sedgwick®

2018

Performance Evaluation of North Dakota Workforce Safety and Insurance

August 1, 2018

August 1, 2018

Governor of North Dakota
The Legislative Assembly
Chairperson of the Workforce Safety and Insurance Board of Directors
Chairperson of the Workforce Safety and Insurance Board Audit Committee
Executive Director of Workforce Safety and Insurance

We are pleased to submit this report summarizing the results of the 2018 Performance Evaluation of Workforce Safety and Insurance (WSI). The Performance Evaluation primarily covers activities at WSI during Calendar Years 2015 through 2017, although some components of the evaluation cover a broader span.

One purpose of this Performance Evaluation was to assess certain aspects of WSI and to provide recommendations for improvement. Another purpose was to evaluate certain North Dakota statutory provisions and administrative practices as compared to similar provisions and practices that we observe around the country and provide recommendations.

The Performance Evaluation features three Elements including:

- Opioid Management
- Safety Programs
- Prior Recommendations

Recommendations in this evaluation were made pertaining to each of the Elements where we felt opportunities existed to improve performance or modify and/or enhance statutory and administrative provisions. Fourteen recommendations were made.

The report consists of an executive summary, sections pertaining to each Element, recommendations, and WSI responses to the recommendations. (Possible additional sentence to include: In some instances, we added a reply to follow up on a WSI response to a recommendation.)

We want to thank all those at WSI who assisted us in the Performance Evaluation process with a special note of thanks to the Internal Audit staff.

Sedgwick CMS – Risk Services Practice

Roseville, California

Table of Contents

Element One – Opioid Medications

Introduction

For this Element, the State of North Dakota is interested in:

- A review of WSI's historical management of prescribed opioids, including rates and usage
- A comparison of average daily morphine equivalents between North Dakota and other jurisdictions which is to include a review and recommendation(s) of statutory or administrative rule requirements limiting the maximum daily morphine equivalents and specific situations which would allow the jurisdiction to override the maximum limits
- Research any limitations on specific opioid medications, whether by duration of action or by type

Note that as part of our review of opioid medications, we also are reviewing prior recommendations from the 2014 Performance Evaluation pertaining to opioid use and that review can be found in our commentary in Element Three. Some references may be made either in this Element or Element Three that pertain to both elements. That is because five of the nine prior recommendations under review in Element Three pertain to opioid management.

Background

To achieve the above objectives, we first sought to gather sufficient opioid data pertaining to North Dakota as well as other states so we could make comparisons in this Performance Evaluation that are similar to comparisons we conducted in 2014. We also undertook the following activities:

- We reviewed data provided by WSI through its pharmacy benefits manager, Envolve
- We reviewed data directly obtained from WSI to look at payment patterns on recent claims, moderately aged claims and older claims to assess how pharmacy costs factor into the cost of claims depending on their age
- We reviewed data provided from Sedgwick sources that looks at opioid use patterns in other states and included those findings in some of the tables that follow
- We met on several occasions with WSI's Medical Services and Pharmacy Director to review various components of WSI's policies and processes in managing opioid use
- We discussed opioid management options with others within WSI as well as outside the organization
- We researched statutory schemes to evaluate how other jurisdictions manage opioid use
- We reviewed various guidelines and articles pertaining to opioid management
- We reviewed Senate Bill 2060 as adopted by the North Dakota Legislature and signed into law by the Governor in 2015

- We reviewed several workers' compensation claims involving opioid use including claims where opioids are prescribed during the acute and chronic phases as well as cases where a WSI business partner was retained in an attempt to curtail opioid use on specific claims
- We reviewed and evaluated documentation available through WSI's Internal Audit Department pertaining to the implementation of prior recommendations (also relevant to our work on Element Three)
- We worked with WSI's pharmacy benefits manager and WSI staff to resolve data consistency questions we had based on our findings in some reports

As a starting point for this Element, we sought to evaluate opioid utilization in a manner that mimics the approach we took in the 2010 Performance Evaluation and again in 2014. A series of tables with explanations follows that accomplishes that objective.

The data in the tables is limited to calendar years 2016 and 2017 for North Dakota as WSI changed its pharmacy benefits manager since the last Performance Evaluation and full year data sets are only available from that source for the last two calendar years. Data provided related to states other than North Dakota has come from Sedgwick and for informational purposes we provide data from 2014 - 2017.

Findings

To evaluate North Dakota against other jurisdictions, we elected to select states that are either reasonably close to North Dakota geographically or where monopolistic workers' compensation systems are in place. Those states include Colorado, Minnesota, Montana, South Dakota, Washington and Wyoming. Colorado, Minnesota, Montana and South Dakota are geographically close to North Dakota while Washington and Wyoming are monopolistic to one degree or another. These are the same states we included in prior performance evaluations.

We have also added to some of the tables the states of New York, Tennessee and Texas. The reasons we added those states are as follows:

- New York will be adding a formulary in 2019, but has had an initial supply limit on opioids since 2016
- Tennessee has a similar formulary makeup to Texas and now has legislation in place limiting the initial supply of opioids
- Texas has been seen as a leader in workers compensation based reform because of their formulary, which limits opioids

These states are not the only relevant states in regard to opioid management but they form a good group of states for comparison purposes. We also comment elsewhere in this Element of practices and/or legislation that is relevant to North Dakota. One of the objectives in this performance evaluation is to look to other jurisdictions for possible guidance on legislation that has been developed that could

potentially limit daily maximum morphine equivalents. These other jurisdictions will include Arizona, Arkansas, North Carolina and Oklahoma.

Table 1.1 displays the opioid-related transactions processed by North Dakota's current pharmacy benefits manager (Envolve) against all pharmacy transactions processed in the respective states. Table 1.2 displays the opioid-related costs processed by Envolve against all pharmacy costs in the respective states.

Table 1.1: Pharmacy Transaction Trends (Opioids as a Percentage of All) for 2014 through 2017 (North Dakota limited to 2016 and 2017 for reasons as stated above)

State/Year	2014	2015	2016	2017
Colorado	29%	28%	27%	24%
Minnesota	33%	32%	31%	28%
Montana	37%	37%	34%	33%
New York	32%	31%	30%	27%
North Dakota			**32%**	**29%**
South Dakota	34%	31%	28%	26%
Tennessee	30%	29%	28%	26%
Texas	32%	30%	28%	25%
Washington	33%	32%	29%	27%
Wyoming	27%	32%	58%	56%

Table 1.2: Pharmacy Cost Trends (Opioids as a Percentage of All) for 2014 through 2017 (North Dakota limited to 2016 and 2017 for reasons as stated above)

State/Year	2014	2015	2016	2017
Colorado	27%	25%	24%	21%
Minnesota	28%	28%	26%	24%
Montana	35%	36%	31%	30%
New York	26%	33%	30%	25%
North Dakota			**41%**	**39%**
South Dakota	26%	26%	21%	22%
Tennessee	26%	24%	23%	20%
Texas	21%	22%	16%	14%
Washington	25%	19%	15%	12%
Wyoming	12%	14%	46%	49%

In reviewing the data in both tables, what we consistently see from one year to the next is a proportionate reduction in opioid prescriptions and opioid costs as a percentage of the overall. The only

exception to this observation is Wyoming where our data sample was very small. We only had about 100 pharmacy bills in Wyoming out of a data set that included more than 182,000 bills.

North Dakota's data tends to show that opioids as a percentage of all prescriptions are higher than in most other states. Leaving Wyoming data out of the comparison, you'll see that for the states cited in Table 1.1 that opioid prescriptions as a percentage of all prescriptions in 2017 range from 24% (Colorado) to 33% (Montana). North Dakota's percentage of opioid fills is 29%. One of the drivers in the opioid use results for North Dakota could be that in contrast to other states, the entitlement to medical benefits is rarely settled. With opioid use more common among older claims, not settling cases would tend to skew results to some extent.

An unexpected result in the North Dakota data according to the information that has come from the pharmacy benefits manager is that the percentage of costs related to opioids is a higher percentage than the percentage of prescriptions. Take 2016 as an example where the data shows that opioids comprise 32% of the prescriptions (Table 1.1) but 41% of the costs (Table 1.2). This pattern runs counter to all other states in the sample. For example, in the 2016 column in Table 1.1, Colorado shows 27% of its prescriptions tied to opioids and only 24% of its costs (see the 2016 column in Table 1.2). We're not sure the reason for this result. It is also worth noting that when we looked at North Dakota data in the 2014 Performance Evaluation that we looked at these same trends for calendar years 2010 – 2013. In 2010, the percentages of fills and costs were virtually identical, while for the other three years, the percentage of opioid fills was consistently higher than the percentage of opioid costs against all fills and all pharmacy costs.

Recommendation 1.1 – Examine if prescribing patterns in North Dakota may show a prevalence of brand drug use (as opposed to generics) in the opioid category. Attempt to switch to generics where possible.

Priority Level: Medium

> WSI Response: Partially Concurs. WSI already has a rigorous generic medication administrative rule that requires objective medical evidence of treatment failure with the generic medication that was not seen with the branded product.
>
> WSI is not in favor of mandating use of generic medications when other indications exist making brand use preferential i.e. abuse deterrent formulations that are available brand name only.

We next looked at pharmacy expenses as a percentage of all medical expenses for select years to discern differences in the patterns based on the year(s) of injury. Table 1.3 displays these results.

Table 1.3: Overall Medical and Pharmacy Payment patterns in CY 2017 by date of injury

Year(s) of Injury	Total Medical Paid in 2017	Total Expense Code 010 (Pharmacy) Paid in 2017	Pharmacy Paid as Percentage of all Medical Paid

2017	$31,087,792	$204,714	.66%
2012	$1,565,546	$272,188	17.4%
2007 and prior	$17,403,004	$5,085,571	29.2%

As we have observed in prior evaluations, the pattern of pharmacy payments as a percentage of all medical payments changes significantly on claims as they age. The last row of data in the table shows that for any claims that occurred in 2007 or prior that about 29% of all medical payments were pharmacy-related. Data was not available from WSI that broke out pharmacy costs between opioid and non-opioid medicines. Data from WSI's pharmacy benefits manager was inconclusive in that date of injury information was not available on many cases to sort the expense by year of injury.

In the opioid data set we gathered from other states, we collected the information into year of injury ranges and table 1.4 displays those results. The results roll up the states we used in Tables 1.1 and 1.2 in an aggregated fashion meaning results are not displayed by individual state. The grouping we have done by year is done in this fashion: If an opioid was filled within two years of the date of injury then it is included in the first row in the table. If an opioid was filled between two and four years from the date of injury then it is included in the second group, and so on. The second column in the table shows how much was spent in opioids over a recent twelve-month period while the third column shows opioid spend over a recent five-month period.

Table 1.4: Other State Aggregate Results Sorting Opioid Spend by Date of Injury v. Date of Fill

Age of Claim	12-Month Opioid Spend	5-Month Opioid Spend
0 – 2 Years	$7,225,964	$2,935,620
2 – 4 Years	$3,714,948	$1,466,151
4 – 6 Years	$3,304,426	$1,268,504
6 – 8 Years	$3,621,214	$1,436,596
8 – 10 Years	$3,690,767	$1,440,596
10 Years +	$23,181,260	$9,607,647
Total	**$44,738,399**	**$18,155,115**

In each of these data sets, opioid spend in the claim group that has aged at least 10 years accounts for about 52% to 53% of all opioid spend. Also, consider that in our review of opioid prescribing patterns in the last performance evaluation that 96% of the people who received an opioid received no more than two prescriptions. Prescribing patterns insofar as the number of pills provided in initial and subsequent fills has been reduced in recent years but the percentage of injured workers getting to a chronic use category of at least 90 days is very small, as it should be.

