2011 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1054

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1054
January 10, 2011
12702

☐ Conference Committee

Committee Clerk Signature Chad Fuchs

Explanation or reason for introduction of bill/resolution: Workers' compensation coverage of prescriptive drugs as part of pain therapy.

Minutes:

Chairman Keiser: We will open the hearing on HB 1054.

Representative Jennifer Clark: Neutral. We have worked with WSI and came up with some recommendations to work with the ND structure. You can break the bill into short-term pain treatment and long term pain management. First section deals with acute stage treatment. When you get to long term treatment, there is going to be some protocol, limitations and requirements from the physicians to take certain steps. There will probably be more discussion on that.

Chairman Keiser: Questions? This has 2 parts, the 30 days and greater than 6 weeks. If longer than 6 weeks there needs to be a treatment plan developed?

Representative Jennifer Clark: Beyond the 30 days it has to be objective support.

Chairman Keiser: Questions? Support?

Tim Wahlin ~ see attached testimony.

Chairman Keiser: Questions?

Representative M Nelson: Why are all schedules of drugs treated the same? We have a medical profession that evaluates drugs for their potential of abuse and schedules them accordingly and yet this treats all of them the same again.

Tim Wahlin: The original draft only dealt with schedule 2 opiates. In discussion with physicians, their suggestions were to the extent of which the patient is drug seeking, the reality is opiates are opiates.

Representative Amerman: Why do you compare California with North Dakota?

Tim Wahlin: They are non-comparable in so many ways, and when our numbers compare with theirs, it's an issue.

Representative Gruchalla: The part about requiring the patient to be subject to random screens, the test will show if he/she is at the right level that was prescribed?

Tim Wahlin: The drugs are there to the extent that you can get a good fix on the levels. We are looking at the fact that the drugs are there or not there.

Representative Gruchalla: Is there any other data about the impact this will have?

Tim Wahlin: No, this is new. This is an area that is growing and has become a concern to the extent that other states are addressing the problem and we are on the front end of this.

Representative Gruchalla: Do you foresee any problems with this?

Tim Wahlin: When we seek to alter a treatment pattern, it will require due process when there is a disagreement. Yes, I fully expect additional areas of conflict.

Representative Gruchalla: I agree with you. It will be the right road to go down.

Representative Clark: The statistics are telling me that Burleigh County is the hot spot for dispensing opiates? Am I reading that right and is there a reason for that?

Chairman Keiser: Yes and Yes.

Vice Chairman Kasper: On page 3, line 20, upon request of the organization, the prescribing physician shall immediately administer a drug screen. How will we comply with that? Don't we need to give some leeway?

Tim Wahlin: The objective is to change to a more palatable formula.

Representative M Nelson: In section 4, page 2, lines 14-19, would this include phantom pain?

Tim Wahlin: Yes it could.

Representative M Nelson: Would pain with no apparent cause be accepted?

Tim Wahlin: The extent that a physician makes a diagnosis of chronic pain, yes it would fit into that category.

Representative M Nelson: Then on B, you are saying the physician has to try other treatments before going to opiates?

Tim Wahlin: Yes, that would be required.

Representative M Nelson: Then in D, say I'm injured and referred to a pain management specialist I've never seen before, then how can I qualify as being known to him when he prescribes the drug?

Tim Wahlin: This is the long term opiate therapy which is at the end of the 6 month window. So that injured person would have to be in the chain of treatment. They would be known at some point of time and there would be documented treatment patterns. The decision could be made by the doctor, not WSI.

Vice Chairman Kasper: On the back of page 3, line 4, you are saying that WSI is going to make that determination or do you do it in conjunction with the prescribing physical and injured? How would that work?

Tim Wahlin: This puts bonus on WSI to review every single one and be consistent. Before we can change the treatment pattern, before we can change what we pay for, we have to have medical support. That is what's required.

Vice Chairman Kasper: Say there is a prescribing doctor working with an injured worker and recommends continuation, yet WSI says no, so we get a second opinion and again your people say no. How is that resolved?

Tim Wahlin: Before making any change, the organization has to have medical evidence that is objective and have to explain the reason why we are choosing one over the other.

Representative M Nelson: If I give a patient a patient a prescription for a pain reliever and it could be filled 6 times, does that count as 6 prescriptions or 1?

Tim Wahlin: I'm going to defer this question to the expert.

