StateWatch

Notice of Regulatory Alerts

Early Spring 2018

Keep current with new legislation and its potential effect on your organization. This regulatory update is for informational purposes only, and provides some key highlights on state initiatives that may impact the services Genex provides. This information is also available online at genexservices.com/legislative-updates.

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National

The FDA recently *approved a new opioid prodrug, Apadaz (benzhydrocodone and acetaminophen)*. The oral tablets are designed for short-term (no more than 14 days) management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

According to the **American College of Occupational and Environmental Medicine (ACOEM)** *employers pay a high price for worker obesity*, whether it's from elevated employee medical costs, more absences from work or an increase in workplace injuries. ACOEM is recommending employers take steps to reduce or prevent obesity among employees, such as implementing workplace wellness programs, offering behavioral counseling or even providing coverage for bariatric surgery in some cases. Published in the January edition of the *Journal of Occupational and Environmental Medicine*, the study also showed that work itself may contribute to obesity through risk factors such as social stressors, working hours, sleep and night shift work, and sedentary behavior.

The **National Council on Compensation Insurance** (NCCI) *recently issued a 2018 Update on Medicare Set-Asides and Workers' Compensation*. The update expands on the previous MSA study published in 2014, using a larger data sample.

WATCHLIST: Recent legislation introduced in Congress would *impose a national three-day limit on opioid prescriptions* for routine, acute care. The bill is a follow-up to the Comprehensive Addiction and Recovery Act (CARA) that took effect July 2016. While many individual states have enacted days-supply limits on initial opioid prescriptions for acute pain, **S.2456, or CARA 2.0**, would also require physicians and pharmacists to check their state's prescription drug monitoring program when prescribing or dispensing opioids. The bill would also allocate about $1 billion to programs such as first-responder training and access to overdose-antidote naloxone, educational campaigns, and support services for recovering addicts. The sponsors of CARA 2.0 said the proposed three-day limit on initial opioid prescriptions is based on CDC's *opioid prescribing guidelines*. The CDC guidelines state that for acute pain, three days or fewer of opioids will often be sufficient, and more than seven days will rarely be needed.

Arizona

WATCHLIST: Arizona physicians would not be allowed to prescribe more than a five-day supply of any opioid medications in most cases, under a bill introduced in the state Senate. **SB 1111** *would impose a five-day limit* on initial opioid prescriptions except in the case of surgery, when doctors would be allowed to offer a 14-day supply of narcotic painkillers. The duration cap would also not apply for most traumatic injuries, cancer cases or end-of-life care. The bill would also require doctors include in their reports documentation of a physical examination of any patient receiving opioids, that a risk-assessment was performed and

the employee gave informed consent for an opioid prescription. It would also require doctors to provide a treatment plan explaining the frequency of face-to-face follow-up visits to re-evaluate the continued use of opioids, criteria and procedures for tapering or discontinuing opioids, and criteria and procedures for referring patients for addiction treatment. SB 1111 would additionally require doctors to consult with the state's prescription drug-monitoring database before prescribing a Schedule II, III or IV opioid or benzodiazepine, and at least once every three months while the prescription is part of the treatment for an injured worker.

WATCHLIST: A lawmaker has introduced legislation that would *allow all injured workers to waive the right to future medical care* when settling a claim. **SB 1100** would allow full and final settlements regardless of whether a claim is denied or accepted. The bill would also eliminate the requirement that injured workers be represented by an attorney when entering a settlement that waives the right to future medical treatment. SB 1100 would require the injured worker to submit a signed attestation that he or she understands what rights are being waived as a result of the settlement. The bill would maintain a requirement that the Industrial Commission approve any full and final settlements, but it would eliminate the requirement for the commission to consider whether the settlement is in the best interests of the worker. The new criteria for approving settlements proposed in SB 1100 would be whether the deal is "fair and reasonable to the employee."

Indiana

WATCHLIST: **Gov. Holcomb** is expected to sign a recently passed bill that *would phase in a requirement for doctors to check INSPECT*, the state's prescription-monitoring database, before prescribing opioids to a patient. SB 221 would apply to doctors in emergency rooms and pain management clinics effective January 2019; clinicians treating patients in a hospital in January 2020; and all practitioners, starting January 2021.

WATCHLIST: *SB 369*, legislation to adopt a drug formulary, is headed to *the governor for signature*. If approved, the bill becomes effective on Jan. 1, 2019. Indiana would join Texas, Kansas, Montana, North Dakota, Vermont, California, New York, Arizona, Wyoming, Tennessee, Delaware, Ohio, Oklahoma and Washington in adopting a workers' comp drug formularies.

