opioids, they generally file the form to initiate the legal process to reduce or eliminate opioids. However, if they do deny claims, an employee can file Form 110-A - Employee's Claim for Post-Lump Sum Medical Mediation which could also initiate the OATP.

If the OATP process does not begin at that point, either because the injured worker or the insurer do not agree to it, the injured worker may challenge the insurers' request and a mediating judge will make a determination. Most likely that determination will be appealed by one side or the other and in the appeal process, the judge will ask for an independent medical evaluation of the case. These independent reviews are charged with determining if the pain is related to the injury and if opioids are appropriate treatment. Taking into account the independent review, the insurers' arguments, and the patient and their lawyers' concerns, the judge will mostly, out of caution, order continuation of the prescription. As with most DIA proceedings, this process is adversarial, contentious, lengthy, and expensive. It does not provide assistance to the worker to reduce their opioid dependence. The "traditional" process may take over a year.

Stated OATP Program Goals

In Judge Hernandez' words[1], the objectives of the OATP are:

- Dramatically improve quality of care for those suffering with chronic pain conditions.
- Reduce time required to resolve clinical disputes.
- Reduce pain, suffering and side effects associated with inappropriate opiate prescribing.
- Provide attorneys, judges and injured workers with better tools for appropriate decision-making.

From the clinical perspective, the goal of the program is to help injured workers learn to manage their pain with less reliance on opioid medication, which in turn reduces the injured worker's risk for an adverse event, such as overdose.

Embedded in these objectives are the goals to reduce the contentiousness of the process, to avoid Judges making medical decisions, and to provide assistance to a willing injured worker to reduce their opioid dependence. Judge Hernandez suggested the following metrics to evaluate the program:

- How many employees discontinue the use of opioids
- How many cases enter the program
- How many parties opt out and return to the normal litigation process
- Reductions in prescription amounts and corresponding alternative care changes
- Average length of time to resolve cases
- Average cost to insurers (the average cost of continued opioid use compared to the average cost of treatment)

Judge Hernandez and others have described this program as a life-saving mission, recognizing that reducing opioid dependence among injured workers with chronic pain is a critical intervention to save workers' lives and can improve their pain management and overall health.

This Document Review contributes to a better understanding of the actual operation of the OATP, but it is not possible to determine the impact of the program based upon these documents. Further

[1] From slides prepared for presentation to the Harvard ERC 2/28/20

assessment of impact could be accomplished by contacting participants and non-participants, including employees, attorneys and DIA judges and other staff. This will be undertaken in phase three of this evaluation.

Methods

Materials

Completed 19A, 108A, and 110A forms from 2016 to 2022 were requested of the DIA. A data use agreement was formed between the DIA and the University of Massachusetts Lowell to protect the data and the confidential information contained in the documents. Social security numbers were redacted from the forms by the DIA. The researcher agreed to use and report on the data is such a way as to prevent the disclosure of identity of any of the individuals associated with the forms. Twenty-seven 19As, 59 108As, and 17 110As were received. The forms were coded with a unique identifying code including the form number type and the year the form was signed.

Abstraction Strategy

As mentioned above, 19A forms are used to document the results of medical mediation, whereas 108A and 110A forms are used to request mediation (by the insurer and employee respectively). The forms contain boxes to record personal information about the "employee" (injured worker) including address and date of injury and of birth, as well as information about the attorneys and employer. 108As and 110As include a required narrative section that records the reason the form is being filed.

In the case of 108As, we would expect to find reference to the Healthcare Services Board (HCSB) opioid protocol or other guidelines that the insurer determined were not being followed by the prescribing physician. Additionally, the 108A form might follow from an Independent Medical Exam (IME) that determined that the medical treatment (opioids) was not "necessary, reasonable, or casually" related to the employee's injury at work – which is the requirement for payment for medical care in the workers' compensation system. Employees' requests would be expected to reference the OATP as the desired goal of mediation, or perhaps, employee requests to re-instate payment for opioids that had been denied at the pharmacy following an insurer's refusal to pay for them.

The 19A form includes a section to record the agreement of the parties. There is no standardized content for these narratives. However, at a minimum, we would expect to find agreement on a Care Coordinator to facilitate opioid weaning and improved pain management, employee commitment to the process of weaning, and insurer commitment to continue to pay for opioids and alternative pain management and care coordination during weaning. We might also expect a description of the acceptable alternative modalities and a timeline for accomplishment of the goals of tapering or discontinuation. While there are no formal program guidelines, it is well understood that the OATP is a "program." Thus, we might expect to see reference to it in the 19A agreements.

An Excel worksheet was used to create a database of the forms' records. In addition to evaluator-assigned codes for each form, data was either transcribed directed from the forms, imputed from form data or from other resources, or interpreted from the narrative text by the investigator. Analysis categories were selected based on the OATP program goals and expectations as described above, and based as well on available information on the forms. Relevant form narratives related to the analysis categories were retyped verbatim in the spreadsheet. For example, the stated purpose of the OATP is to

come to agreement on a goal to reduce opioid dependence and improve pain management. Thus, analysis categories related to tapering and/or discontinuation and pain management plans were created, and the narratives were scrutinized for content related to tapering and pain management plans. Where Care Coordinators or Independent Medical Examiners were named, these names were recorded. Notes were generated by the investigator as questions or commentary on the narrative sections of the forms. For example, if "prescription medications" was written instead of narcotic or opioid medications, this was noted. If a form narrative was particularly comprehensive or illustrative, this was also noted.