Dr. Harvey Hanel - WSI: Each fill is counted as a separate entity. So that would count as 6.

Representative Kreun: The comment on that there is a problem in Burleigh County. Have the numbers been given to the medical association to deal with those individuals that are working with somebody else?

Tim Wahlin: We just had our initial discussions, so that will be taking place. If you look at the numbers, is there a problem with one or two? There is a pattern that allows the progression. The way to address that is to do so early on in treatment.

Representative Kreun: It was said that there are ways that they would deal with that within their own organization, is that taking place?

Tim Wahlin: No.

Representative Kreun: So in other words it is not working?

Chairman Keiser: The purpose of this legislation is to address that very issue. Questions? Support? Opposition on HB 1054?

Duane Houdek ~ Opposition. See attached testimony.

Representative N Johnson: Does it have to be a patient request to look at a case or can it be an agency?

Duane Houdek: It does not have to be a patient.

Representative Amerman: Did you testify in the interim on this bill?

Duane Houdek: No, I did not.

Chairman Keiser: On occasion I've heard the comment that there are so few physicians in ND that it is very difficult to make decisions relative to censoring another physician. Do you find that to be true?

Duane Houdek: Not at all. I find just the opposite.

Chairman Keiser: Almost all of the rest of our health care is patient physician directed kind of health care system. WSI is really a managed health care system. Isn't this in large part and attempt for WSI to provide a managed system where they recognize an internal problem? Is this really inappropriate?

Duane Houdek: Yes, I think it is. The prescription of pain medication is complex and very difficult to get right. I think it could be asking too much of the physicians and unnecessarily.

Chairman Keiser: Any other opposition?

Bruce Levi: We would like to echo Mr. Houdek's comments and go on record for opposition.

Chairman Keiser: Questions? Opposition?

David L. Kemnitz: Ditto.

Chairman Keiser: Anyone else in opposition?

LeRoy Volk: Using same workman's compensation, how are you going to regulate this? I don't want to be totally helpless.

Chairman Keiser: If you want to sign a release and have us look at it we will, but stick to the issue.

LeRoy Volk: My doctor knows what my prescription is.

Chairman Keiser: Opposition?

Renee Pfenning: Opposition. Ditto, we have same concerns.

Chairman Keiser: Opposition? Neutral? We will close the hearing on HB 1054.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1054
January 12, 2011
12814

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:
Workers' compensation coverage of prescriptive drugs as part of pain therapy.

Work Committee Minutes:

Chairman Keiser: Opens the work session of HB 1054.

Representative N Johnson: The first stages talk about the opioid using at the acute stage where you can up to 30 days; there is no difficulty in prescribing it. If the use gets to become long term opioid therapy, then it requires them to state a plan that they get approved with the physician and individual.

Chairman Keiser: There are 3 critical dates, less than, equal to 30 day and from 30 days to 6 months, what happens?

Representative N Johnson: They need to have an approved plan. It takes out cancer.

Chairman Keiser: What happens after 6 months?

Representative N Johnson: After 6 months there has to be long term plan and the prescribing physician has to do drug screenings, make sure the drug that is supposed to be there is there, drugs that are not to be there, aren't there and check information on chemical dependency and at that point they can go for a longer term with an annual checkup.

Chairman Keiser: Any questions? This has two amendments on it. Is that correct?

Representative N Johnson: I just have the one amendment and that was just the incorrect word usage on page 2, line 23, when he wrote the amount where it should be lessening with acute therapy.

Chairman Keiser: Have we adopted that amendment to change "lessening with acute stage opioid therapy"?

Representative N Johnson: Move to adopt amendment.

Representative Ruby: Second.

Chairman Keiser: We have the amendment before us, what are the wishes of the committee?

Voice roll call taken, motion carried.

Representative Ruby: I do remember discussion to change on page 13, under section 3, line 20, remove "immediately".

Chairman Keiser: Do we have a motion?

Representative Sukut: Moves to adopt the 2nd amendment to remove "immediately".

Representative N Johnson: Second.

Voice vote taken, motion carried.

Chairman Keiser: We have HB 1054 as amended in 2 places, what are the wishes of the committee?

Representative M Nelson: I have some problems with this bill. Talks about his personal situation with opioid. I can't support this bill as written.

Chairman Keiser: Further comments?

Representative Nathe: I show four groups opposed this bill; can someone remind me why they opposed this bill?