One other way that we look at how opioid spend is occurring is by looking at payment patterns on claims according to opioid spend on individual cases. The three tables provide the number of prescriptions written for injured workers whose annual costs reached certain thresholds. We further provide the opioid-related cost of these claims and the count of claims in each group. So we can see

how patterns within these thresholds have changed over the years, we've included 2011 and 2012 data along with the two most recent calendar years (2016 and 2017).

Table 1.5: Distribution of Opioid Fills by Claim Cost Grouping (2011, 2012, 2016 and 2017)

Population	2011 Rx Count	2012 Rx Count	2016 Rx Count	2017 Rx Count
$10K or More	2,409	2,424	2,248	1,908
$5K or More	5,323	5,135	4,647	3,859
Top 200	5,959	5,910	5,008	4,806
All Opioid	41,682	44,396	26,462	21,506

Table 1.6: Distribution of Opioid Costs by Claim Cost Grouping (2011, 2012, 2016 and 2017)

Population	2011 Cost	2012 Cost	2016 Cost	2017 Cost
$10K or More	$1,188,100	$1,224,763	$1,431,024	$1,277,915
$5K or More	$1,901,076	$1,894,576	$2,133,180	$1,871,803
Top 200	$2,028,021	$2,033,007	$2,210,551	$2,050,681
All Opioid	$3,094,404	$3,162,531	$3,422,784	$2,829,432

Table 1.7: Distribution of Claims by Claim Cost Grouping (2011, 2012, 2016 and 2017)

Population	2011 Claim Count	2012 Claim Count	2016 Claim Count	2017 Claim Count
$10K or More	72	72	80	72
$5K or More	172	170	184	159
Top 200	200	200	200	200
All Opioid	5,982	6,162	4,148	3,459

One positive finding about the financials in Table 1.6 is that overall opioid spend in 2017 was the lowest of the four years in the Table. The 2017 year shows opioid costs to have declined by slightly more than 17% when compared to 2016.

The final table that we updated that is similar to what we prepared in the 2014 Performance Evaluation follows and it shows a distribution of opioid fills by county within North Dakota and also includes fills that occurred in other states. We are again repeating values we had in the prior report from 2011 and 2012 and including 2016 and 2017 in Table 1.8

Table 1.8: Opioid Costs by Locality for 2011, 2012, 2016 and 2017

Locality	2011 Opioid Spend	2012 Opioid Spend	2016 Opioid Spend	2017 Opioid Spend
Burleigh Co	$1,653,282	$1,713,491	$1,738,453	$1,518,765
Cass Co	$310,289	$400,652	$319,397	$223,264
Grand Forks Co	$188,449	$212,606	$249,897	$229,613
Other Counties	$392,569	$456,619	$344,774	$271,555
All N. Dakota	$2,544,589	$2,783,368	$2,652,521	$2,243,197
Non-N. Dakota	$370,263	$363,681	$770,263	$586,235
Null Zip Codes	$167,852	$5,278	$0	$0
Sub-Total	$538,115	$368,959	$770,263	$586,235
Grand Total	**$3,082,703**	**$3,152,327**	**$3,422,784**	**$2,829,432**

The data in Table 1.8 is collected based on the zip code of the prescriber, not the injured worker. Knowing where the prescription was written is more revealing of prescribing patterns, and we know that Burleigh County is a location where there is a concentration of pain management specialists and they are frequently involved in the medical treatment of those with long-term pain complaints and opioid use.

We note that opioid spend has declined in nearly all locales across North Dakota for 2017 when compared to all previous years in the table. The exception is Grand Forks County where the differences are relatively modest when compared to the overall spend. We also believe that there was an uptick in out-of-state opioid costs due to the number of workers who came to North Dakota during the oil boom. With that said, out-of-state costs declined by about 24% when comparing 2017 to 2016. Overall, a reduction in opioid spend was achieved in 2017 of about 17% and the 2017 result is the lowest opioid spend of any year since we have been measuring this value. It is also fair to point out that the 2016 opioid spend was higher than 2010 – 2013 as reviewed in the 2014 Performance Evaluation, so the reduction in opioid spend is a recent phenomenon. We don't know that we have an entirely comprehensive answer but there are results we see in some of the data from both WSI and its pharmacy benefits manager that may help to explain significant reasons for this reduction.

First, the number of claims has declined dramatically from FY 2014 through FY 2017. Claims filed in 2014 amounted to 26,395 and that count has steadily declined so that as of FY 2017, claims filed had dropped to 20,045. Along with this decline in claim volume, the incidence of indemnity claims or time loss claims has also declined from 3,480 in 2014 to 2,369 in 2017. Indemnity claims made up 13.2% of all claims filed in 2014 and 11.8% of all claims filed in 2017. Fewer of the less serious injuries should lead to fewer cases where opioids would be prescribed. As well, as claims age fewer and fewer of them require treatment with an opioid.

Second, with the passage of SB 2060 in 2015, WSI was empowered with somewhat greater administrative authority over opioid use. That bill spelled out requirements for injured workers to in a sense qualify for opioid use and who along with his/her treating provider develop a treatment plan that

would include quarterly assessments of pain reduction and improvements in functionality. The bill also allowed for random drug screening, limited the injured employee to a single provider, and created an avenue for WSI to discontinue opioid therapy if the injured employee was not compliant.

While there are many components to this bill, one of its more significant provisions relates to a single provider. The Centers for Disease Control (CDC) has published its own study and guidelines related to chronic opioid use. The CDC analyzed various risk groups to evaluate the incidence of overdoses. Their risk groups included:

- a single provider prescribing a daily dose of less than 100 mg of morphine equivalents (Group A)
- a single provider prescribing a daily dose of at least 100 mg of morphine equivalents (Group B)
- multiple doctors, typically in cases involving drug diversion (Group C)

Group A cases accounted for 80% of the cases and 20% of the overdoses. Groups B and C each accounted for 10% of the cases and 40% of the overdoses. Put another way, Group A patients were 16 times less likely to suffer an overdose.

Recently, WSI's pharmacy benefits manager updated certain aspects of its monthly reporting. One of the categories they capture pertains to the number of injured workers who receive an average daily morphine equivalent of 120 mg or more. In January 2016, the count of injured workers in this category was 505. In December 2017, that count of employees at 120 mg or more had dropped to 326. When we compare these results, we find that 270 of the people who were on the January 2016 listing were not on the December 2017 listing. Of the 326 on the December 2017 listing, 233 of them were on the January 2016 listing and 93 of them are new. Note also throughout this report that when we talk about morphine equivalents, we consider those to apply to an individual rather than to an individual medication.

Recommendation 1.2: WSI doesn't currently track all the reasons why injured workers drop off the listing but we think there is value in knowing why. Some reasons for this result can include:

- **Use of SB 2060 to discontinue opioid therapy**
- **Good coordination of care between patient and provider**
- **The desire of an injured worker to reduce their opioid use because of the potential for addiction**
- **Intervention by WSI or one of its business partners with a provider that leads to a reduction in opioid use**
- **Death of the injured worker**

Assuming the legislature addresses the management of daily morphine equivalents as outlined later in this Element, we recommend that the pharmacy benefits manager revise its threshold for tracking daily morphine equivalents and that WSI periodically review and document the reasons for these results. Tracking results at six month intervals would seem reasonable. We believe knowing why

successes are achieved can lead to greater success in the management of opioids with other still active cases.

Priority Level: Medium

> WSI Response: Concurs. WSI already tracks those instances when opioid therapy is discontinued due to application of SB 2060. Other reasons could be implemented without an onerous burden on the agency. These include death of an injured worker, those claims where close monitoring by a medical case manager exists, or claims which have been referred to one of our business partners that has direct intervention with the provider.

The findings above address from a variety of perspectives trends in opioid use in North Dakota and how those trends have evolved over the past several years. The findings also provide a glimpse into how North Dakota's opioid use trends compare to other jurisdictions around the country. We now move on to the statutory and research portions of this Element.

The State of North Dakota has requested that this report address how other states manage opioids, what statutory and administrative controls they may have in place notably for daily maximum morphine equivalents, and what information may be available on specific opioid medications whether by duration of action or type. To accomplish these objectives, we reviewed various publications relating to chronic opioid use as well as statutory and administrative schemes that are in place elsewhere in the United States.

While not specifically part of the project request, we think it is also useful for the State of North Dakota to be aware that slightly more than half the states around the country have controls in place on the duration of a first opioid fill. The duration of the first fill may vary from as little as three days to as much as 14 days. Supply duration may also vary depending on whether a first fill occurs following surgery or simply in response to pain complaints. As North Dakota considers statutory changes it may make relative to chronic opioid use, it may also choose to set up guidelines for first fills that are similar to those we observe in other jurisdictions. In this regard we view a first fill in two ways. A first fill would simply be the first time someone receives an opioid. It could also be the first time someone is receiving an opioid following an opioid hiatus, and we think the duration of the hiatus should be six months. Let's say that an injured worker receives opioids for about a month following injury and then discontinues its use until having surgery many months later. If following the surgery, an opioid is prescribed we think the same rules should apply to both of these "first" fills.

Fewer states currently have regulations related to daily maximum morphine equivalents for chronic opioid users. States don't all agree on the appropriate daily maximum dose for morphine equivalents but the range of dose for most of the states that have adopted regulations is between 50 milligrams and 90 milligrams. The states we summarize below fall within that range.

This range is very much in keeping with the Centers for Disease Control "Guidelines for Prescribing Opioids for Chronic Pain." These guidelines include the following:

- "When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day."
- "Long-term opioid use often begins with treatment of acute pain. 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."

The American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 – Guidance states, "We are recommending up to 40 mg of morphine equivalent doses as low dose, 41 to 90 mg of morphine equivalent dose as moderate dose, and greater than 91 mg of morphine equivalence as high doses." These morphine equivalents are similar to those expressed by the CDC.

The American College of Occupational and Environmental Medicine's Guidelines include the following statement: "Consensus recommendations also include consideration of carefully conducted trials of chronic opioid treatment for highly select patients with subacute and chronic pain and to maintenance opioid prescriptions only if documented objective functional gain(s) results. A strong and reproducible dose–response relationship identifies a recommended morphine equivalent dose limit of no more than 50 mg/day. Higher doses should be prescribed only with documented commensurately greater functional benefit(s), comprehensive monitoring for adverse effects, informed consent, and careful consideration of risk versus benefit of such treatment. Chronic opioid use should be accompanied by informed consent, a treatment agreement, tracking of functional benefits, drug screening, and attempts at tapering." (Note: The categorization of opioid usage by duration is divided up into three time increments. The acute phase is up to one month; the sub-acute phase is from one month up to three months; and, the chronic phase pertains to more than three months.)

In summary, we have three sources of information pertaining to opioid dosing. The consensus among these three sources is that a morphine equivalent dose of anywhere from 40 to 50 milligrams constitutes a low dose; up to 90 milligrams would be considered a moderate dose; and, above 90 milligrams would be considered a high dose.

If we consider the continuum of care from the outset, we see emerging in jurisdictions around the country efforts to control the extent of initial fills, the management of opioids during the sub-acute phase, and more detailed requirements for patients with chronic pain complaints for which opioids are prescribed.