Data was recorded or interpreted from each form as follows:

19A Data Characteristics and Source:

Transcribed from Form: Date 19A Co-Signed, Judge/AJ/Conciliator (if legible), Employee Town/City, Date of Injury
Imputed: DIA Region (from Employee Town/City and DIA assignment list), Gender (from name and/or use of pronouns); Date of Birth (from 108A/110A); Age to Date 19A Signed (calculated); Years between Injury and 19A (Calculated); Prior 110A (from matching date of injury and other employee characteristics); Prior 108A (from matching date of injury and employee characteristics)
Interpreted from Narrative Sections: Injury Description, Mention of Care Coordinator; Name of Care Coordinator; Goals of Agreement; Acknowledgement of Opioid Harms; Pain Management Plan; Taper Plan; Healthcare Services Board Chronic Pain Guideline or Opioid Protocol Referenced; Restrictions on Care Plan; Urine Screen for Opioids; Narcan (overdose reversing medication); Opioid Use Disorder Treatment; Insurer Commitments; Employee Commitments; Time Frames for the Agreement or Program; Reference to OATP; Original or Amended 19A; Metrics of Success/Evaluation; and Notes.

108A Data Characteristics and Source:

Transcribed from Form: Date 108A Co-Signed, Employee Town/City, Date of Injury, Date of Birth
Imputed: DIA Region (from Employee Town/City and DIA assignment list), Gender (from name and/or use of pronouns); Age to Date 108A Signed (calculated); Years between Injury and 108A (Calculated)
Interpreted from Narrative Sections: Reason for Insurer's Request; HCSB Guideline Referenced; OATP Referenced; Independent Medical Examiner Recommends Opioid Wean/Discontinue; Name of Medical Review Reviewer; 19A in Place; and Notes

110A Data Characteristics and Source:

Transcribed from Form: Date 110A Co-Signed, Employee Town/City, Date of Injury, Date of Birth
Imputed: DIA Region (from Employee Town/City and DIA assignment list), Gender (from name and/or use of pronouns); Age to Date 110A Signed (calculated); Years between Injury and 110A (Calculated)
Interpreted from Narrative Sections: Reason for Employee's Request; HCSB Guideline Referenced; OATP Referenced; 19A in Place; 108A also; and Notes

Descriptive statistics and qualitative summaries were created for these characteristics as appropriate. Numbers were too small to permit statistical analysis.

Results

Table 1 describes the basic characteristics of the injured employees with these forms in their files. In only a few cases did employees have more than one form from a prior year. The time between injury and the filing of these forms was 12-15 years. While we don't know if the employee was using opioid medications from the time of injury to the time of the form, we can assume that opioid use was long term for all of these cases – some potentially for as long as 30 years and others for a minimum of 5 years. More than half had more than 10 years between the date of injury and the filing of the 110A and more than three-quarters had more than 10 years between the date of injury and the filling of the 19A or 108A. Additionally, these employees were generally older (in their late 50's). The population for all form types was more likely to be male. The DIA regions were all well represented, with a greater number of forms filed in Boston and the fewest in Worcester. Stamps with the Judge's name were generally not legible.

Table 1: Population/Form Characteristics

	19A (Medical Mediation Agreement)		**108A (Insurer Request for Mediation)**		**110A (Employee Request for Mediation)**	
	n	**%**	**n**	**%**	**n**	**%**
Number of Forms	29		59		17	
Number of Injured Workers	27		55		17	
Avg Years btwn Injury and Form	14		15		12	
# more than 10 years	22	76%	45	76%	10	59%
Years Max	28		31		30	
Year Min	5		1		3	
Avg Age at signing*	59		57		57	
Age max	70		75		70	
Age min	31		31		35	
Gender (based on name)						
Female	8	28%	20	34%	7	41%
Male	21	72%	39	66%	10	59%
Region						
Springfield	6	21%	12	20%	5	29%
Lawrence	4	14%	9	15%	3	18%
Boston	10	34%	20	34%	5	29%
Fall River	6	21%	10	17%	2	12%
Worcester	3	10%	7	12%	2	12%

*Age is not reported on 19A forms. Ages for 19As only for those also with 108A/110As

Since the purpose of 108A and 110A forms is to request mediation around payment for medical care – most often regarding opioid medications, we would expect to see subsequent 19A mediation agreements for those employees where either they or the insurer had requested mediation. Additionally, multiple 19A forms would be expected for the same employee as the medical treatment changes. Specifically, while the employee's settlement will have specified paying for opioid medications, following involvement in the OATP, a new agreement may specify non-opioid medical care. **Table 2** details the observed overlaps between the requests for mediation and the mediation agreements and multiple requests as well as multiple agreements. Two-thirds of 19As had prior requests for mediation from the insurer. Employees requested mediation that resulted in agreements in 6 cases or 22%. There were also 6 cases where a 19A was agreed to without the filing of a request. There were only 2 cases where employees had more than one 19A agreement. One third of insurer requests for mediation around opioid medications resulted in 19A agreements (thus far). Almost half of employee requests have resulted in mediation agreements.