Chairman Keiser: They see is as placing another limit on access potentially for injured workers. The North Dakota Medical Association comes back to what Representative M Nelson said, this is the practice of medicine and they don't need to be managed in this way. Then WSI says that this is an area that we need management and what we are proposing is a 3 tiered system of reporting and implementing this type of therapy.

Representative Gruchalla: When I first read this bill I thought it was mainly for an attempt to control the illegal dispensation of the drugs. Like Representative M Nelson said about the testing levels, if you prescribed the drug and that you are using it and that part I support but I don't know if we can get at that through this bill.

Vice Chairman Kasper: I want back to the bill on page 3, line 26, upon request of the organization, shall reduce the prescription level or provide justification, again the practice of medicine between the patient and client. If you go to page 4 at top on line 4, if the prescriber or injured employee does not comply with one or more the section or if the probably of eminent harm to the injured employee is high, after the organization provides reasonable notification to the injured employee, the organization may discontinue. I'm uncomfortable giving WSI that much power.

Chairman Keiser: Representative Ruby and Representative Amerman served on the interim committee; do you have any background to add to this?

Representative Ruby: The recommendation mainly wanted to get at the management of the use of some of these drugs. It was not so much as to control costs but to manage addiction and get some kind of managed treatment with that. It was to make sure you are prescribed for your benefit; it's showing up in your system, if you aren't, they want to find out why you are not. It was mainly for the providers who don't justify continuing it on for life. At least the plan is set up go give WSI an understanding why the patient be extended on that period of time. There was the issue of the bad one who are over prescribing, they are the main problem. It was mainly for the benefit for the long term employee, also to make sure of the bad factors in the medical professional are put on notice, you tell us why because we don't think it's in the best interest of the employee.

Representative Kreun: If you look at those, it isn't required, it is with the employee and the prescriber to make that managed program of pain management. That is what Representative Ruby is getting at is pain management. Right is the thing to do with the employee and as well employer.

Representative Ruby: One last point, as technology in medicine progresses, when they get to a point for some people, is there now another therapy that could fix this and they don't necessarily need to be on that now.

Vice Chairman Kasper: If you go top of page 4, line 5, who determines that? The same phrase on page 5, line 2, I think that in some cases, I have to trust my doctor.

Chairman Keiser: All of health care is managed. This bill is one of the best things we could do for injured workers. Opiods is serious business. I do support this bill. It's good management, it's a plan.

Chairman Keiser: What are the wishes of the committee?

Representative Ruby: Moves a Do Pass as Amended.

Representative Kreun: Second.

Roll call was taken on HB 1054 for a Do Pass as Amended with 10 yea's, 4 nay's, 0 absent and Representative Ruby is the carrier.

FISCAL NOTE

Requested by Legislative Council
01/14/2011

Amendment to: HB 1054

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The engrossed bill defines requirements relating to opioid therapy acute stage coverage and long-term opioid therapy coverage; provides procedures for prescribers of long-term opioid therapy; and establishes requirements for prescriber treatment plans.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

WORKFORCE SAFETY & INSURANCE
2011 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

BILL NO: Engrossed HB 1054

BILL DESCRIPTION: Narcotics Utilization Bill

SUMMARY OF ACTUARIAL INFORMATION: Workforce Safety & Insurance, together with its actuarial firm, Bickerstaff, Whatley, Ryan & Burkhalter Consulting Actuaries, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The engrossed bill defines requirements relating to opioid therapy acute stage coverage and long-term opioid therapy coverage; provides procedures for prescribers of long-term opioid therapy; and establishes requirements for prescriber treatment plans.

FISCAL IMPACT: Not quantifiable, however, we anticipate the proposed legislation will result in less addiction issues and less medical-induced disability ultimately resulting in improved return to work outcomes for injured workers. To the extent outcomes are improved, we would anticipate reductions in overall system costs which would ultimately be reflected in subsequent premium rate levels.