As mentioned previously, we see slightly more than half of the states around the country with some degree of control on the first opioid fill. Here is a partial summary of individual state practices:

- In Arizona, a first opioid fill is limited to five days in most cases. An initial 14-day supply of opioids is allowed in surgical cases
- In Arkansas, the first opioid fill is limited to five days
- In Oklahoma, the first opioid fill is limited to seven days
- In North Carolina, the first opioid fill is limited to a five-day supply generally or up to seven days for post-operative pain

Within the states referenced above, the Arkansas rules specify that the initial morphine equivalent dose (MED) should not exceed 50 milligrams/day. With prior authorization, a prescriber may increase the MED up to 90 milligrams but Arkansas does not allow the prescriber to go above a daily MED of 90 milligrams. To receive opioids beyond the initial five-day supply, the prescription must be written by the authorized treating physician, it must be related to the workers' compensation injury and be reasonable and medically necessary, and the medication as prescribed thus far has to be shown to be effective in controlling pain. The rules as promulgated in Arkansas are effective for injuries occurring on or after 7/1/18.

Among the rules in Oklahoma, treating providers and their patients must enter into a pain management agreement upon the prescribing of a third opioid fill. Given that first and subsequent fills are limited to seven days, the pain management agreement would begin on or about the 15th day following the initiation of opioid therapy.

In North Carolina, opioid fills during the acute phase of treatment must be limited to only one opioid medication, may only involve the use of short acting opioids, and may not exceed a daily MED of 50 milligrams. Once an injured worker reaches the chronic phase, prescriptions may not be filled above a MED of 90 milligrams without prior authorization. The North Carolina requirements regarding short acting opioids are also in keeping with guidelines for clinicians as promulgated by the CDC, as referenced previously in this Element.

What emerges from medical and statutory sources of information is the following set of criteria:

- Prior to starting patients on opioids, other modalities of care should be considered to include therapies that are both pharmacologic (e.g., non-steroidal anti-inflammatory drugs) and non-pharmacologic (e.g., heat, ice, exercise, physical therapy, etc.)
- Avoid the use of extended release and long-acting opioids
- Initial opioid fills need not be longer than seven days, although a longer period of time for the initial fill may be appropriate in surgical cases
- Control the daily MED (up to 50 at the outset, up to 90 later in the care of a patient, and beyond 90 only with medical justification and prior authorization)
- Make sure that a treatment plan and other provisions exist for chronic opioid therapy (the literature suggests practices similar to those within SB 2060)
- Be able to check a Prescription Drug Monitoring Program (the electronic data system used by healthcare professionals at the state level to report prescribing and dispensing data of

controlled substances for individual patients) to determine if a patient is an excessive and inappropriate user of opioids

- Have available treatment programs to assist chronic users who have opioid use disorders. Such programs may involve treatment with medications like buprenorphine or methadone
- Understand that there will be exceptions to the above MED rules. Those exceptions may include conditions/circumstances such as patients who are involved in active cancer care, those receiving hospice or palliative care, those residing in a long-term care facility, those who are actively participating in substance abuse or opioid dependence programs, those who are hospitalized, those who are receiving treatment for burns, and those who are already identified as chronic users with existing workers' compensation cases

We repeat that all of the criteria suggested above come from medical or statutory sources. Further, these criteria are in recognition that opioid use in the United States is clearly a public health issue that requires logical controls to both treat pain and assure patient safety as much as possible.

Recommendation 1.3: We recommend that WSI draft legislation to be considered in the next biennium that seeks to accomplish the following:

- **Limit the duration of first opioid fills**
- **Limit the first fills to short acting opioids with scientifically supported limits on maximum morphine equivalents**
- **Limit daily morphine equivalents for chronic opioid use injured workers to scientifically supported guidelines throughout the treatment cycle unless one of the exceptions referenced above (e.g., active cancer patients) has been met**

As part of this recommendation, WSI would upon passage of this legislation develop administrative rules. The rules would be predicated on current science, which seems to suggest that initial fills should be limited to 50 maximum morphine equivalents while patients requiring use for longer periods of time should not exceed a daily morphine equivalent of 90 milligrams. Providing WSI with administrative authority would over time allow the agency to respond to the evolving science regarding opioid use.

Priority Level: High

WSI Response: Concurs. WSI supports legislation which would give the agency broad support to promulgate administrative rules which would specify limits on day supply and maximum morphine equivalents for both acute and chronic opioid therapy.

Since these limits would be enacted by administrative rule versus statute that would also allow the agency to modify these limits to keep pace with the latest advancements documented in the medical literature.

We are hesitant in this performance evaluation to recommend more stringent controls. While there are studies that indicate that the cost of claims is significantly higher due to chronic opioid use, we're not certain how studies have factored in the relative severity of injuries to the equation. It would seem that the more severe the injury, not only the higher the cost but the greater the potential need for higher levels of pain medication. There may also be situations where an injured worker undergoes surgery with certain recovery expectations and those expectations are not met because of the severity of the injury or a poor surgical result. Another cost driver in such cases could be an employer's inability to accommodate an injured worker's restrictions, which also leads to higher claim costs.

We view the management of opioids to be something that generally can be regulated to include reasonable approaches to first fills and daily morphine equivalents, while at the same time providing sufficient latitude for treating providers, payers and patients to develop treatment strategies that can be applied to individual cases.

Earlier this year, the California Workers Compensation Insurance Rating Bureau (WCIRB) published a study on the weaning process for chronic opioid users and we encourage policy makers to review this study in detail. The WCIRB study relies on data from its Medical Data Call system which houses more than "1.4 million claims with dates of injury from July 1, 2012 through December 31, 2016." The study focused on a group of 1,030 injured workers with dates of injury in 2013 and 2014, some of whom weaned from opioid use and some who did not within the 24-month post-injury window of the study. All were considered "chronic opioid claimants." These claimants "were defined as those with prescribed opioids of 50 Morphine Milligram Equivalents (MME) or greater per day for at least three consecutive months within the first two years from the date of injury. Weaning was defined as the process of gradual reduction in opioid use after chronic opioid status was achieved." Of the 1,030 claimants in the study, "47%...weaned off of opioids completely within the 24-Month study period. Injured workers who did not wean off completely over the Study period still reduced opioid dosage by an average of 52%."

One conclusion reached for the Study population was that, "No clear patterns of non-drug treatments (e.g., Physical Medicine) for weaning off of opioids were evident, although the weaning process typically involved a gradual decrease in opioid prescribing combined with a mix of alternative non-drug treatments and non-narcotic drugs."

One factor for North Dakota policy makers to keep in mind about the WCIRB study is that the duration of time from date of injury to date of chronic opioid use was a relatively short period. "The Study group of injured workers reached 50 MME in a median of 11 months from the date of injury." We are reluctant to conclude that successes similar to those in the California study could be achieved through legislative directives if we think about the aged population of the chronic opioid users in North Dakota.

In Recommendation 1.3, we suggest rules for first fills, rules for an upper limit on MMEs, and exceptions that may exist due to the severity/complexity of an injury or illness. We think these rules can be applied prospectively. In Recommendation 1.2, we suggested that WSI is in a position to track how and why

injured workers come off the current benchmark threshold of 120 MMEs. Along with Recommendation 1.2, and given the 90 milligram MME we suggest as a chronic use cap in Recommendation 1.3, we think WSI will want to apply targeted managed care approaches to individual cases that exceed the threshold of 90 MMEs.

Recommendation 1.4: Upon adoption of legislation as suggested in Recommendation 1.3, revise the manner in which WSI's Pharmacy Benefits Manager captures morphine equivalencies on its monthly benchmark report to align with that legislation. For instance, if the legislation establishes a 90 milligram MME, then the benchmark used would be for daily morphine equivalents exceeding 90 milligrams rather than the current 120 milligrams.

Priority Level: Medium

> WSI Response: Concurs. WSI would work with our Pharmacy Benefit Manager to modify monthly reporting to accommodate target maximum morphine equivalents promulgated via administrative rule.

While we were onsite as part of the Performance Evaluation process, we had an opportunity to meet with the Director of the Department of Human Services (DHS) Behavioral Health Division and learn a little bit about the "Free Through Recovery" program that was launched earlier this year. In partnership with the North Dakota Department of Corrections and Rehabilitation, DHS has developed a community-based program designed to increase access to recovery services for individuals engaged with the criminal justice system who have serious behavioral issues. While the population of people who participate in this program is a different group from chronic opioid users who have workers' compensation claims, the road to recovery typically will involve similar questions. How do I get started? Where can I get support? What might that support look like? Who can I turn to on the clinical side to help me address my addiction while still addressing my health issues constructively? What commitments do I have to make to be successful?

As a starting point in examining how to deal with the chronic opioid group, particularly those with extremely long periods of use, let's presume that it is a responsible public health policy to pursue reductions in opioid intake. Assuming support for this position, might we then through the development of a treatment plan consider modest reductions in opioid use over time? This seems to have been a key factor in the management of the injured workers in WCIRB's study along with alternative pharmacy therapies (e.g., non-steroidal anti-inflammatory drugs) as well as other non-pharmacologic therapies that seem to help in individual cases. Such therapies could include acupuncture, physical therapy, chiropractic, and home exercise. There would not be a "one size fits all approach," but instead reasonable target reductions of opioid use coupled with helpful alternatives.

For purposes of establishing targets, we might take the group of injured workers that show up on the monthly reports from the Pharmacy Benefits Manager benchmark report and agree that an initial treatment goal might be to reduce the opioid intake from 120 mg (or more) to 90 mg, and then achieve gradual declines thereafter.

In the WCIRB study, the median time for an injured worker to reach MME usage of at least 50 milligrams was about 11 months post-injury. WCIRB also reported that, "Claims that weaned off completely took a median of 8 months to wean off after 50 MME status was achieved." Taking injured workers from 120 mg to 90 mg to 50 mg to completely weaned is something that could take a fair amount of time. Nonetheless, this gradual approach may offer injured workers appropriate time to adjust and to identify other treatment modalities that assist them in dealing with their chronic pain complaints.

For injured workers who have an opioid use disorder, a treatment plan could include the use of "buprenorphine or methadone in combination with behavioral therapies," as suggested by the CDC. For still others, detoxification facilities may offer a solution.

In terms of ongoing support of the injured worker, regardless of the approaches selected, it makes sense to include case management services as part of the process. Case managers supporting the process should be experienced in working with injured workers who have relied substantially on opioids. Providers/Prescribers and payers also have to partner in the process. Among this group, providers/prescribers have to be open to strategies leading to reduced dosing. In short, the effort has to be collaborative and supportive.

We conclude by saying that the formal recommendations made in this Element are intended to create a framework for managing opioid use on new claims, just as other jurisdictions have already done. For those injured workers who have been long-term opioid users we recommend a more gradual course based on the various options suggested previously and the willingness of all those involved in this effort to proceed with modalities that best suit each injured worker.

Element Two – Safety (Risk Management and Loss Control) Programs

Introduction

For this Element, the State of North Dakota is interested in identifying and evaluating Workforce Safety and Insurance's safety programs and:

- determining whether legislative intent is being fully accomplished;
- determining the utilization, and to the extent practical the effectiveness of the safety programs, and;
- Recommending improvements to WSI workplace safety programs for North Dakota workers and policyholders.