Table 2: Forms Overlap

19As with prior 108A	18	62%
19As with prior 110A	6	21%
19As with both 108A+110A	3	10%
19As with prior 19As	2	7%
19As w/o prior 108A or 110A	6	21%
108A with subsequent 19As	18	31%
Multiple 108As	4	7%
110A with subsequent 19As	5	29%
110A with 108A	3	18%

As shown in **Table 3**, in a majority of cases where the insurer requested referral of the case to mediation, an IME had recommended weaning or discontinuation of opioids. The medial reviewer was named in about half of the cases with Dr. Roberto Feliz as the reviewer in 12 cases (about 20%). The IME was referenced in several cases. The purpose of the IME is to determine if the medical care is reasonable, necessary, and causally related to the original injury. Continued opioid use may be challenged as not meeting these criteria. However, treatment for the problematic opioid dependence is considered related to the original injury.

Table 3: 108A Insurers' Request for Medical Mediation Characteristics

Characteristic	**n**	**%**
HCSB Guideline Referenced	7	12%
OATP Referenced	11	19%
IME Recommends Wean	37	63%
Medical Review Reviewer Named	29	49%
19A in Place	18	31%

One of Dr. Feliz' IME's was included in documentation and is included (redacted) as an appendix to this report. It details the complexity of the medical condition and recommended approach for weaning and pain management. The following quote is an illustrative case from the 108A forms is the following IME's opinion on the patient's need for tapering:

> *"The employee has been prescribed morphine and oxycodone since surgery in 2003. Dr. Feliz's IME recommended wean down or off. He provided detailed recommendations including weight loss and Cognitive Behavior Coping Mechanisms: 'Hopefully, these recommendations will reduce or eliminate the claimant's reliance on narcotic analgesics; improve his overall health by reducing his weight and improve his physical conditioning, and provide an overall more healthy and satisfying life.'"*

Additionally, insurers may have attempted to reduce employee's dependency on opioids either through the insurer's case management nurses contacting the patient or prescribing physician, or through denying payment for the prescription. In some cases, the 108A took note of conflicts between an IME

and the prescribing physician and in other cases, the parties had been able to engage the prescriber in the weaning process:

> *“treating provider is neglecting to address a weaning plan per Utilization Review”*
>
> *"claim settled and claimant continued to take opioids. Treating physician refuses to initiate weaning program."*
>
> *"letter from treating physician says that he would like to have employee admitted for detox"*
>
> *“Hearing deposed the treating physician who agreed that tapering was in the employee's best interest. Disagreement about transferring care to another physician…requesting mediation. ‘All parties agree that it is in the employee's best interest to taper her prescriptions for controlled substances.’”*
>
> *“Attempts to discuss this issue [the patient’s opioid usage] with the treating prescribing physician has gone unanswered”*

In seven cases, insurers made either direct or indirect reference to the HCSB’s opioid and/or chronic pain guideline as justification for their request for mediation. For example:

> *“IME says employee's medication regime does not comport with DIA circular letter no. 340, Chronic Pain treatment guideline, or CDC guidelines for opiate prescribing."*
>
> *"Claimant is currently receiving opioids at a level of MEQ 420 mg/day, when federal and state guidelines recommend less than 90 MEQ/day. He refused to attend an IME with a prominent pain medicine physician, although it was rescheduled 3 times and transportation was provided. Treating physician is not following the recommended guidelines for toxicology screens and other guidelines set forth at (ref. HCSB chronic pain guideline.)"*

The OATP was mentioned or described in 11 cases (19%) of the 108A “reasons for request” narratives. In one third of cases, an 19A was subsequently in place. In several cases, after a review of an IME recommending weaning, the parties agreed to move to mediation and the OATP and the 108A is the mechanism to get the judge to “move” it there:

> *“Upon receipt of that report, the employee agreed to start to attempt to wean and insurer agreed to pay for whatever modalities are recommended. As the parties are working together to achieve weaning...all parties agree that the OATP would be the appropriate tract for this matter as opposed to a hearing. The parties request that this matter be moved to the OATP."*
>
> *“The OATP has been discussed at length since the initial filing of the form 108. Since the filing of the form 108, the employee has been working with (treating physician) to wean. Both parties are agreeable to participating in the OATP and request it be moved from conciliation to OATP docket."*

Echoing findings of a previous report, OATP was sometimes not identified by name or understood. For at least three cases, there was clear recommendation to a program like OATP, but it was not mentioned:

> *"insurer is seeking to have employee weaned from excessive opioid drug use. Attempts to work with prescribing physician and or attempts by the insurer to have the employee enter a rehabilitation program have not been successful. Employee is willing to cooperate in a program with the hopes of reducing her reliance on medication."*
>
> *"Weaning should be carried out carefully and slowly to avoid withdrawal symptoms after careful discussion with the patient."*
>
> *"would benefit from gradual tapering … function-oriented pain management that provides a multidisciplinary program for weaning in a supportive, collaborative, informed, and monitored environment."*

In two cases, the insurer's attorney characterized the OATP as the "opioid diversion program" for employees who the IME determined had developed a "tolerance" to opioids. (In criminal proceedings for drug possession, the defendant may be offered a "diversion program for drug offenders.")