DATE: January 14, 2011

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	John Halvorson	**Agency:**	WSI
Phone Number:	328-6016	**Date Prepared:**	01/14/2011

FISCAL NOTE

Requested by Legislative Council
12/15/2010

Bill/Resolution No.: HB 1054

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

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WORKFORCE SAFETY & INSURANCE
2011 LEGISLATION
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DATE: December 15, 2010

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

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Name:	John Halvorson	**Agency:**	WSI
Phone Number:	328-6016	**Date Prepared:**	12/22/2010

FISCAL NOTE

Requested by Legislative Council
12/15/2010

Bill/Resolution No.: HB 1054

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

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WORKFORCE SAFETY & INSURANCE
2011 LEGISLATION
SUMMARY OF ACTUARIAL INFORMATION

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Name:	John Halvorson	**Agency:**	WSI
Phone Number:	328-6016	**Date Prepared:**	12/22/2010

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1054

Page 2, line 23, replace "lesion" with "lessening with acute stage opioid therapy"

Renumber accordingly.

Date: Jan 12-2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1054

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Johnson Seconded By Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

voice vote - motion carried
change to "lessening w/acute therapy"

Date: Jan 12-2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1054

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Sukut Seconded By Rep Johnson

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

2 amendment.
p 3, sec. 3, line 20 remove "immediately"

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Title.03000

Adopted by the Industry, Business and Labor Committee

January 12, 2011

VIC
1/13/11

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1054

Page 2, line 23, replace "lesion" with "lessening with acute stage opioid therapy"

Page 3, line 20, remove "immediately"

Page 3, line 21, after "administer" insert "within a reasonable time"

Renumber accordingly

Date: Jan 12-2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1054

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Kreun

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman		✓
Vice Chairman Kasper		✓	Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson		✓
Representative N Johnson		✓			
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 10 No 4

Absent _____

Floor Assignment Rep Ruby

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1054: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 4 NAYS, 0 ABSENT AND NOT VOTING). HB 1054 was placed on the Sixth order on the calendar.

Page 2, line 23, replace "lesion" with "lessening with acute stage opioid therapy"

Page 3, line 20, remove "immediately"

Page 3, line 21, after "administer" insert "within a reasonable time"

Renumber accordingly

2011 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1054

2011 SENATE STANDING COMMITTEE MINUTES

Senate Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1054
March 7, 2011
Job Number 15021

☐ Conference Committee

Committee Clerk Signature Jan Liebold

Explanation or reason for introduction of bill/resolution:

Relating to workers' compensation coverage of prescriptive drugs as part of pain therapy

Minutes: Testimony Attached

Chairman Klein: Opened the hearing on House Bill 1054.

Representative Ruby: Stated that the bill dealt with opioid therapy and sets up further requirements for the physicians when they are prescribing opioids for the injured workers. He goes over the bill and states after thirty days there are justifications and a time table or plan on how long this would be subscribed. There will be requirements for the physician and they will need to fill out a form for the Workforce Safety and Insurance.

Chairman Klein: Said that in the discussion the question would be if we trust our Doctor and asked if they are not over regulating.

Rep. Ruby: There are cases where doctors would only prescribe for a certain amount of time and would ethically decide it was time to discontinue the usage. He said it has led to some doctor shopping and there is a high percentage for prescribing from just a few. They do trust the doctor and they are asking for reasonable information on to how the drug is working and how it benefits the injured worker and what the plan is to potentially get them off of that. He said it does not apply to someone dealing with a malignant process such as cancer or when the pain therapy is aimed at relieving intractable pain and suffering in the terminally ill. He said there are situations where this will be left to be prescribed, other times we need to justify over diagnoses.

Tim Wahlin, Chief of Injury Services at WSI: Written Testimony.

Senator Schneider: Asked if the doctors were broken down by how many patients they had?

Tim: No they were not. He said they can't pull that information out of their system. They don't get the number of patients per prescriber.

Senator Schneider: Said he feels bad for Doctor A if he is treating more injured workers and that is why it looks like he is prescribing more narcotics.

Senator Laffen: Asked what it was about the Bismarck group and if there was anything that they knew of that was causing that differential.

Tim: Said they don't have an explanation from Sedgwick for why you would see the remarkable difference between Burleigh County and other areas of the state. He said numbers are numbers trying to explain why they are and when you can't come up with an explanation, that becomes an issue.

Senator Andrist: Said they would like to sort out the difference between doctor A and the rest of them, it is so remarkable and couldn't be related to patient load alone.

Tim: Said he would agree with that. It is broken out not by patient locality but by provider locality. He continues going over his testimony.

Questions and Answers followed

Senator Andrist: He asked if the agency had taken any steps to solve this situation primarily Burleigh County by making contacts to the state medical licensing board. He said they have a responsibility to look for people who are doing inappropriate things.