Background

To achieve the above objectives, we first sought to gather sufficient information. We have reviewed Chapter 65-03 pertaining to workplace injury prevention, Chapter 92-05-02 on risk management programs, and Chapter 92-05-03 on grant programs.

We also undertook the following activities:

- We participated in an introductory meeting with the Director of Loss Control, the Education/Special Programs Supervisor, a Safety Consultant Supervisor, and the Loss Control Ergonomics Coordinator to receive an overview of all the Safety Programs that WSI offers.
- We received the following download of data:
    - Claims reported between 7/1/14 – 6/30/15, valued as of 6/30/15
    - Claims reported between 7/1/15 – 6/30/16, valued as of 6/30/16
    - Claims reported between 7/1/16 – 6/30/17, valued as of 6/30/17

  For each of these downloads we received basic claimant and policyholder information, amounts paid and incurred, lost time days, event description, part of body affected, cause/type of injury, result/nature of injury, and whether the policyholder was an SMP/SAM participant at the time of the injury.
- Met with WSI staff who clarified how the data is pulled and analyzed for accuracy in preparation for compiling the annual Detailed Claims and Injury Characteristics Report.
- Gathered similar reports from other monopolistic states such as Ohio and Wyoming.
- Met with several loss control staff to gain an understanding of all the different ways that data is being used in their daily work. Gathered sample copies of the various reports.
- Gained an understanding of the consultative services, safety incentive programs, grant programs, and training and education that is available to North Dakota policyholders through the Loss Control Department.

- Looked into processes to investigate and address catastrophic injuries/fatalities. Obtained copies of some representative accident investigation reports of catastrophic losses.
- Obtained access to the Learning Management System that is offered to policyholders for online education and reviewed representative training modules.
- Learned how STEP grants are awarded and used for educational purposes.
- Learned how the Ergonomic Initiative Grant Program works to assist policyholders in the purchase of ergonomic equipment and consultative services.
- Gained an understanding of the daily activities of the loss control supervisors and consultants.
- Attended an onsite safety audit of a long term care facility with one of the safety consultants.
- Reviewed the 2016 employer satisfaction survey conducted in regard to the WSI safety offerings.
- Reviewed loss control notes in the CAPS system for 40 representative policyholders. These policyholders were chosen randomly, to represent a wide variety of safety incentive plan participants, a wide variety of industries, and a wide variety of safety consultants.
- Gained a better understanding of the 92-05-03-04 Transitional return-to-work program statute and its history.

Findings

Code 65-03-01 allows WSI to have power to "issue and enforce all necessary and proper rules and safety regulations." Further, 65-03-02 allows them to assess penalties for violation of safety rules or regulations. While these statutes are available to them, WSI has made a purposeful decision not to exercise them. They make an effort to not be viewed among policyholders as compliance driven, but rather having more of a consultative approach. Having more of a consultative nature encourages policyholders to open up and allow greater participation in the safety programs and services they offer. Their goal is to be seen as educating and motivating, not as enforcing. They can and will point out OSHA violations to policyholders when they observe them, and in some cases they may ask employees to stop working until appropriate changes are made. They make every effort to preserve the client relationship in order to encourage a safer work environment for all North Dakota employers.

Code 65-03-04 states that "the organization shall create and operate work safety and loss prevention programs to protect the health of covered employees and the financial integrity of the fund, including programs promoting safety practices by employers and employees through education, training, consultation, grants, or incentives." With this goal in mind, WSI has created several programs. On the following pages, we will discuss WSI's safety incentive programs, training and education, consultative services, and grant programs. Finally, we will also discuss the Loss Control Department's use of workers' compensation data.

Voluntary Safety Incentive Programs

The Safety Management Program (SMP) involves developing or improving current safety management systems and is set up quite similar to the OSHA Voluntary Protection Program (VPP). In fact, the elements of WSI's SMP and OSHA's VPP are listed below for comparison purposes:

OSHA VPP	**WSI's SMP**
Management Leadership and Employee Involvement	Management's Commitment to Safety
Worksite Analysis	Safety Training
Hazard Prevention and Control	Hazard Recognition Program (includes taking corrective action)
Safety and Health Training	Accident Investigation Program
	Annual Safety and/or Claims Management Seminar

A WSI safety consultant audits the policyholder's program annually based on the SMP requirements in each of the categories above and develops plans to assist policyholders in making improvements. Employers who successfully participate in WSI's SMP can receive a premium discount of 10%. At the time of our review, there were 1133 participants in this program. These policyholders represent roughly 40-50% of the total premium.

The Safety Action Menu (SAM) consists of specific programs that allow policyholders options to customize their safety efforts toward their business. For each SAM they choose to successfully participate in, they can receive a 5% premium discount (up to a maximum of 15%). Employers are encouraged to participate in both the SMP and the SAMs, for a possible maximum premium discount of 25%. The SAM programs consist of the following:

- Certified Safety Management (emphasizes safety mentoring). Currently, there are 60 participants in this program.
- Drug Free Workplace. Currently, there are 1105 participants in this program.
- Learning Management System. Currently, there are 106 participants in this program.
- Return to Work/Designated Medical Provider Program. Currently, there are 478 participants in this program.
- Safe Driver. Currently, there are 420 participants in this program.
- Safe Lift. Currently, there are 379 participants in this program.
- Safety Committee. Currently, there are 845 participants in this program.
- Safety Orientation Systems. Currently, there are 288 participants in this program.

For policyholders that sign up and commit to participating in the SMP and/or the SAM, there is about a 90% rate of successful participation. The reason for this is because the safety consultants really work with their policyholders to help them achieve success.

The incentive programs that WSI offers are quite similar to those of other monopolistic states such as Ohio, Wyoming and Washington.

- The Ohio BWC Division of Safety & Hygiene provides consultative services in safety, industrial hygiene, and ergonomics. They offer online resources and training (offering in-person classes, online courses and a video library). They sponsor safety councils regionally throughout the state, offer safety grants, and sponsor the Ohio Safety Congress and Expo (a 3-day conference annually). Finally, they have safety related discount programs similar to WSI:
    - Industry-specific safety program (ISSP) that gives a 3% discount for completing one, two, or three activities during the year (the number of activities to complete are based on the payroll size of the employer).
    - Drug-free safety program (can achieve a 4-7% discount)
    - Transitional work program (can achieve a 10% discount)
    - Safety council (can achieve a 2-4% rebate)
- The Wyoming WCSR provides consultative services in safety and industrial hygiene. They offer online and in person training resources. They have a safety improvement fund that can help finance needed equipment or training. The discount programs they offer are:
    - Drug-free workplace (can achieve a 10% discount)
    - Safety Program Discount (can achieve a 3.33% – 10% discount)
    - Consultation Discount (can achieve a 3% - 10% discount)
    - Deductible Program (can achieve a 4-50% discount depending on the portion the employer pays of the claims)
- Washington State L&I similarly provides complimentary consultative services and training (in person, regional workshops, online resources and video). Grants are available for safety and health programs as well as return to work programs. They offer the following premium discount programs:
    - Return to Work: Stay at Work (reimburses for 50% of the base wages they pay to the injured worker as well as some of the cost of training, tools or clothing the worker needs to do the light-duty or transitional work.)
    - Return to Work: Preferred Worker Program (offers financial protection against subsequent claims, premium relief, incentive payment for continuous employment, and reimbursement for 50% of the base wages paid to the preferred worker and some of the cost of tools, clothing, and equipment the worker needs to do the job.)
    - Claim Free Discount (can achieve a 10%-40% discount)
    - Retrospective Rating

Tables 2.1 and 2.2 below illustrate a comparison of SMP and SAM participants vs. non-participants. We received three years of claim data, FY15-FY17, each valued as of 12 months. For each of the claims, we also had noted whether the claimant's employer was participating or not participating in a safety incentive plan at the time the claim occurred. The claims reported by policyholders who were

participating in a safety plan had average paid and incurred amounts that were 29-34% lower than those who were not participating.

Table 2.1. Comparison of SMP Participants and Non-Participants

SMP Participation	Number of Claims	Average Total Paid	Average Total Incurred
Yes	19,034	$2,273.18	$3,737.89
No	28,633	$3,228.36	$5,647.04
(blank)	117	$0.00	
Grand Total	**47,784**	**$2,839.98**	**$4,884.69**

Table 2.2. Comparison of SAM Participants and Non-Participants

SAM Participation	Number of Claims	Average Total Paid	Average Total Incurred
Yes	19,893	$2,294.03	$3,788.88
No	27,770	$3,243.32	$5,670.25
(blank)	121	$27.82	$841.52
Grand Total	**47,784**	**$2,839.98**	**$4,884.69**

We also reviewed the 2016 Loss Control Effectiveness Study, a survey conducted by an outside firm to evaluate the effectiveness of WSI's current loss control programs. Some of the significant findings of the evaluation that we noted were that:

- Employers who used WSI's safety services were generally happy with them.
- One of the biggest challenges WSI faces is the lack of awareness of their safety resources, especially among smaller companies.
- Policyholders who participated in the SMP/SAM experienced higher numbers of claims after beginning participation in the programs, but lower average costs per claim. This is consistent with what we would expect following the implementation of a new safety program. Often employers may see their claim numbers rise because of increased awareness among employees, but this can be good as injuries are being treated earlier and more successfully.
- Employers who used the loss prevention consultants indicated they were a beneficial resource, but many mentioned that the consultants seem to be overloaded with their current workload and suggested it has impacted the level of personal service the safety consultants are able to provide.

WSI has made considerable effort to increase the awareness of and the voluntary participation in the safety incentive programs. Recently, several Loss Control Education sessions were provided across the

state in the smaller market areas. Ahead of these sessions, claims data was pulled and analyzed from each of these areas to specifically target/invite the high loss leaders in these areas. Additionally, reports are prepared throughout the year that list experience rates and/or premiums by policyholder. Safety consultants receive these and they can identify the high loss policyholders in their area and potentially reach out. Finally, new loss time claims are sent out to the consultants every day. The policyholder name and area/safety consultant are identified, along with a link to the claim in the computer system. This is provided so safety consultants can review the information and then potentially reach out to the policyholders. As a secondary level over-sight the safety consultant supervisors also receives the new loss time claims. As they notice concerns or trends in injuries, they will ask the safety consultants to follow up, if they haven't already done so.

Fall/slip claims were frequent in the three years of workers' compensation claims that we obtained (claims occurring during FY15-FY17, each year valued as of 12 months). All the categories of slip/fall claims combined accounted for 19% of the claims and 32% of the total cost incurred.

Table 2.3. Slip/Trip/Fall Claim Breakdown

Cause of Injury	Number of Claims	Average Total Incurred	Average Total Paid
Fall from level/ladder/into opening	1,696	$17,023.75	$9,632.71
Slip/same level/liquid/ice/stairs/snow/misc.	7,544	$6,178.71	$3,590.11
All other claims combined	38,544	$4,094.88	$2,394.27
Grand Total	**47,784**	**$4,884.69**	**$2,839.98**

Recommendation 2.1: Given this high frequency and severity of slip, trip, fall claims, serious consideration should be given to adding an incentive component to the SAM program to raise awareness and mitigate the frequency and severity of this injury type.

Priority Level: High

> WSI Response: Concurs. WSI will review the slips, trips, and falls claims and consider actions to raise awareness to mitigate the frequency and severity of this injury type.