The filing of the 108A form was in several cases an attempt to "force" a mediation in light of a determination of problematic opioid dependence and a reluctant patient, or where the employee refused to participate in an IME:

> *"the employee carries the diagnosis 'opiate dependence, uncomplicated' and weaning downward or adjustment is clinically necessary. Employee needs a "drug holiday" Low dose is ok, but the high dose opiate as presently being prescribed is not clinically necessary."*
>
> *"Employee has not reduced pain meds as promised."*
>
> *"employee currently taking excessive narcotic medication. His treating physician has recommended weaning. Employee failed to appear at 3 scheduled IMEs."*

Table 4: 110A Employees' Request for Medical Mediation Characteristics

Characteristic	**n**	**%**
HCSB Guideline Referenced	0	0%
OATP Referenced	2	12%
19A in Place	5	29%
108A also	3	18%

Far fewer in number, employees and/or their attorneys filed 17 110A requests for medical mediation related to prescription medications, as shown in **Table 4**. In none of these cases were HCSB guidelines mentioned, and in two cases the OATP was directly mentioned. Despite limited mention of OATP by name, in several cases employees describing wanting assistance with non-opioid pain treatment and weaning.

In some cases, the employee was attempting to retain access to opioids after the insurer had taken actions to limit them:

"The self-insurer has denied payment of opioid medications and a claim was filed that resulted in an impartial examination. Based on the impartial (Feliz), the employee has reduced some of the medication but doesn't believe she needs to terminate all opioid medications."

"Insurer has denied pay of prescription medication since 2015. Injured Workers Pharmacy has continued to pay for the medication pending litigation and has a lien on the claim. The medications are prescribed by Dr. (treating physician) and are reasonable, necessary and causally related to the incident."

In several other cases, the employee is trying to bring the insurer to the table to negotiate an 19A in order to get payment for non-opioid pain treatment as well as assistance with the taper:

"Employee has been on long-term opiate treatment prescribed by her doctor. Employer is looking to terminate opiate treatment. Employee is open to exploring pain management alternatives for her long-term safety."

"The insurer has filed a request to discontinue the employee's benefits. The employee's treating Dr was deposed, and the employee has started to taper off her medications. The parties are looking for oversight and assistance as the employee reduces her medications."

“The employee desires to engage in a supervised opiate reduction plan.”

As described above, the 19A mediation agreements were analyzed for their content in the categories listed in **Table 5.** There is no “fixed” content for 19A agreements. Indeed, even though the purpose of the 19A form is to negotiate the terms of the OATP, the program itself was only mentioned in one-fifth of the forms. In some cases, it was not clear that the OATP was “engaged” – the 19A reflected an agreement to continue opioid therapy with no commitment to reduce use beyond what had already been achieved. In two cases the 19A appeared to be an agreement to allow nurse case management, but not necessarily require a taper.

The OATP’s central component is the engagement of a Care Coordinator to facilitate the reduction or eliminate of opioid dependency and necessary healthcare and pain management. Care coordination was mentioned in just under two-thirds of the 19As and the Care Coordinator was named in just over one-third of 19As. Only two Care Coordinators were named, with Michael Pringle named in eight forms. In a few cases, the agreement specified that a Care

Table 5: 19A Medical Mediation Agreement Characteristics

Characteristic	n	%
Injury described	3	10%
Care Coordinator	18	62%
Care Coordinator Identified	11	38%
Goals Described	21	72%
Opioid Harm Acknowledgment	2	7%
Pain Management Plan	8	28%
Taper Plan	7	24%
HCSB Guideline Referenced	6	21%
Restrictions	3	10%
Urine Screen	2	7%
Narcan	1	3%
OUD Treatment	4	14%
Insurer Commitment	24	83%
Employee Commitment	17	59%
Time Frame	5	17%
Reference to OATP	6	21%
Amendments	3	10%
Metrics of Success/Evaluation	4	14%

Coordinator would not be engaged and that the treating physician would carry out the taper and any other medical treatment.

Many 19As included no details and only a few sentences. A few were comprehensive "model" mediation agreements. (A redacted model 19A is included in the Appendix along with a checklist of recommended components to a 19A agreement.) For example, while each plan for tapering and for pain management will be unique to each particular case, including preliminary plans for each would seem to be an important part of a 19A agreement.