Kentucky

WATCHLIST: **HB 2** would *mandate a drug formulary, medical treatment guidelines* and a 15-year cap on permanent partial disability medical benefits. Kentucky ranked 36th in the nation for employer cost of workers' comp coverage, according to a *2016 benchmarking study* by Oregon regulators. Kentucky premiums cost an average of $1.52 per $100 in payroll, 82 percent of the national median.

Massachusetts

WATCHLIST: **Bill H.4033** would direct the Department of Industrial Accidents (DIA) to *establish its own formulary of "clinically appropriate" medications*, including opioids and related medications, and to craft regulations on how to administer it. The DIA would work with the Health Care Services Board and the new Drug Formulary Commission to establish a formulary based on "well-documented, evidence-based methodology" and to update the formulary every two years, if necessary. The formulary would be required to include a complete list of medications that are approved for payment, as well as any specific payment, prescribing or dispensing controls associated with drugs on the list. According to the CDC, Massachusetts had the *seventh-highest drug overdose death rate* in 2016.

Nebraska

Effective Jan 1, the state **Department of Health and Human Services** requires all dispensed prescriptions to be *reported to Nebraska's Prescription Drug Monitoring Program (PDMP).* The PDMP stores the information in a secure database and makes it available to healthcare professionals as authorized by law.

New York

The **Workers' Compensation Board** has also *adopted its new permanency impairment guidelines*, which are used to determine schedule loss of use awards. Under the guidelines, which became effective Jan. 1, SLU awards are given to workers who permanently lose the use of an upper extremity, lower extremity, eyesight or hear-

ing. Compensation is limited to a certain number of weeks based on the body part and severity of the disability, according to a schedule set by law. Temporary benefits that have been paid are deducted from the total SLU award.

WATCHLIST: The **Workers' Compensation Board** selected the Reed Group as its prescription drug formulary vendor and *adopted revised permanency impairment guidelines*, according to notices published in the latest New York State Register. The board accepted public comments on the formulary's draft rules. The proposed effective date is July 1, when every new prescription would be required to comply with the formulary regardless of the injury date unless prior authorization is granted to dispense a non-preferred or unlisted drug. Beginning Dec. 31 every refill and renewal prescription must go through the formulary. Preferred (or "yes") drugs would not require prior authorization. Non-preferred (or "no") drugs would require preapproval by the insurance carrier or self-insured employer, as would drugs not listed on the formulary. Providers would also need prior approval for formulary brand name drugs when generics are available, combination products and compound medications. Requests for prior authorization can be made orally or in writing, and the requests would have to be approved or denied within four calendar days, or they would automatically be deemed approved under the proposed rules. Preauthorization for non-preferred drugs would be waived if they are prescribed at the initial treatment visit within seven days of the date of injury or disablement, are deemed medically necessary by the treating physician and if the drug is approved by the U.S. Food and Drug Administration. The draft rules would require the formulary to be updated at least annually to account for new medications available on the market.

Nevada

Before prescribing opioids to a patient for the first time, doctors in Nevada must now review the patient's prescription drug monitoring report and discuss non-narcotic treatment options, *under a state law that took effect on Jan. 1.* Under the **Controlled Substance Abuse Prevention Act.,** practitioners must also perform a patient risk assessment, which includes reviewing the patient's medical history, conducting a physical examination and assessing the patient's mental health and risk of abuse, addiction and dependency. The requirements apply to prescriptions of Schedule II, III or IV controlled substances for the treatment of pain. If a clinician opts to write an opioid prescription after assessing the patient, the dosage frequency must be limited to 14 days for acute pain, and for no more than 90 mg morphine equivalents for patients new to opioids. If opioid prescribing is to continue past 30 days, the doctor and patient must enter into a prescription medication agreement that includes treatment goals and patient assurances that he will take the drugs as prescribed, not share it with anyone, and report use of other pharmaceuticals he's using that might affect use of the prescribed medication.

North Carolina

WATCHLIST: A *notice has been issued* under the recently passed **Employee Misclassification Law** in response to *N.C. Gen. Stat. § 143-764(a)(5)*, which established the Employee Classification Section under the commission to crack down on misclassification — the intentional misclassification of an employee as an independent contractor to avoid tax liabilities and workers' compensation coverage. The Employee Classification Section statute stems from *Senate Bill 407*, which was prompted by an *investigative report* by *The News & Observer* in Raleigh and the *Charlotte Observer*, which found that misclassification by the state's construction industry cost North Carolina $467 million in annual tax revenues. The statute requires the Employee Classification Section to report by Oct. 1 of each year to the governor and Joint Legislative Commission on Governmental Operations on the number of reports of misclassification received, and the amount of back taxes, wages, benefits and penalties assessed and collected.