The Learning Management System (LMS) is the least utilized component of the SAM with only 106 current participants. However, the LMS is also used outside of the SAM program, and there are approximately 250-300 active employers at any given time. Since inception, the Learning Management System has been used by over 900 employers. Employers and their employees have completed 684,762 courses. There are currently over 13,000 active users on the system from 280 different employers.

The number of active employers varies as it depends on the way that the employer has chosen to utilize the LMS. Currently, the following usage options are available to employers:

1. **LMS Menu Discount Program**. Employee quarterly participation is required and the required number is based on a pre-determined percentage which is outlined in the SAM brochure.
2. **Safe Driver Discount Program**. The employer chooses to utilize the LMS as part of this discount program and each authorized driver is required to complete the 10 required courses in the eligible premium period to meet the training component of the program.
3. **Stand Alone**. The employer can be trained as an administrator and provide safety training to its employees based on business needs and is not tied to any discount program or minimum usage requirements.
4. **Individual Learner**. The safety contact or risk manager can utilize the LMS and take classes for their own personal knowledge.
5. **New Hire Training**. This option allows employers the ability to choose from one of the predefined curricula or build one from the catalog of courses based on their business needs to provide to their newly hired employees.

The LMS is currently marketed on the WSI website, by the Safety Consultants and also discussed at educational sessions and conferences throughout the state.

The LMS is a dynamic safety training tool with a wealth of training resources including over 550 safety training modules. Safety training is an effective tool for raising the awareness of employees and providing them with knowledge on safe work practice and compliance issues. The LMS is well suited to benefit both small and large employers but may provide more benefit for small to mid-sized employers that lack resources and personnel fluent in specific safety topics. The LMS can fill that gap to provide high quality safety training at no cost to the employer. Marketing and outreach as described in Recommendations 2.4 and 2.5 below can increase use of the LMS. The focus should not only be on the discount program use of LMS but on any and all use of the system (individual learner, stand alone, discount program, new hire training and the safe driver discount program).

Recommendation 2.2 – Encourage more use of the Learning Management System by policyholders.

Priority Level: Medium

> WSI Response: Concurs. WSI will review and explore options to encourage more use of the Learning Management System.

<u>Safety Training and Education</u>

Safety training and education programs are offered by WSI in varying formats. The LMS system, discussed in detail above, is the online learning tool with over 550 modules. It is important to note that any policyholder can use the LMS program and it is complimentary, regardless of incentive plan participation. For policyholders who prefer video based training, the Video Resource Library has over

600 physical DVDs and VHS tapes that can be checked out as needed. The OSHA 10-Hour General Industry and Construction online training programs are offered as well and those who successfully complete the course can become certified. Finally, STEP grants are available to provide funding for safety training that is hosted by specialized trade associations or employee organizations across the state.

Consultative Services

Complimentary consultative services are available to all policyholders, regardless of whether they participate in the safety incentive programs or not. There are thirteen safety consultants positioned regionally throughout the state. In addition to assisting and auditing policyholders who are participating in the safety incentive programs, they also provide safety assessments and conduct accident investigations, particularly when catastrophic losses occur. It is estimated that Safety Consultants spend roughly 80% of their time assisting safety plan participants and about 20% of their time with non-participants and performing outreach. The safety consultant supervisors typically audit two policyholders per consultant per month in order to ensure quality of work and provide them with feedback.

Regarding the more broad-based targeting of policyholders, in addition to the experience rate report mentioned above, WSI generates a top 100 report of the policyholders with the highest experience rates. This report is run approximately annually. After it is run, WSI conducts a bit more research into each of the policyholders. For example, are the costs for this policyholder being skewed because of one expensive claim? What are their injury trends? Is there any other background information that would be helpful? Then, the safety consultant receives all this background information and attempts to set up a meeting with the policyholder. Sometimes, as background preparation for the meeting, they will do a detailed trend analysis report or a loss control assessment that analyzes what would happen if they could lower the severity of claims, or just the frequency, etc.

Occasionally WSI Loss Control will also target specific industry groups for outreach. As an example, during the oil boom they were doing analyses on policyholders in this industry based on severity and subsequently reaching out to those policyholders who needed assistance.

When catastrophic cases occur, the claims adjuster fills out a C173 form and sends it through the CAPS computer system to the safety consultant. However, if it happens to be a fatality, there is one adjuster who handles all the fatality cases, and she will call the safety consultant ahead of the formal C173 form coming to them. This saves time because of the urgent nature of the situation. When significant injury trends are noticed by adjusters, then they fill out the same form, the C173, and it is routed to a Loss Control Consultant through CAPS, then to the safety consultant supervisors, then to the safety consultant. If for some reason the trends were missed by the adjusters, the loss time claims listing will typically show these.

When investigating a fatality case, WSI safety consultants typically investigate independent of OSHA. The time they are able to investigate varies as well, depending on the circumstances. They might arrive ahead of OSHA, sometimes after OSHA, or even at the same time. They do not investigate motor vehicle accidents, and there may be other instances when they cannot get onsite to investigate at all (the oil field is an example of this).

Grants

WSI currently provides grants to policyholders who wish to offset the costs of either ergonomics projects or Safety Training and Education Programs (STEP Grant). There is also a statute available for providing funds for transitional return-to-work program that will be discussed later in this section.

The Ergonomic Initiative Grant program has been in place since 2009, and offers resources for addressing work-related musculoskeletal disorders (MSDs). Ergonomics was specifically chosen because ergonomic related injuries account for approximately 35% of all the claims reported in the state. When a policyholder applies and is approved, WSI will pay for 75% of the professional fees of an approved ergonomics provider (primarily Occupational and Physical Therapists). The provider conducts an ergonomic assessment and makes recommendations. The fund will also subsequently reimburse the policyholder for equipment that has been recommended by the provider and approved through a grant committee. Finally, the fund reimburses 100% of the cost of ergonomic educational services. Ergonomic grant monies are capped based on the premium size of the policyholder.

Our own analysis of the three years of workers' compensation claims that we obtained (claims occurring during FY15-FY17, each year valued as of 12 months) supports the frequency of ergonomic claims that WSI has reported. If we separate claims with natures of injury that are typically ergonomic in nature, we arrive at the table 2.4 below.

Table 2.4. Ergonomic Claim Breakdown

Nature of Injury	Number of Claims	Sum of Total Paid	Sum of Total Incurred
49 - Sprain/Strain	16,289	$34,710,988.77	$56,944,508.25
78 - Carpal Tunnel Syndrome	282	$1,226,267.83	$1,990,616.21
80 - All Other Cumulative Injuries	319	$967,231.62	$2,460,004.58
92 – Tendonitis	335	$841,406.78	$1,467,455.55
Ergonomic Claims Combined	**17,225**	**$37,745,895.00**	**$62,862,584.59**
Non-Ergonomic Claims Combined	30,559	$97,959,614.60	$169,975,954.57
Grand Total	**47,784**	**$135,705,509.60**	**$232,838,539.16**

Ergonomic claims account for 36% of the frequency of claims, 28% of the total paid, and 27% of the total incurred amounts. This is a well-chosen area of focus for the grant program. And, ensuring that the ergonomic equipment is recommended by an occupational or physical therapist that is external to the employer ensures there is some control over not funding excessive or unnecessary equipment.

The STEP Grant provides funding to state associations and employee organizations who promote occupational training and education. As an example, the grant provides scholarships to attend the North Dakota Safety Council. It also provides smaller associations with the funds to cover special speaker fees and expenses.

Code 92-05-03-04, Transitional return-to-work program was enacted in 2006 during the time of a different WSI Director. In the regulatory analysis found in the implementation of Admin Rule 92-05-03-04 - 2006 document, it says that the purpose of this statute is to "reward policyholders who operate a safety workplace and provide opportunities for injured workers to safely return to work as soon as possible after the injury. WSI will provide transitional return to work grants to policyholders that successfully develop and implement transitional return to work programs." Later, the wording of the statute was modified to remove the word grant, because it was acknowledged that "this program is more than a grant program and contemplates onsite assessment of work spaces, development of job descriptions and transitional work for injured employees." The statute was approved, but it was never utilized as the agency determined that the existing return to work consultative services provided by WSI Injury Services (under the direction of the Return to Work Director) were adequate. The wording of the statute, "the organization may create programs," leaves this open as an optional statute, and it is under the discretion of the organization to exercise it or not. A decision was made to leave this provision active in the law, should the need for return to work funding arise in the future.

Recommendation 2.3 - If this provision is utilized in the future, then we recommend it be managed by the Return to Work Director in Injury Services, and these efforts closely coordinated with Loss Control in Employer Services. The Return to Work Program already has a solid working relationship with the medical and return to work communities. However, Loss Control safety consultants work with the policyholders on an individual level and would be able to identify when their policyholders are having a difficult time accommodating modified duty. Safety consultants would be the ideal experts to conduct "onsite assessment of work spaces" to assist the employer in accommodating or even permanently modifying jobs to accommodate workers.

Priority Level: Low

> WSI Response: Concurs. If this provision is utilized in the future, WSI will coordinate efforts between the Return to Work Director in Injury Services and Loss Control in Employer Services.

Loss Control Department's Use of Workers' Compensation Data

The Detailed Claims and Injury Characteristics Report is prepared annually, and each report covers the previous 5 fiscal years. The report provides broad trends in the frequency of claims by a number of different ways – by part of body, nature of injury, cause of injury, age of claimant, day of occurrence, by gender of claimant, and by rate class. This report focuses on the frequency of claims reported, but not the severity or cost of claims reported. In preparing the report, the data for the most recent year of claims (based on the date reported to WSI) is downloaded in September, three months after the close of the fiscal year. The reason for waiting three months is to allow continued work on many of the cases, so that claims may be converted from a "pending" status to an accepted or denied status. Next, the part of body, nature of injury and cause of injury fields are reviewed for claims that may be missing this information. If the proper coding in any of these fields can be determined by reviewing the claim notes, then the coding is updated in the data accordingly. If not, then it is left as "unknown". The date of birth field is also corrected, if this information can be found by looking at the claim system. This data is then combined with the number of covered workforce employees and fatalities information (these pieces of data come from different sources), and then the information is tallied into the usual report format of charts and graphs. Wyoming WCSR provides a similar report on their website, giving 5-year injury frequency broken down by industry (using NAICS codes), nature of injury, and cause of injury. Ohio BWC also provides a 5-year breakdown of claims by industry (using NAICS codes) for their state, but they use an incidence rate based on hours rather than raw frequency.

Throughout their work, the WSI Loss Control Department uses workers' compensation data in various ways to make decisions and guide their actions. In addition to the daily emails containing new loss time claims and the bi-weekly listing of older claims that convert to loss time claims that the safety consultants receive (as discussed in the Safety Incentive Program section above), the consultants also have access to the following reports:

1. The Dashboard report is run by policyholder, sometimes in preparation for an audit and sometimes mid-year as well. It gives a five year history of various annual measures such as standard premium, gross payroll and number of employees, number of claims, number of loss time days, total cost incurred, experience rating, dividends and discounts. It also shows information on safety training courses completed and grant monies received over the time period. These are saved in the CAPS computer system by account. Policyholders receive copies of these as well.
2. The Detailed Claims Analysis is a detailed, 22+ page five-year analysis that covers a single policyholder's trends in frequency and severity of claims by part of body, cause of injury, nature of injury, day of occurrence, month of occurrence, length of employment, time of day, and age of claimant. Areas where combinations of nature, cause, and body part show frequent or expensive claims are also noted. As an example, it might be noted that 7 sprain/strain injuries attributed to lifting that affected the lower back were reported.