Most 19As included the goal of reducing use of opioid medications and an employee commitment to a "good faith effort" to work with the provider to do so. Employee commitment language examples include:

> *"cooperate and work with OATP CC and follow reasonable recommendations and referrals"*
>
> *"employee is willing to consider alt pain management recommended by PCP"*
>
> *"agrees to try to wean"*
>
> *"agrees to cooperate fully with the proposed program protocols"*

However, while the HCSB Guideline which discusses limits of 90 MEQ/day was mentioned in almost a quarter of the cases, most 19As goals were more vaguely phrased as "reduction" or "elimination" of narcotic medication. Examples of language related to goals is as follows:

> *"assist the employee in reducing or eliminating his need for opioid medication to control his chronic pain"*
>
> *"smooth and healthy cessation of the employees prolonged use of narcotic medication"*
>
> *"attempt to reduce and possibly eliminate the need for the narcotic medications"*
>
> *"favorable medical outcome"*

Insurer commitments generally included a commitment to continue to pay for opioid medications during the taper and for alternative treatments. Generally, there was also an agreement to pay a one-time fee to the employee's attorney. In a few cases, the 19A included restrictions on what medical care would be paid for by the insurer, such as excluding medical marijuana. In one case, the insurer was explicit that medical care related to the agreement would not be subject to Utilization Review. In other cases, specific treatments were approved, or the insurer committed only to "reasonable treatments." Insurer commitment language examples include:

> *"incur the cost of treatment, including reasonable alternative medical treatment or other reasonable recommendations of the Care Coordinator"*
>
> *"good faith effort to approve the alternative treatment recommended by the CC"*

“continue to pay for opioids and other medications”

“pay for aquatic therapy; orthopedic eval; pay out of pocket expense for oxy”

"authorize ongoing opiate reduction strategies"

In a few cases, medical processes related to substance use disorder and treatment were mentioned including stays at rehabilitation facilities, Narcan, and urine drug testing for compliance with reductions. Very few 19As included timelines, milestones, reporting requirements, or metrics of success or failure. There were three cases in which more than one 19A was signed, but in a few others there was not yet another 19A. In one case, the subsequent 19A noted that the goals of first were met and the "employee successfully completed his treatment program."

Most 19As also included reference to release of medical records to the Care Coordinator or other providers and also the possibility of return to the traditional litigation route in the event that either party deemed the OATP to be not working.

Discussion

The documents reviewed here offer insight into the performance of the OATP. Twenty-seven injured employees had 19A forms. It is not clear that all of these employees were participating in the OATP as it is not a program with definitive enrollment or a “sign-up.” Indeed, in some cases the 19A form seemed to suggest no involvement of a Care Coordinator and no explicit goal to reduce opioid dependence. On the other hand, it appears from review of the 108A forms that some employees were able to get assistance in reducing their opioid dependence without a formal 19A agreement.

The most common pathway to get assistance with taper and non-opioid pain management appeared to be the insurance company requesting an IME, and IME that recommended weaning, and the subsequent filing of a 108A to enter mediation with an employee towards the goal of reducing opioid dependence. In some cases, it was clear that the IME alone was sufficient to incentivize a taper with or without a 19A agreement. In far fewer cases, employees themselves sought insurer support for alternative medical treatment and a taper.

The total universe of employees who are eligible for assistance with a taper via the OATP is not known. There were six 19As without prior 108As or 110A and there were 69 injured workers who were the subject of 108As and 110As. Thus, we may estimate that approximately one-third of eligible employees have participated to some degree in the OATP. However, it is quite possible there are more eligible employees than are represented by these forms. Additionally, through the “traditional” litigation process, judges may have ordered insurers to continue to pay for opioids and/or opioids plus alternative treatments including those related to weaning.

We know that in some cases, employees were denied opioid prescriptions. However, the abundance of 108A forms that focus on requests for mediation that would result in weaning suggests that several insurers are aware of the dangers of rapid cessation of opioids and are seeking alternatives to traditional litigation to reduce harmful opioid dependency among injured workers. We do not know how many physicians weaned patients without involvement of the DIA.

The open narrative structure of all three forms most often did not include formal reference to the OATP or DIA HCSB guidelines, identification of Care Coordinators, nor tapering or pain management plans. However, the goals of weaning and improved medical care were represented in a majority of 19A agreements. Timelines, milestones, metrics of success or failure and or reporting requirements were virtually absent from these forms, although they may come into play following the negotiation of the 19A.

To promote success of the goals of the OATP, the following items are recommended as components of a 19A guideline for medical mediation regarding opioids and the OATP:

- Acknowledgment that the employee's current opioid medication regime is not meeting recommended guidelines and/or is not in the best interest of the employee's health.
    - Provision of overdose-reversing naloxone medication to the employee and/or their family.
- Acknowledgment that the employee's current medical treatment needs to be augmented with non-opioid pain management modalities and medical treatment for opioid dependence.
- Employee agreement to participate in the OATP and good faith effort to cooperate with medical providers, including the designated Care Coordinator.
- Identification of the Care Coordinator or other medical provider who will assist with the process, or how that person will be chosen.
- Insurer agreement to pay for reasonable and necessary medical care, including opioid medications and other strategies recommended by the Care Coordinator and other providers without burdensome Utilization Review.
    - Agreement to pay for non-medical services that may be helpful with the taper and pain management, including psychological and physical therapy, pain self-management training, and exercise services.
        - Discussion of excluded services to prevent misunderstanding
- A tapering plan consistent with HSCB and/or CDC recommendations for tapering, to be individualized as necessary.
    - Use of Substance Use Disorder Treatment as necessary including medications, counseling, in and out-patient rehabilitation, and compliance testing.
- A pain management plan consistent with recommended best practices, and/or how non-opioid pain management will be approached.
- Establishment of health goals including target dosages of opioids, improved function, self-reported improved pain management, and other personal health indicators such as improved sleep and other goals identified by the employee and Care Coordinator.
- A timeframe for evaluation of progress towards the goals of opioid reduction or cessation and improved pain management with a schedule of reports and or in-person meetings.

