The legal prescription narcotic crisis is a major factor in driving skyrocketing workers compensation costs. This crisis threatens a company’s productivity and profitability. It can increase direct costs, indirect non-insurable costs, and future workers’ compensation costs. The usage statistics paint a dire picture:

- The United States, which accounts for only 4.6 percent of the world’s population, consumes 80 percent of the global narcotic supply and 99 percent of its hydrocodone supply.¹
- Prescriptions for narcotics have increased by 402 percent (milligrams per person) in the United States, from 1997 to 2007.²
- Sales of oxycodone (OxyContin) in the United States grew 866 percent, from 1997 to 2007.³
- Approximately 16,000 prescription narcotic overdose fatalities, 144,000 prescription drug abuse treatment admissions, 480,000 emergency department visits for prescription drug misuse / abuse, 1.9 million people with abuse / dependency issues, and 12.7 million nonmedical users in the United States, in 2009.⁴
- Admissions to rehabilitation centers due to painkiller addiction have grown by 400 percent in the United States, from 1999 to 2010.⁵
- Hospital emergency room treatments, related to prescription pain medications, increased 400 percent from 1998 to 2008.⁶

**The Crisis Impact**

If used too early in treatment, too frequently or too long, prescription narcotics can drive up associated disability payouts and medical expenses by delaying an employee’s return to work. Workers’ compensation claim expenses are up to nine times higher when narcotics are prescribed to treat pain. Workplace insurers spend an estimated $1.4 billion annually on narcotic painkillers, or narcotics.⁷

Multiple research studies indicate that narcotic treatment may actually retard patient functional recovery, and impede returning to work.⁸ The detrimental impact of prescription narcotics can linger even after an employee has returned to work. Someone on narcotics for about three months already is getting dependent and developing severe tolerance of the drugs, especially when escalating their dosage.⁹

Increased workers’ compensation costs are not the only exposure that employers face. Appellate courts in four states have held that employers, and insurers, are financially accountable for overdose deaths tied to injured workers.¹⁰

**Best Practices**

Employers need to develop an effective partnership and a strong business relationship with their occupational medical provider, in order to support your execution of an effective return-to-work process. Since research studies have demonstrated that the use of narcotics by injured workers can impair their ability to return to work, the critical control point must focus upon the prescribing physician. Employers should, where legally permissible, obtain a commitment — preferably a written statement — from their occupational medical care provider that they will follow a conservative pain management treatment strategy, by implementing an effective narcotic prescription control program to include:

- Before prescribing narcotics, utilize risk screening tools to assess patient’s history of substance abuse and the potential for narcotic misuse. If the patient is assessed as high risk, pursue nonnarcotic alternatives.
- Narcotics are prescribed only as a last resort, through incremental step dosages, by using a lower-dose, short-acting narcotic. The dosage is increased incrementally only if absolutely necessary, and based upon evidence of positive reduction in pain symptoms and improvement in activities of daily living.
Narcotics are prescribed in conformance with treatment guidelines as promulgated by Official Disability Guidelines™ and applicable State workers compensation medical treatment guidelines.

Narcotics are prescribed only after communicating:

- The benefits and risks of taking narcotics, through patient counseling and education.
- Instructions about proper dosage and warnings about interaction with other medications, food or alcohol.
- Potential and known side effects of the medication and the impact of long-term narcotic use including risk of physical tolerance, dependency and other physical or emotional side effects.

Patient pain medication agreements are contracted with all patients receiving narcotic therapies, stipulating adherence to:

- Clearly defined objectives.
- Dosage and frequency.
- Using only one pharmacy.
- Urine drug screenings.
- Medication security – only for personal use.
- Medication reduction and discontinuation dates.

Generics are always prescribed when available.

Utilize baseline and periodic urine drug screenings to determine:

- Absence of prescribed medication.
- Presence of prescribed medication based on prescribed therapeutic dose.
- Presence of illicit substances or other non-prescribed medications.

Discontinue narcotic therapy if there is:

- No, or minimal, reported pain relief.
- No, or minimal, reported improvement in activities of daily living.
- Adverse side effects.
- Aberrant drug-taking behaviors, misuse, drug diversion, requests for specific brands, dosages or types of drugs; reports of lost prescriptions or medications; requests, etc.

Periodic evaluation of narcotic therapy continuation, using established evidence-based guidelines for the diagnosis and the treatment plan.

Advise the employer if any prescription medication may impair the employee’s ability to perform their job functions safely, particularly operating machinery and vehicles.

To whatever extent a state affords or limits the opportunity to direct an injured worker to a medical care provider, employers need to have an effective partnership with an occupational medical care provider, preferably in our CNA PPO Network, who supports a Return-to-Work Program. To achieve this goal, the occupational medical care provider must be committed to following a conservative pain management treatment strategy, by implementing an effective narcotic prescription control program. In states where employees may select their own physicians, a company may be able to introduce its workforce to an occupational medical care provider, through wellness programs, health care educational events, promotions and communications. These are all worthwhile programs and initiatives to benefit employees, their health and well-being.

We are all working to achieve what is best for your injured employees, which is to provide them with the best medical care, and to return them to productive employment.
1 Pain Physician Journal, “Effectiveness of Long-Term Opioid Therapy for Chronic Non-Cancer Pain,” E134, Laxmaiah Manchikanti, MD; Ricardo Vallejo, MD, PhD; Kavita N. Manchikanti, BA, MS IV; Ramsin M. Benyamin, MD; Sukdeb Datta, MD; and Paul J. Christo, MD, 2011.


3 Pain Physician Journal, “Effectiveness of Long-Term Opioid Therapy for Chronic Non-Cancer Pain”, E134, Laxmaiah Manchikanti, MD; Ricardo Vallejo, MD, PhD; Kavita N. Manchikanti, BA, MS IV; Ramsin M. Benyamin, MD; Sukdeb Datta, MD; and Paul J. Christo, MD, 2011.

4 Centers for Disease Control and Prevention, National Rx Drug Abuse Summit, New York, NY, April, 2012.


6 Substance Abuse and Mental Health Services Administration, SAMHSA Newsletter, Virginia Hartman, July/August 2010.


University of Washington Medical School, “What is the Evidence for the Effectiveness of Opioid Analgesics for Chronic Pain from Clinical and Administrative Data, Jane Ballantyne, MD, 7/10/12.

9 Ending the Inappropriate Use of Narcotics in Workers’ Compensation, Alex Swedlow, EVP-California Workers Compensation Institute, The Forum 2011: Dialogue to Improve Workers’ Compensation, IAIABC on March 14-18, 2011 in St. Louis, MO.

The Journal of the American Medical Association, “What Are We Treating With Long-term Opioid Therapy?”, Mark D. Sullivan, MD, PhD; Jane C. Ballantyne, MD, FRCA, 3/12/12.

10 Business Insurance, 5/20/12, Court Ruling in Commerce & Industry Insurance Co. vs. Kimberly Ferguson-Stewart et al, Roberto Ceniceros, 5/11/12.