3. The EMOD Scenarios are a 7-8 page analysis that is run individually by policyholder. It gives different "what if" scenarios that show how the policyholder's experience rate, and therefore their premium can be affected by reducing different types of claims.
4. The Loss Run Summary report covers five years of claims and can be run independently by the safety consultants through Oracle Reports as they prepare for policyholder meetings. This report lists (per year) the number of claims, paid and reserved amounts, and number of loss time days broken out by medical only claims vs. time loss claims. Loss runs by policyholder are run based on the date of injury.
5. A Loss Run by Injury Date can be run for any desired period of time, such as the most recent quarter or year. This too can be run independently by the consultants through Oracle Reports as they prepare for policyholder meetings. This lists the individual claims that occurred during the desired time period along with their corresponding reserve and paid amounts, total incurred part of body, cause of injury and nature of injury. Loss runs by policyholder are run based on the date of injury.
6. The Book of Business report lists policyholders, their premium size, and the number of employees and is prepared on an ad hoc basis. Safety consultants receive these and they can identify the larger policyholders in their area and potentially reach out.
7. The Experience Rate report is also prepared on an ad hoc basis and lists policyholders, their premium size, the number of employees, their experience rate for the last two years, and their assigned safety consultant. Safety consultants receive these and they can identify the policyholders in their area with the most severe claims and potentially reach out.
8. Frequency/severity reports are prepared individually by policyholder that list claims during a certain time period along with total costs associated with each claim. The severity report also gives loss time days for each claim. Policyholders receive copies of these.
9. The Top 100 report is run approximately annually and shows the highest premiums by employer. It is used by the safety consultants to target specific employers to potentially meet with and discuss the state's safety offerings.

As part of the audit, we reviewed loss control notes in the CAPS system for 40 random policyholders, representing a wide variety of safety incentive plan participants, industries, and safety consultants. The majority of the documentation reviewed in the CAPS system illustrated that the energy and focus of the safety consultant is spent helping their policyholders meet the requirements of the various programs that they are enrolled in. While this is very important (as we have established that participation in the programs helps to reduce claim costs), we believe they could take their consultative services a step further. The Detailed Claims Analysis report contains a wealth of information concerning injury trends, but it is likely not being used to its fullest. Additionally, Dashboard reports, although not as detailed, are being prepared by safety consultants and provided to policyholders during consultations or as part of safety audits.

Recommendation 2.4 - Consider including a brief Executive Summary in Detailed Claims Analysis[1] and Dashboard Reports[2] that are provided to policyholders listing risk improvement recommendation(s) or areas of focus based on their historical loss trends. If the safety consultant composed an executive summary for these reports that lists one, two or three potential risk improvement recommendations or areas of focus based on the current data trends, this could help to set SMP/SAM goals that could really have an impact on that individual policyholder's loss experience. Specific WSI resources that are associated with these specific areas of focus should be recommended or offered. As an example, an executive summary might consist of the following:

- ***The severity of lifting claims has increased over the last two years. WSI offers training in safe lifting techniques (name specific courses that are pertinent to their industry). There is also a grant program that covers ergonomic evaluations and interventions as well.***
- ***The number of falls from ladders has doubled in the last year. Consider our online ladder safety training course.***

The benefit of assisting the policyholder on focusing and setting goals around specific trends will also encourage follow up on these issues from year to year, particularly if claims are still occurring in these areas.

Priority Level: High

> WSI Response: Concurs. WSI will consider including a brief Executive Summary when providing Detailed Claims Analysis and Dashboard Reports.

WSI has made significant efforts to increase awareness and participation in the Safety Incentive Programs thus far. Specifically, we noted the following activities:

1. At the time of underwriting, underwriters will direct the employer to the WSI website explaining the safety programs and application process.
2. The document titled *Employer's Guide: For Your ND Workers' Compensation Account* is mailed to all new policyholders at the time of underwriting and to all existing policies at time of renewal. This document gives a brief overview of the SMP/SAM programs available to them.
3. Social media outlets are being used to market the benefits of the safety incentive programs to employers.
4. Loss Control Education sessions are being held by Safety Consultants across the state in the smaller market areas (and Safety Consultants are personally inviting the high loss leaders to attend).

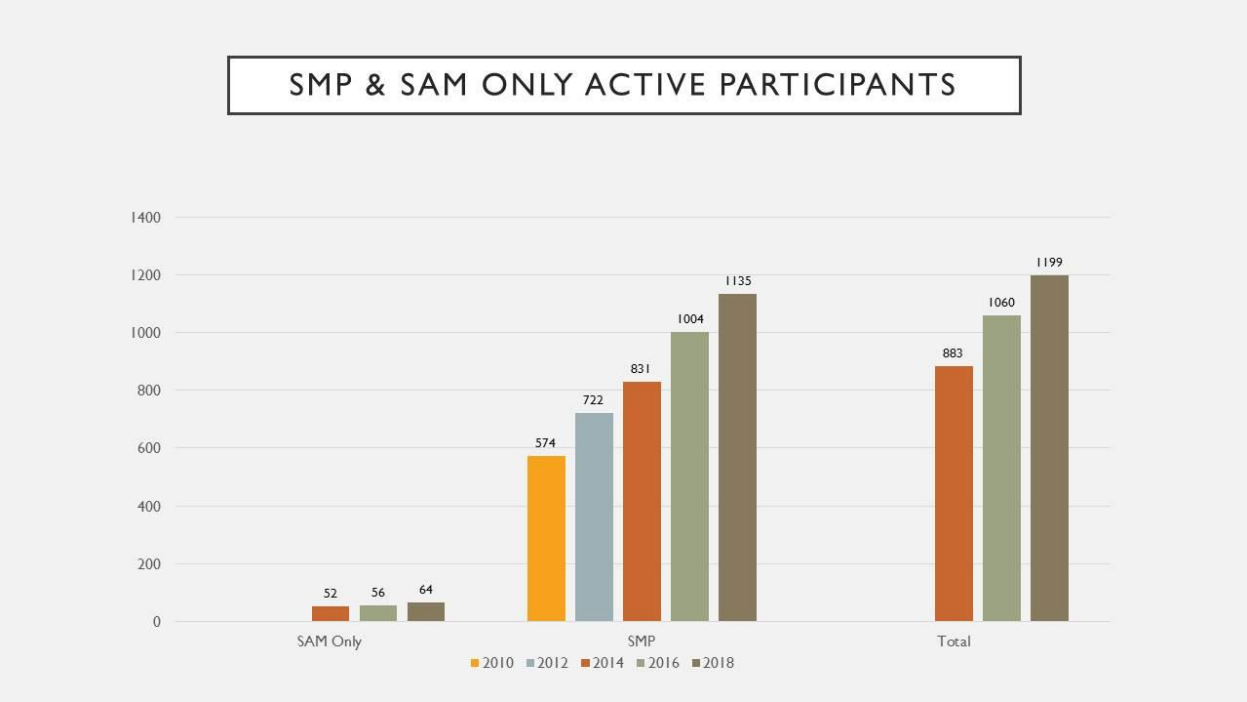
[1] The Detailed Claims Analysis report is the detailed, 22+ page five-year analysis that covers a single policyholder's trends in frequency and severity of claims by part of body, cause of injury, nature of injury, day of occurrence, month of occurrence, length of employment, time of day, and age of claimant.

[2] The Dashboard report is a 3-page, five year history of a single policyholder's various annual measures such as standard premium, gross payroll and number of employees, number of claims, number of loss time days, total cost incurred, experience rating, dividends/discounts, completed safety training courses and grant monies received.

5. WSI maintains a significant presence at conferences and on-site trainings throughout the state so as to be available to interested employers.
6. A Top 100 list of the non-safety program participants by the highest premium is compiled annually and subsequently the Safety Consultants reach out to the employers in their regions that are on this list.

It appears these efforts have been successful, as the chart below illustrates the continual increase in the number of the safety incentive plan participants over the last 8 years.

Chart 2.1. SMP & SAM Only Active Participants



Previous sections of this report have noted that participating in the Safety Incentive Programs can lead to lower average claim costs. Therefore, continue your current efforts to increase participation. We believe that the Detailed Claims Analysis and Dashboard reports mentioned previously could also be a powerful tool to recruit new participants, if an executive summary were included that listed areas of focus and potential resources that are specific to the needs of the employer.

Recommendation 2.5 – To continue promoting the safety incentive programs to non-participants:

- **Consider targeting policyholders not currently active in SAM/SMP that have not already been personally made aware of the safety programs within the last three years. Use a combination of claim frequency and claim severity to target employers.**

- **For the targeted employers, the local Safety Consultant would review the employer's Detailed Claims Analysis or Dashboard report and add an executive summary that lists one, two or three potential risk improvement recommendations or areas of focus based on the current data trends. When the Safety Consultant reaches out to these targeted employers, they would be able to provide them with this customized report based on their specific needs.**

Priority Level: Medium

WSI Response: Concurs. WSI will continue to promote the safety incentive programs to non-participants.

Element Three – Prior Performance Evaluation Follow-Up

Introduction

For this element, the State of North Dakota is interested in reviewing a limited number of prior recommendations from the 2014 Performance Evaluation Report. In our review of prior recommendations, we are to determine if the related issues have been addressed to the extent practical. If not, considering the unique environment in North Dakota, provide recommendations, or alternatives to the prior recommendations, to practically address needs of applicable stakeholders.

Prior recommendations from the 2014 Performance Evaluation that are the subject of this performance evaluation are summarized as follows:

- Prior Recommendation 1.4 - A review of whether WSI made attempts to locate North Dakota physicians that will serve as Independent Medical Evaluators to improve the frequency of use of North Dakota physicians
- Prior Recommendation 1.7 - A review of whether all IME related Claims Procedures were reviewed with the Claims staff, more specifically the Claims Supervisors to ensure that the processes and procedures are being followed
- Prior Recommendation 2.2 - A review of whether WSI developed a process in conjunction with its medical vendors to review atypical payment trends as a starting point for provider fraud investigation
- Prior Recommendation 2.3 - A review of whether WSI developed techniques in data mining to detect fraud, notably as regards medical providers, given the lack of provider fraud detected not only in the performance evaluation period but before that as well
- Prior Recommendation 6.1 – A review of whether WSI worked with its new pharmacy benefits manager to reinitiate its Patient Utilization Review report
- Prior Recommendation 6.2 - A review of whether WSI updated its process to include a form letter to the provider receiving an FL 423-1 letter. The letter would request the provider to identify a date when they believe the patient will be able to discontinue use of opioid treatment
- Prior Recommendation 6.3 - A review of whether WSI drafted legislation to be considered in the next biennium to seek to accomplish that chronic opioid use cases can be more effectively managed
- Prior Recommendation 6.4 – A review of provider profiling as regards to opioid prescribing patterns and higher cost/use cases
- Prior Recommendation 6.5 – A review of WSI's formulary, specifically controls on long acting opioids

Background

Our approach to this topic utilized a combination of activities. Generally speaking, as you consider the activities identified below, more was researched for recommendations that were partially accomplished or not completed at all than for those where we saw evidence that a prior recommendation had been fulfilled or an alternative to the prior recommendation has been considered. Activities included:

- Conducted various telephonic and in-person interviews with WSI's Medical Services and Pharmacy Director, Claims Director, Internal Audit, SIU Director, Bill Review Staff, Bill Review and Provider Relations Supervisor, and Quality Assurance Director
- Reviewed various Operational Data Metrics
- Reviewed varying types of Claims Processes, Procedures and Forms relative to Opioid Management, Independent Medical Evaluations, and Fraud
- Reviewed Internal Audit Documentation
- Reviewed the Independent Medical Evaluation referral process of Wyoming, Ohio, South Dakota, Washington, and Minnesota
- Reviewed claims filed where Independent Medical Evaluation and/or Independent Medical Reviews were completed, and for claims for injured workers where opioid medications were prescribed (42 cases relating to IME matters and 69 cases pertaining to opioid use)
- Requested documentation supporting WSI's process to locate North Dakota IME candidates during the evaluation period
- Requested, reviewed and analyzed data provided by WSI to identify claims filed with IME evaluations performed in the performance evaluation period
- Requested and reviewed updated claim related IME policies and procedures to identify any changes
- Met with WSI's Claims Director to review the updates to the claim procedures, the implementation process, and discuss the need for Supervisory oversight in the claims process
- Met with a WSI's Claims Unit Supervisor to discuss IME process changes, staff training, and the implementation process at the claims adjuster's desk level
- Contacted the Ohio Commission Medical Adviser to determine whether they utilize in-state medical providers to perform medical reviews on in-state peers
- Met with WSI's Medical Services and Pharmacy Director, SIU Director, Bill Review and Provider Relations Supervisor, and the Senior Medical Bill Auditor regarding anti-fraud activities
- Requested and reviewed WSI Operating reports
- Reviewed CGI Federal and Envolve Pharmacy Benefit Manager reports
- Explored data mining, data management and anti-fraud training opportunities
- Reviewed Senate Bill 2060

Prior Recommendation 1.4: We recommend that WSI immediately resume its attempts to locate North Dakota physicians that will serve as Independent Medical Evaluators to improve the frequency of use of North Dakota physicians in this area…WSI needs to reach out and develop relationships within the state's medical community, offer training and provide incentives to welcome its in-state medical partners into their IME preferred vendor pool.

Other relevant findings were cited in the recommendation. The priority of this recommendation was considered high.

After the 2014 Performance Evaluation, WSI indicated that this recommendation was partially implemented and that through several meaningful attempts they have been unable to locate qualified North Dakota physicians interested in conducting independent medical exams or independent medical reviews.

On October 8, 2014, WSI solicited a proposal from independent third parties to survey vendors who would be capable of identifying North Dakota medical providers capable of and willing to be trained to perform independent medical examinations and independent medical reviews. The scope of work included the use of an independent third party to survey medical providers within the state of North Dakota in order to identify qualified, interested and willing North Dakota providers capable of conducting IMEs and IMRs. Four vendors responded and one was awarded the contract in December 2014. Final results were due to WSI by May 1, 2015.

By August 7, 2015, the vendor partner submitted a final report advising that their recruitment efforts were successful in identifying 25 physician specialists out of the 500 surveyed in the state of North Dakota that were interested in performing medical evaluations on behalf of WSI, and were willing to complete an application and credentialing process. 19 of the specialists were in the process of completing application/credentialing process as of March 2015: 9 orthopedists, 2 occupational medicine specialists, 5 physical medicine & rehabilitation/pain management, 2 psychiatrists/psychologists, and 1 neurologist. The vendor advised WSI that some were excited about the opportunity and were calling requesting a start date.

WSI notified the vendor on August 28, 2015 that all items agreed upon in the contract arrangement had not been fulfilled. A subsequent letter from the vendor partner dated in November 2015 advised that after their further outreach to the medical professionals who were interested, asking the following questions, there were only three remaining with interest in becoming an IME.

- Have you performed IME's or IMR's in the past?
- Are you willing to critically evaluate an in-state peer's treatments?
- Have you written IME or IMR reports in the past? (Please provide samples, if possible)
- Do you understand that by writing an IME or IMR for WSI, you will be required to appear, testify, and defend your conclusions?
- Do you have the time and staff available to handle scheduling?

The vendor partner representative further wrote in correspondence dated November 9, 2015 "Of these respondents, only one physician indicated he was willing to testify and defend his conclusions in court." The name of the medical provider was not disclosed in the documentation. "All respondents stated that they do not currently have enough time or staff available to handle IME scheduling. When these physicians had originally expressed interest, they were under the impression that all administrative tasks would be handled for them. The constant change in pricing, logistics or type of service, lack of providing final contract, and the legal requirements related to IME has dissuaded physicians from pursuing this opportunity. The few physicians who are willing to pursue this opportunity will not do so without administrative support."

Based upon the number of communiques surrounding the absence of contract elements along the way, WSI determined that the vendor selected for the project failed to perform up to the agreement, and their services were terminated formally in November 2015. We were advised that the pending list of interested medical providers was sent to a different vendor partner to continue the recruitment efforts. We were not able to validate with the new vendor partner that contact by WSI had occurred to continue recruitment efforts.

We reviewed the number of and location of independent medical evaluators (IME) that were requested on North Dakota workers compensation claims in calendar years 2015, 2016 and 2017 via a report generated by WSI.

IME medical providers performed 402 evaluations on behalf of WSI in this performance evaluation period. In contrast, there were 217 IMEs performed in the prior 2014 performance evaluation period, a number we previously recommended be increased.

Independent medical examinations are sought by the WSI claims staff at the claims adjuster's desk, usually by requesting the appropriate specialist based upon the diagnosis and treatment recommended. Consideration is also given as to utilizing medical providers that have produced credible medical reports in the past. One IME provider partner is trying to locate facilities closer to where injured workers live, so less travel is involved. However, the preponderance of evaluations performed for North Dakota residents are still taking place in the state of Minnesota.

We find that this recommendation was partially completed.

Recommendation 3.1: We recommend that WSI continue to take steps to identify North Dakota medical professionals it can add to its group of IME medical vendor/partners. We also recommend that WSI work closely with one or more IME provider groups to have them recruit and vet in-state physicians.

Priority Level: High

> WSI Response: Concurs. WSI will continue to identify potential providers to expand the pool willing to perform IMEs or IMRs within the state of North Dakota.

When WSI has identified potential providers in the past we have referred them to one of our IME vendor partners and will continue to do so.

Prior Recommendation 1.7: WSI should review its IME related Claims Procedures in their entirety with current staff, more specifically supervisors, to ensure that the procedures and processes as documented are being followed. Further, claims with IME requests should be sampled regularly by supervisory staff to ensure that all procedures/policies that pertain to claimant advocacy issues have not been overlooked.

The priority level on this recommendation was considered high.

In seeking to validate this response we interviewed WSI's Claims Director and a WSI Claims Unit Supervisor to discuss progress made on this prior recommendation. Documentation was requested and submitted supporting a review of IME claim procedures in use prior to October of 2014, and a number of staff meetings for Claims Unit Supervisors and Claim Adjusters in fiscal year 2015 wherein the revised IME procedure 310 was reviewed and discussed. The claim department procedures were compared with claim procedure documents provided in the 2014 Performance Evaluation period. Procedure 310 has been updated, providing new direction on WSI Independent Medical Evaluations (IME), Second Opinions, Functional Capacity Assessments, Functional Capacity Evaluations, and Independent Exercise Programs.

The most current revision requires that all prior injury information pertinent to the claimed body part(s) and associated records/films, etc. be provided to the IME prior to the date of the examination. Detailed instruction as to how to locate, solicit and forward prior records to the evaluating specialists are provided, well thought out and specific enough to ensure process can be followed. There also is evidence that multiple staff meetings occurred in fiscal year 2015 wherein Claims Procedures 301 and 301-1 were also reviewed in their entirety. 42 IME/IMR claims were sampled at random from the IME/IMR claims scheduled in this performance review period. We found a timely and appropriate request for prior records/films in each of the 42 claims. Other facets of the IME procedures were also reviewed as we reviewed claims.

The second part of the recommendation was that IME requests be sampled regularly by supervisory staff to ensure that all procedures/processes that pertain to claimant advocacy issues were not overlooked. WSI responded that with the current staffing levels and the claim volume – in light of the recommendation to increase the use of IMEs – they would not be able to add this additional responsibility to supervisory staff as they felt sufficient review of IME processes was already occurring.

Given the above perspective, we find that the prior recommendation was partially implemented.

Recommendation 3.2: We continue to recommend that Supervisors review IME processes just as they might other claims management practices to assure that processes and policies are being followed. We suggest that the Claims Director should also have a role in the review process. Collectively, we think a sample of one IME process review/week by the Claims Director or Supervisor can be accomplished without increasing workload in a significant way. There are nine supervisors and a Claims Director, so what we are suggesting amounts to about five reviews per year per person. Review results should be reviewed quarterly to determine if additional training in this area should be accomplished to assure process compliance.

Priority Level: Medium

> WSI Response: Concurs. The Claims Director will conduct sample reviews. Additional training will be provided if necessary based on the findings of the reviews.

Prior Recommendation 2.2: We recommend that WSI develop a process in conjunction with its medical vendors to review atypical payment trends as a starting point for provider investigation. One component of this process should include an assessment of referral patterns for ancillary medical services in which a treating provider has a financial interest. Information of this sort could be available through state records relating to corporate filings. Another way of obtaining this information would be to require by statute that providers disclose any financial interest they have in ancillary services if that interest is equal to or greater than 5%. Once WSI has this information, it can evaluate trends by comparing providers of like specialties treating injuries in the same geographic area.

The priority level on this recommendation was considered high.

WSI concurred with the response advising that they would explore the area of atypical payment trends with our vendors, including referral patterns for ancillary medical services in which a treating provider has a financial interest, to determine the best available options for WSI to pursue. After further review, WSI then decided not to implement this recommendation due to limited resources.

Following completion of the 2014 Performance Evaluation, WSI's SIU Department agreed to work with two vendor partners to determine what options were available for use. Little progress was made over the next six months at which time WSI staff reviewed this matter internally. As a result of its internal review, WSI believed that in order for WSI to conduct an assessment of referral patterns for ancillary medical services in which the treating provider had a financial interest, it would essentially require a credentialing process of all WSI's providers. It was felt that manpower was inadequate for WSI to develop the system capability to credential its providers.

In assessing implementation of this recommendation, we also reviewed data from WSI's Special Investigations Unit. There were two provider investigations reported in fiscal year 2016, and two again in fiscal year 2017. No cost avoidance investigations were reported for providers in fiscal 2016. In June, 2017, an order was drafted by the SIU because WSI determined that one medical payment should not be made for 14 physical therapy sessions to a particular provider because the provider allegedly provided inaccurate and misleading information to WSI. There is very little provider investigation and this continues a trend we have observed over the years at WSI.

The intent of this recommendation was for WSI to be able to identify atypical payment patterns as a preliminary investigative step. As an example, let's say that there are five doctors who treat similar injuries. Let's say that four of those doctors prescribe physical therapy and diagnostics in a manner that is similar. The fifth doctor regularly prescribes more physical therapy and more diagnostics. Might it be reasonable to question the doctor on his/her ordering of ancillary medical services? Might the question take on greater significance if the doctor had financial interests in a physical therapy and radiology clinic where services on his patients were regularly performed?

WSI might consider online resources, recommendations and training opportunities to improve its provider investigation efforts. We provide some sources below.