Conclusion and Recommendation

These documents provide insight into the OATP program as actually utilized for this generally older injured worker patient population experiencing long-term opioid therapy. Although the forms portray only part of the picture, they suggest that there is wide diversity in how the OATP is conceptualized, carried out, and documented. In many cases, the agreements include plans for improved non-opioid

medical care and reduction of opioid dependence. In other cases, employees appear to continue to rely on opioids and may have serious opioid dependence and, potentially, opioid use disorder.

Earlier program evaluation efforts have emphasized that tapering and pain management programs need to be individualized. However, following a guidance document in making this individualized plan may save time and effort and may avoid missed opportunities and confusion. Additionally, the "checklist" approach may assist in promoting best practices and greater success for the process where employees, insurers, and the DIA judges feel that "good faith" efforts have achieved their desired result in a reasonable timeframe without adverse consequences.

According to care coordinators interviewed for this program evaluation, the process of supporting a taper and achieving better pain management for long-term opioid users can be extremely challenging. This review makes clear that OATP agreement guidance may help in encouraging more participation in the OATP, supporting strong OATP plans, and achieving success in reducing dangerous opioid dependence while improving well-being. Thus, the overwhelming recommendation of this document review is the adoption of a checklist guidance document for 19A agreements based upon the draft contained in the appendix to this report.

Appendix

Independent Medical Review (sample)

"Model" 19A Sample

Guidance Checklist for 19A Agreements (draft)

BOSTON PAIN CENTER INC.

188 Providence Street
Hyde Park, MA 02136

Tel. (617) 361 2166
Fax (617) 364-3871

Treating Provider: Roberto Feliz MD

Date of Service:
August 08, 2019

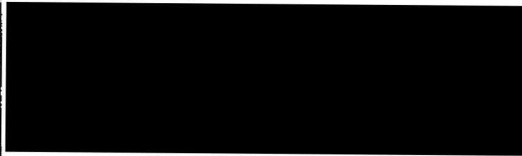
All Current Medications
oxycodone 5 mg tablet, 1 Tablet(s) PO QID.

Past Medical History
Low back pain
Opioid dependence, uncomplicated
Other instability, right knee
POSTLAMINECT SYND-LUMBAR
Sacroiliitis, not elsewhere classified
Spondylosis without myelopathy or radiculopathy, lumbosacral region

Surgical History
back surgery Recorded Date: April 24, 2019
Right Hand Surgery Recorded Date: April 24, 2019

Family History

Chief Complaint/History of Present Illness
The Commonwealth of Massachusetts
Division of Industrial Accidents
Impartial Unit
One Congress Street, 10th floor
Boston, MA 02114



I have been asked to provide a supplemental report on And, to address a series of hypothetical questions:

Hypothetical questions:

Kindly assume the following facts are true:

1) The employee is currently 56 years of age.
2) O 998, the employee was in the course of his employment as an when he fell from a ladder landing on his buttocks.

Social History
Marital status Married
Tobacco history Denies tobacco use
Alcohol history Drinks alcohol socially
Number of children 2

Allergies
NO KNOWN DRUG ALLERGIES

NO KNOWN FOOD ALLERGIES

3) The insurer has accepted liability for L4-5 discectomy and right sided radiculopathy.
4) The employee underwent post lumbar laminectomy at L4-5 in 1999 and a 2 level intradiscal electrothermal annuloplasty at L3-4 and L4-5 in 2000.
5) The employee's nonsurgical treatment has included therapy, a transcutaneous electrical nerve stimulation (TENS) unit, opioids and epidural steroid injections (ESIs).
6) His current medication regimen includes: a. 5mg every 6 hours of Oxycodone. b. Motrin
7) The employee continues to complain of ongoing pain due to his industrial injury.

ASSUMING THE ABOVE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY, AND BASED UPON YOUR EXAMINATION, YOUR REVIEW OF THE RECORDS, AND YOUR KNOWLEDGE AND EXPERIENCE PLEASE ADVISE:

A. Are the employee's ongoing monthly visits to the pain clinic reasonable and necessary based on the amount of pain med is he is taking?

Yes. As long as the patient remains on chronic opioid, the standard of care for this region is to visit the prescriber every 4 to 6 weeks for close monitoring, random urine screening, PMP monitoring.

B. In your opinion, based on the amount of pain medication the employee is taking, what would be the recommended frequency of office visits?

As stated above, every 4 to 6 weeks. In MA, opioid medications can not (or should not) be refilled. This forces monthly visits not only for close monitoring while on opioids but also for medications refills.