WATCHLIST: **The Industrial Commission** has *published its proposed opioid-prescribing guidelines* in the state Register. The proposed guidelines would limit daily dosages for acute pain to a 50-mg morphine equivalent dose for initial prescriptions, not to exceed a five-day supply. Initial prescriptions of any targeted controlled substance for post-operative pain would be limited to a seven-day supply. Health care providers would be prohibited from prescribing fentanyl, benzodiazepines and the potent muscle relaxer carisoprodol for acute pain, under the guidelines. The proposed rules, which "do not constitute

medical advice or a standard of medical care," exclude claims in which the worker takes opioids for more than 12 consecutive weeks immediately before the May 1 effective date.

Ohio

The state **Board of Workers' Compensation** (BWC) reported the *number of injured workers who were dependent on opioids fell to 3,315* at the end of fiscal 2017. This represents a 19 percent decrease from 2016, and a 59 percent decrease from 2011 levels. This marks the 6th consecutive year that the number of injured workers using opioids has dropped since the BWC adopted a drug formulary, officials said. Board officials also reported that its total drug cost fell to $86 million in 2017, which is $47 million less than it was in 2011. That includes $24 million less spent on opioids.

BWC officials have also announced that they've recently begun enforcing a *new rule designed to limit lumbar fusion surgeries.* Reportedly the most restrictive rule on lumbar surgery in the nation, **Rule 4123-6-32** requires providers to prescribe at least 60 days of alternative, conservative therapy before an injured worker can undergo surgery. The new rule was triggered by data showing that lumbar fusion surgery leads to prevalent opioid use, high rates of disability and longer workers' compensation claims, officials said. Ohio is one of a few states which requires employers to obtain workers' compensation coverage from a compulsory state fund. The BWC, which is the nation's largest state-run workers' compensation fund, no longer authorizes lumbar fusion surgery unless surgeons meet various treatment guidelines, with few exceptions for the most severe back injuries.

Pennsylvania

WATCHLIST: The **Insurance Department's** approval of a 6.06 percent rate increase stemming from the state Supreme Court's Protz decision will raise system costs by at least $163 million, the state rating bureau says. The rate hike nearly negates a 6.2 percent loss cost decrease that the Insurance Department approved in March 2017. The emergency rate increase is the largest in decades and the first ever enacted mid-year, bringing added focus on the insurance industry's push for a legislative remedy to the Protz defect in Section 306(a.2) of the Workers' Compensation Act, officials said. Last year, in *Mary Ann Protz v. Workers' Compensation Appeal Board (Derry Area School District)*, the state Supreme Court declared *Section 306(a.2)* unconstitutional as an unlawful delegation of authority, costing insurers an option to reduce long-term exposure to claims. Specifically, the act's requirement that physicians use the "most recent edition" of the American Medical Association Guides to the Evaluation of Permanent Impairment violates the constitutional requirement that all legislative power "be vested in a General Assembly, which shall consist of a Senate and a House of Representatives," the court opined.

South Carolina

WATCHLIST: South Carolina is the latest state to move toward a *supply limit for initial prescriptions of opioids* for acute pain. **Gov. McMaster** recently issued an executive order directing the state Department of Health and Human Services to limit initial opioid prescriptions for acute and post-operative pain to a maximum of five days for state Medicaid recipients. At the governor's request, the state Public Employee Benefit Authority agreed to similar limits for participants in the State Health Plan.

Tennessee

The state **Bureau of Worker's Compensation** (BWC) recently issued a reminder about new Fee Schedule Rules. The *new rules* are for services rendered on or after Feb. 25 regardless of the date of injury. Among the provisions, the rules require the authorized treating physician to see an injured worker at least every 60 days if the injured worker is receiving temporary disability payments, to assess progress toward return to work. The rules allow payment to a chiropractor for an additional evaluation. Utilization review for physical, occupational and psychological therapy will become discretionary. The new rule can be seen here. The bureau's summary is available here.

Tennessee has now joined North Carolina, Minnesota and Texas as the only states to require workers' compensation *payers and providers to invoice and pay medical bills electronically*. The only exceptions to the initiative approved by the **BWC**, which will be implemented July 1, are medical providers with 10 or fewer employees or those who submit fewer than 120 bills for workers' compensation treatment in the previous year,

and payers who process fewer than 250 workers' compensation medical bills in the previous calendar year. The BWC also may grant exemptions on a case-by-case basis for both providers and payers if they can establish that e-billing would result in an "unreasonable financial burden," the new rules state.

WATCHLIST: The **Bureau of Workers' Compensation** has proposed a rules change that would *give regulators more flexibility over the peer review process* for medical impairment ratings, and also announced a change to a form. The bureau also announced that it has released a new Statistical Data Form. The new SD Form 2 will replace SD Form 1 as of May 6.