- The Association of Certified Fraud Examiners (ACFE) has an online site which contains a 2018 Fraud Examiners Manual along with offsite training opportunities, in addition to fraud recognition/prevention training resources. *http://www.acfe.com/products.aspx?id=4295000210*

- *Fraud Prevention Seminar – a* CPE accredited course in how to combat fraud more effectively and economically. *https://www.acfe.com/Fraud-Prevention-Seminar/*

- *Pharmacy Fraud* - this article explores the essential elements for building and maintaining a successful program to battle pharmacy fraud, specific procedures a fraud examiner can use to develop a pharmacy fraud case and legislative actions that might unintentionally hinder these efforts - *http://www.acfe.com/article.aspx?id=414*

- *Using Data Analytics to Detect Fraud* – this is an ACFE CPE accredited Basic Course introducing basic techniques of uncovering fraud through data analytics. *https://www.acfe.com/Using-Data-Analytics-to-Detect-Fraud/*

- *Obtaining, Managing and Searching Electronic Evidence* – this is an ACFE CPE accredited course held in conjunction with the 2-day seminar entitled *Financial Institution Fraud*, discussing how electronic evidence is obtained and secured. It is an intermediate IT professional's level field of study and may be of value for IT to attend this segment, while SIU attends the *Financial Institution Fraud* portion of the seminar. *https://www.acfe.com/Obtaining-Searching-Electronic-Evidence/*

2) Obtain a list of legitimate businesses that cannot submit bills to a U.S. federal government health program. If they are on the exclusions list, review the Office of Inspector General's U.S. Department of Health & Human Services website information to determine why they are on the list. *https://oig.hhs.gov/fraud/consumer-alerts/index.asp*

In addition to these links, partner with WSI's SIU Department to obtain and review information received from tips and complaints derived via their relationships with North Dakota's State Department of Insurance, the State Attorney General's Office, the Department of Insurance, via Department of Law Enforcement requests, news stories, and requests from Health Care Group insurance carriers due to investigations they may be conducting.

We consider this recommendation not to have been implemented.

Recommendation 3.3*:* We recommend that WSI invest in fraud detection training for staff that will support its ability to identify atypical payment and referral trends found in their data. A sample of a few online links has been provided to assist WSI in training to develop their internal processes, policies and procedures.

Priority Level: High

> WSI Response: Concurs. WSI will review fraud detection options for provider fraud. This includes a review of the online links provided in the recommendation.

Prior Recommendation 2.3: We recommend that WSI develop techniques in data mining to detect fraud, notably in regards to medical providers, given the relative lack of provider fraud detected not only in the performance evaluation period but before that as well.

The priority level on this recommendation was considered high.

Given our findings relative to Prior Recommendation 2.2, we can also state that this recommendation was not implemented. We make no further recommendation as we think implementation of new recommendation 3.3 will assist WSI in identifying both outliers and potential fraud cases.

Before addressing the specific prior recommendations related to opioid use, we want to restate that our task here is to address the extent to which prior recommendations have been fulfilled. The State of North Dakota also asked us to consider "alternatives to the prior recommendations, to practically address needs of applicable stakeholders." Given our findings in Element One, we have considered "alternatives to the prior recommendations," where we believe that makes sense.

Our review of the five prior opioid use related recommendations follows.

Prior Recommendation 6.1: Since the change from US Script to PMSI, the new pharmacy benefits manager has not produced the Patient Utilization Report. This report is used to identify patients whose opioid use has continued for at least 90 days. We recommend that WSI work with PMSI to reinitiate this report.

The priority level on this recommendation was considered high.

Shortly after this recommendation was made in 2014, WSI's Pharmacy Benefits Manager started producing a bi-weekly Patient Utilization Report. The PBM at that time was PMSI. The PBM also provided a Clinical Escalation Alert when opioid use reached the chronic stage (@ 90 days). WSI subsequently switched PBMs to Envolve, which provides utilization reports and notification to WSI when injured workers reach the 90-day threshold.

We consider this recommendation fully implemented.

Prior Recommendation 6.2: When WSI sends out the FL 423-1, we recommend it be accompanied by a form letter to the provider asking them to identify a date when they believe their patient will be able to discontinue the use of opioid treatment. (As we point out earlier in this Element, proportionately few patients receive more than two narcotic prescriptions so addressing those cases with a potential third fill seems a reasonable prudent step in opioid management.)

The priority level on this recommendation was considered medium.

Through a review of workers' compensation case files, as well as documentation from WSI's Internal Audit Department's review, we were able to confirm that this recommendation was fully implemented. The Internal Audit Department's review was finalized in October 2016.

At some point subsequent to the review by internal audit, WSI stopped sending the form letter and advised us that they did so because in many instances providers did not respond and in other instances reporting by providers was either incomplete or vague. We found examples of these kinds of responses in our evaluation.

Given the recommendation we made in Element One regarding first opioid fills being limited to a seven-day supply, we think a different provider letter is warranted and this letter will be needed in a much smaller population of cases. The premise of the recommendation made below is that with a first fill control as recommended in Recommendation 1.3, communication with providers during the sub-acute phase (at the time a third fill occurs) and the statutory language already in place via SB 2060 that there is a continuum of oversight and controls on opioid use.

Recommendation 3.4: We recommend that a letter go out requesting information from providers once an injured worker is prescribed a third fill. The information requested would be similar to the prior recommendation but would simply occur at a later point in time. Most injured workers will receive no more than two fills, so the intent of such a letter would be to ask providers to address longer term treatment needs at a time when opioid use is being extended into the sub-acute treatment phase, but before the case reaches a chronic state.

Priority Level: Medium

WSI Response: Concurs. WSI will modify its process and send out the FL423 once a new injury has reached the third opioid fill. This is contingent upon our Pharmacy Benefit Manager having the capability of identifying those claims and providing a report to WSI.

Prior Recommendation 6.3: We recommend that WSI draft legislation to be considered in the next biennium that seeks to accomplish the following:

- **Require the pain management contract to be signed by the injured worker and treating physician in all cases where opioid therapy has extended beyond 90 days**
- **For cases of opioid use beyond 90 days, require no less frequently than quarterly that the treating physician address how the current opioid regimen is either decreasing pain or improving function. (In those instances where neither is demonstrated, WSI may use independent medical evaluations to determine if ongoing opioid therapy is necessary. These evaluations could lead to a decision by WSI to disallow certain opioids, to reduce the dosage or to allow the treatment to continue as is.)**
- **For cases of opioid therapy beyond 90 days, mandate that appropriate and random drug screens are accomplished to ascertain if medication is being taken as prescribed. Drug screens should occur no less frequently than semi-annually and may at the treating physician's discretion be conducted more frequently up to four times annually. Failed tests would be considered a breach of the pain management contract and under such circumstances WSI should have the discretion to discontinue payment for opioid therapy**

The priority level on this recommendation was considered high.

WSI did draft legislation for consideration by the legislature in keeping with the recommendation and the legislature passed SB 2060. SB 2060 includes language defining chronic opioid therapy in keeping with the recommendation. Further, SB 2060 contains language pertaining to quarterly updates from the treating provider that he/she must document ongoing improvement in function or improvements in pain control. As well, random drug screening provisions are included in SB 2060.

WSI has adopted procedures and form letters to track progress and compliance in cases involving chronic opioid use. The first form letter (FL435) is sent once an injured worker reaches the 90-day threshold. Following this first letter, an event is created for adjusters to review cases 45 days later to make sure that the provider has complied with the requests made in FL435. If the provider has complied, then the adjuster addresses whether or not opioid therapy has resulted in improved function or pain complaint reduction. Subsequent 90-day diaries follow to monitor ongoing progress and compliance. When providers don't comply, additional form letters are sent to obtain responses. Failure on the part of the provider to comply can lead to the development of a Notice of Decision (NOD) to deny ongoing opioid therapy. The injured worker must be contacted both in writing and over the phone to inform him/her of the impact of the NOD. One possible outcome from the Notice of Decision could be

that the injured worker motivates the provider to respond to the prior form letter requests, which may then result in opioid therapy not being discontinued.

The procedures implemented in response to SB 2060 are appropriate to assure compliance with the statute. We consider this recommendation to be fully implemented.

Prior Recommendation 6.4: Provider profiling was recommended in the prior Performance Evaluation but the prior PBM could not accomplish that. We recommend that WSI pursue the profiling recommendation made in 2010 with the new PBM, PMSI. To accomplish the profiling, we recommend that WSI profile and manage results according to the following criteria:

- **Identify those physicians who have prescribed opioid medications over a certain dollar threshold in the past year (consider $20,000 as a starting point to see what the data reveals)**
- **Create a report that goes to the physicians who hit this threshold that provides for their patients the names of the injured workers, their dates of injury, when they commenced opioid therapy, the amount prescribed in morphine equivalencies, and a return to work date (if one exists)**
- **Schedule peer to peer meetings on cases selected by WSI with these treating physicians to include a review of the current opioid intake, morphine equivalencies, opportunities to reduce or discontinue opioid use, pain level, functional level, urine drug screening outcomes and the use of generic medication in lieu of brand name**
- **Establish goals or revised treatment plan objectives on each case and follow for compliance**
- **Pay treating physicians for their time at an appropriate professional hourly rate for participating in these reviews**

The priority level on this recommendation was considered high.

Rather than profiling providers, which includes the first two parts of the recommendation, WSI decided to review at least some of the cases on a "top 100" list based on the cost of opioids. In working with a vendor partner, revisions to the opioid treatment plan are considered or recommended with the treating provider. We reviewed several cases involving the vendor partner and found their work to be relevant to the task at hand; namely, to develop safer opioid treatment plans that reduce health risks to the injured worker. The treatment plans as recommended typically were designed either with an objective of weaning the injured worker off opioids altogether or reducing opioid use to a less risky level. As part of its review, the vendor partner would also identify in its reporting to WSI how much savings could be anticipated through the revised treatment plans. Estimates in the reports are based on annual and life expectancy savings. Often when the vendor partner reviewed opioid use, it referenced guidelines as promulgated by the Centers for Disease Control or the American College of Occupational and Environmental Medicine. These are the same sources upon which we have relied to make our recommendation on maximum morphine equivalents and first fills.

Recommendation 3.5: Assuming recommendation 1.3 is adopted and recommendation 1.4 is implemented, we recommend that the Medical Services and Pharmacy Director and Injury Services

staff develop claims procedures designed to track how cases with maximum morphine equivalencies exceeding 90 milligrams are being managed. The claims procedures should require that claims staff make sure there is either an opioid reduction/weaning treatment plan in place or that there is sound justification for why no reduction should be considered. We recommend that claims staff review such cases quarterly to evaluate progress. (Note: WSI already has in place a program with a vendor partner to address cases where opioid reduction or weaning should be more aggressively managed. With the objective of trying to reduce maximum morphine equivalencies to 90 milligrams or less, more referrals could occur.)

Priority Level: High

> WSI Response: Partially Concurs. WSI agrees that due diligence be given to those opioid claims where the maximum morphine equivalencies exceed the threshold which will be placed in the proposed administrative rules. A policy will be developed to staff those claims and determine if a referral to one of our vendor partners should be made to assist in implementing an opioid tapering program if that is deemed appropriate.
>
> These will be staffed as needed as they are identified by our Pharmacy Benefit Manager.

Prior Recommendation 6.5: We recommend that WSI evaluate its current formulary and build in a prior authorization process for long acting opioid medications that are requested within the first three months post-injury.

The priority level on this recommendation was considered high.

We reviewed the updates made to the formulary. This recommendation has been fully implemented.