A. What are the employee's work-related diagnoses?

1. Chronic lower back pain with right sided radiculopathy.

2. Failed surgery lower back pain syndrome

3. Chronic opioid Dependency

B. What ongoing treatments are recommended, if any?

1. Oxycodone 5 mg every 6 hours (20 mg per day):

Oxycodone (20 mg per day or 30 mg of Morphine equivalent per day is below the DIA recommendations of 90 mg of Morphine per day) as currently prescribed is low dose and is reasonable and within acceptable standard of care for similar patients. However, Mr. keenan must be educated/re-educated that when opioids are prescribed chronically they do led to not only tolerance (becoming much less effective with time), but also the ingestion of chronic opioids (paradoxically and unintuitive) lead to the development of opioid induced hyperalgesia and peripheral nerve hypersensitization making patients on chronic opioid more sensitive to pain; as well as, the development of opioid induced microglia and astroglia cells mediated/cause central/spinal cord and brain neuroinflammation leading to the real possibility of experiencing more painful

sensations.

Moreover, the recent study by Erin Kreb, et. al (Jama, 2018,; 319 (9):872-882, showed that treatment with opioids was not superior to treatment with nonopioid medications (Nsaids) for improving pain related function over 12 months for lower back pain.

As such, minimization (and if possible weaning off) of chronic opioids is always recommended for any patient with chronic pain.

2. Spinal injections/interventional injections.

In this geographic region, 2 to 3 spine injections (lumbar ESI, lumbar facets) per year is reasonable and within acceptable standard of care to maintain relative comfort in a patient with Mr. [redacted] clinical history of lower back pain.

3. A Program of lumbar spine stabilization and functional restoration therapeutics kinetic and dynamic exercise to strengthen and recondition his deconditioned and weakened lumbar spine.

C. What ongoing treatments are causally related to the industrial injury?

1. The medications as above, the spinal injections and the functional restoration program as above.

D. Is the employee's ongoing use of Oxycodone reasonable, necessary and causally related to the industrial injury?

As dictated above. The low dose Oxycodone is reasonable. But medically necessary not in the absolute, see Krebs study as above. The need for Oxycodone is causally related to his industrial accident.

E. In your opinion, would the employee benefit from a weaning of Oxycodone? If yes, please set forth the specific weaning protocol that you would recommend for each medication.

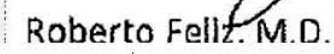
1. As stated above the continued prescribing of 20 mg of Oxycodone per day is reasonable but not absolutely necessary and potentially can be making Mr. [redacted] pain worse and more intense. Oxycodone is a good medication for acute inflammatory pain. Unfortunately, for chronic pain, oxycodone loses its effectiveness and pain relieving capacity as tolerance, opioid induced hyperalgesia and opioid induced neuroinflammation sets in. As well as, the others side effects associated with chronic opioid ingestion.

In this geographic region, then, the decision to maintain a patient like Mr. [redacted] on chronic low dose oxycodone (20 mg per day or 30 mg of morphine equivalent) is left up to the treating physician (and the patient).

In my clinical pain practice, treating a multitude of similar patients with chronic lower back and failed back pain, I always aim to wean and minimize chronic opioids

dependency. And as of yet, I have not seen any significant deterioration of the pain with a slow and gradual wean from chronic opioid dependency. And paradoxically, most patients reports feeling better and with improved mental clarity and more get up and go.

If the decision is made to attempt a slow and gradual wean (over 3 to 5 months), I suggest weaning 5 mg of Oxycodone per month until off.



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Medical Director, BPC Post-Injury Stabilization and Functional Restoration Program.
The Feliz Center for Neuralgia/Complex Regional Pain Syndrome Management.
(617) 361-2166 Fax (617) 364-3871.

Roberto Feliz MD

Generated on 8/8/2019

RE: Employee -
Employer -
Insurer -
Date of Injury - /2003
DIA #

SECTION 19A AGREEMENT - Referral to OATP

Whereas this matter was settled previously by lump sum agreement;

Whereas the insurer has filed a request to discontinue or reduce medical benefits provided by M.G. L. c. 152 Sections 13 & 30, contesting adherence to DIA opioid and controlled substances protocol; reasonable, necessary and related treatment; mitigation of damages and functional benefit or palliative relief;

Whereas current medication treatment represents significantly high morphine equivalency as noted in medication review by Optum Clinical Services dated November 11, 2020;

Whereas both parties recognize that long term opioid treatment creates health risks and dependence; and that reduction or elimination of the use of, or dependence on, opioids and controlled substances provides a significant health benefit;

Whereas both parties seek a favorable medical outcome for the employee;

Now therefore, the parties hereby agree as follows:

1. The current dispute shall be referred to the DIA opioid alternative treatment pathway, a.k.a. OATP.

2. Both parties shall undertake this alternative program in good faith.

3. The employee agrees to cooperate and work with the OATP qualified Care Coordinator and to follow reasonable recommendations and referrals.

4. The employee agrees to provide and sign all necessary medical authorizations and releases as required or requested by the mediating Judge or Care Coordinator, or reasonably requested by the insurer.