Texas

The **Division of Workers' Compensation** (DWC) *has published its 2018 Medical Quality Review Annual Audit* Plan. Health care providers will be reviewed at random for appropriateness of prescribing opioids and for record-keeping of opioid prescribing, and for referring patients for testing. The testing could include muscle testing, range of motion testing, needle electromyography and nerve conduction tests, the audit states. Texas Labor Code §413.002 requires the division "monitor health care providers, insurance carriers, independent review organizations and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the commissioner relating to health care, including medical policies and fee guidelines." Texas Administrative Code *Section 180.3* lays out the parameters of compliance audits.

The DWC has also *posted its notice for annual reporting* for employers without workers' compensation insurance. By law, Texas employers that do not opt into the state system must submit two types of forms to the DWC, the notice states. *DWC Form-005*, Employer Notice of No Coverage or Termination of Coverage, must be filed each year between Feb. 1 and April 30. The DWC recently revised Form-005 to make it easier for employers to know what is required on the form and to update the frequently asked questions section. *Form-007*, Employer's Report of Non-covered Employee's Occupational Injury or Disease, also is required and notifies the DWC that a non-subscribing employer, with five or more employees, has experienced a workplace-related injury, illness or fatality. A pair of YouTube videos show employers how to complete *Form-005* and *Form-007*. Form-005 can *be filed electronically.* Both forms can be faxed to 512-804-4146 or mailed to 7551 Metro Center Drive, Suite 100, MS-96, Austin, TX 78744-1645.

The **Texas Department of Insurance** has finalized higher maintenance fees and assessments for workers' compensation carriers in 2018. Section 1.414 outlines the maintenance *taxes and fees insurers pay on premiums* or other assessment base. For workers' compensation carriers, the rates were published in the Texas Register on Dec. 29 and became effective Jan. 2. Insurers and regulators say the higher assessments are needed as premiums continue to decline following the passage in 2005 of HB 7. Section 7.1001 outlines the 2018 assessments for *covering expenses to examine domestic and foreign insurance companies*, and self-insurance groups, providing workers' compensation insurance.

The **Texas DWC** has revised several plain-language notices, which insurance carriers use to notify injured workers of their actions. Carriers must begin using the following revised forms immediately. Forms PLN-3a, PLN-3b and PLN-3c, must be completed by April 1. These forms notify workers about issues relating to maximum medical improvement and permanent impairment. Questions can be directed to Emily McCoy at *Emily.McCoy@tdi.texas.gov*. Plain-language notices are available *here*.

WATCHLIST: The **Division of Workers' Compensation** has proposed an amendment that *would require preauthorization of all compounded drugs.* Proposed amendments to 28 Texas Administrative Code §134.500 would exclude all prescription drugs created through compounding. Amendments to §§134.530 and 134.540 would require preauthorization of compounds for claims subject to and not subject to certified networks. "The proposed rule change does not prohibit the use of compounded drugs for injured employees when medically necessary; however, it does require that the medical necessity be determined prior to dispensing these drugs," the DWC said in a *memorandum* to stakeholders. Legislators asked the DWC to consider preauthorization of all compounds after agency research revealed that the overall cost of such drugs doubled to $12

million between 2010 and 2014, and the average cost per prescription increased 133 percent, from $356 in 2010 to $829 in 2016. The explosion of compound drugs was triggered by a loophole in the closed formulary created in 2011 to control pharmacy spending. If approved, Texas would join California, Florida, Tennessee, Nevada and Oklahoma in mandating preauthorization for all compounded medications, regardless of ingredients.

Washington

WATCHLIST: SB 6050 *would limit most first-time opioid prescriptions to a seven-day supply* and prohibit a first-time prescription of more than a seven-day supply of opioids to patients at least 21 years old. The bill would limit prescriptions to a three-day supply for people younger than 21. Limits proposed by SB 6050 would not apply to treat end-stage cancer pain, or for palliative, hospice or other end-of-life care. It would also require providers to discuss the risk of addiction and overdose before any first-time opioid prescription exceeding a three-day supply. Providers would also be required to keep in a patient's medical record a consent form documenting the drug being prescribed, the quantity and dose, signed by the patient.

West Virginia

According to the state **Board of Pharmacy's** annual report, the number of prescribed controlled substances declined from 267.2 million to 235.9 million doses, an 11.7 percent drop from 2016 to 2017. That includes prescription painkillers, anti-anxiety medication and amphetamines. The most prescribed pain medication, hydrocodone, fell by 8.4 million tablets while oxycodone prescriptions decreased by 9.3 million. If a medical professional is linked to a significant number of overdose deaths, medical licensing boards also are alerted about possible overprescribing. *Charleston (WV) Gazette-Mail* reported West Virginia has the *highest overdose death rate in the nation*.

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