5. The employee shall attend reasonable independent medical examination(s) scheduled by the insurer.

6. The insurer agrees to incur the cost of treatment, including such alternative medical treatment or other recommendations of the Care Coordinator, insofar as the same are reasonable, necessary and related to the above industrial injury.

7. The insurer agrees to incur all referral fees for OATP and to pay to employee's counsel upon approval of this agreement the legal fee specified below.

8. The employee suffers from other health conditions. This agreement does not change, increase or expand insurer's obligations beyond those accepted in the original lump sum agreement for the above industrial injury. This agreement suspends but does not ratify or resolve any disputed issues including without limitation those raised in the pending request for discontinuance or modification.

9. Both parties understand and agree that at the request of either party this matter may be removed from the OATP system and returned in its present status to the traditional DIA dispute resolution system.

10. Any provision or portion of this agreement which is deemed unenforceable or in conflict with any applicable law, regulation, or finding may be severed and voided, whereupon the remaining agreement shall remain unaffected and all other provisions shall continue in full force and effect.

Signed this 18th day of December, 2020.

APPROVED

Administrative Judge
Department of
Industrial Accidents
01/07/2021

19A Guidance Checklist (DRAFT)

19A Agreements should consider inclusion of the following items. The sentences following the item include potential language which should be tailored to meet the needs of the parties.

- ☐ Participation in the OATP
    - The employee and the insurer acknowledge voluntary participation in the Opioid Alternative Pathway Treatment program (OATP) and commit to participate in good faith.
- ☐ Right to Traditional Litigation
    - Participation in the OATP does not indicate waiving of rights to traditional litigation. Parties understand and agree that at the request of either party this matter may be removed from the OATP system and returned in its present status to the traditional DIA dispute resolution system.
- ☐ Adherence to Opioid Guidelines
    - Current medication regime does not adhere to the DIA HCSB's Opioid Protocol and/or Chronic Pain Guideline and/or other guidelines (CDC, American College of Occupational and Environmental Physicians). At a minimum, the medical care must meet these guidelines.
- ☐ Independent Medical Review Recommendations
    - An Independent Medical Review has recommended a reduction or discontinuation of opioid therapy and the following alternatives […]. The employee shall attend reasonable independent medical examination(s) scheduled by the insurer.
- ☐ Goal of Better Health
    - The goal of the OATP is improved health and well-being for the employee, including improved pain management.
    - Long-term opioid treatment creates health risks and dependence. Reduction or elimination of the use of, or dependence on, opioids can provide health benefits.
    - The employee and the Care Coordinator shall establish and document health goals for the employee such as [… examples: improved ability to care for one's daily needs, improved sleep, ability to walk without assistance, no barriers to attending family events, etc.].
- ☐ Taper Plan
    - The parties acknowledge that the opioid tapering plan should follow recommended guidelines [ref] and that rapid tapers should be avoided.
    - The employee's goal is reduction of [opioid medications] below [dose/day] through a slow taper of [dose/month] within [#] months and elimination of use of opioids by [date].
    - Reduction in opioids can cause a perception of increased pain temporarily known as opioid hyperalgesia. The employee shall be provided with supportive therapies to manage pain and withdrawal symptoms during the taper and shall adhere to the tapering protocol.

   - The parties acknowledge that reduction of opioid dependence can be a difficult and lengthy process and may need repeated attempts. The provider should not abandon the patient.

- [ ] Care Coordinator Selection and Payment
   - The parties agree to engage […] as the Care Coordinator or facilitating provider for the purposes of reduction and/or elimination of opioid dependence and improved pain management.
- [ ] Cooperation with Care Coordinator
   - The employee agrees to communicate and cooperate with the Care Coordinator and to follow reasonable recommendations and referrals.
- [ ] Timeline
   - The parties agree to evaluate progress toward the goals of this agreement at 6 months and at one year from the signing of this agreement. This agreement shall be renegotiated at one year. The Care Coordinator will provide monthly reports to the Insurer and mediating Judge.
- [ ] Medical Authorization
   - The employee agrees to provide and sign all necessary medical authorizations and releases as required or requested by the mediating Judge or Care Coordinator, or reasonably requested by the insurer.
- [ ] Opioid and Non-Opioid Pain Treatment Payment
   - The insurer agrees to incur the cost of treatment, including opioid medications and such alternative medical treatment or other recommendations of the Care Coordinator, including functional restoration, exercise programs, physical therapy, chiropractic therapy, massage and acupuncture, psychological pain management training, and others including [….] insofar as the same are reasonable, necessary and related to the above industrial injury.
   - The following approaches shall be excluded [….].
- [ ] Opioid Dependence Treatment Payment
   - The insurer agrees to incur the cost of treatment and other recommended modalities related to the reduction and elimination of opioid dependence, including consultation with addictions specialists, medication-assisted therapy, management of withdrawal symptoms, treatment of opioid side effects, addiction counseling and recovery support, naloxone prophylaxis, urine screening, and residential or non-residential rehabilitation treatment.
- [ ] Care Coordinator, Referral and Legal Fees
   - The insurer agrees to pay the Care Coordinator’s fees, referral fees, and to pay to employee's counsel upon approval of this agreement the legal fee specified below.