Tim: Said they had discussed this situation with one of their representatives. He said it is important to look at the differences. They are trying to address what are the differences in their roles. Their role is for discipline, to deal with inappropriate practice of medicine and does doctor A or any of them fall into that category, possibly.

Senator Andrist: Asked if he was saying that they have made the medical licensing board aware of this.

Tim: Said that they have had discussions but have not packaged up any information to send over there.

Chairman Klein: Commented about the need to seek out fraud and asked if with this information if they can't examine the doctors' side of this particular case.

Tim: He said to the intent of fraud, they would have to look at what fraud is. It is an intentional misstatement to drive some sort of monetary benefit. Is there an intentional misstatement or is it an individual who has a more aggressive interpretation on how they treat or a different method of treatment. It may be the conclusion of WSI that intentional acts cannot be shown.

More questions and answers

Opposition

Shelly Killen, MD: In opposition to the bill. Testimony Attached (2). She stated that most of the injuries are from the oil fields and that is why their numbers are higher because they are covering the entire western part of the state. She said that they do a lot of drug screening and she shared the different types of tests they do.

Questions and answers

Trina Kaiser, Nurse Practitioner: Written Testimony (3).

Chairman Klein: Asked if she understands that they have a problem and that there is an issue as brought forward by the performance evaluators that we need to address this somehow.

Trina: Said she did agree with that.

Chairman Klein: Asked if with her recommendations and working with the agency if they could come to something that would be more acceptable to her but still give them some ability to regulate.

Trina: Said she thinks so.

John Olson, North Dakota Board of Medical Examiners: Written testimony of Duane Houdek and he reviews that written testimony. Testimony Attached (4).

Courtney Koebele, Director of Advocacy for the North Dakota Medical Association: Written Testimony (5).

Senator Nodland: Said that the industry says that no one has told them about this but the industry must know that there is an abuse problem out there. What have they done to put more restraints or regulations on doctors' with prescriptions?

Courtney: She said these specific figures had not been presented. It was testified of the protocol used in several of the practices. She said they feel they have addressed as best they could the problem that has been presented. She said if there are doctors with a problem the board of medical examiners would address anything that was brought to them. She further stated that it isn't their job to go out there and find these complaints on people.

Kim Krohn, President of the North Dakota Medical Association: She said she appreciated Mr. Olson's remarks about the sanctity of the physician- patient relationship. She said that is there biggest opposition to the bill, it invites workforce safety into their exam room. She said that unfortunately there are pain related complaints that they can't fix. She said they are not going to go away and some are from workforce safety injuries and some are from other things. She talked about the patient that will have pain everyday of their life and someone decides who doesn't know them, that they don't get the option of opioids. She talks about the patients that are using opioids. She said that to have to fill out paper work every time to treat that patient it is disrespectful to the patient, it can delay their treatment and it makes her not want to work with the WSI patients. She said that they will see more and more physicians not wanting to work with WSI patients.

Chairman Klein: Asked how she thinks they should address the issues brought forward.

Kim: She said she hasn't seen the report and all physicians work hard to figure out appropriate treatment and how to figure out when they are being fooled and how to get around that to safely treat the patient. She talked about all they have to be concerned with. She said they are willing to continue to work with payers as long as they can keep the patient as the client.

Chairman Klein: Said that they will try to find some common ground and find something everybody can be in agreement with.

David L. Kemnitz, NDAFL-CIO: Said that the workers take exception to having an insurance company interfere between the doctor and what was worked on to bring the patient to a comfort level that they can live with.

Chairman Klein: Closed the hearing.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1054
March 29, 2011
Job Number 16134

☐ Conference Committee

Committee Clerk Signature Ella Lutsky

Explanation or reason for introduction of bill/resolution:

Relating to workers' compensation coverage of prescriptive drugs as part of pain therapy

Minutes: Proposed Amendment and Discussion

Chairman Klein: Called the committee meeting for bill 1054. He handed out an amendment that he had worked on with WSI Attachment (1).

Bryan Klipfel, Director of WFS and Insurance: He gave a brief overview. He said that they worked on this bill since last year. They had a study done and one of the elements was to study the narcotic use in the state of North Dakota. Through the study they found some areas in the state where excessive amounts of narcotics were being prescribed. He said they worked with the interim work comp review committee to come up with a bill that they thought would address some of those issues dealing with treatment plans and random drug checks for injured workers who were prescribed narcotics. The one bill went through the House side and when it came here we had the State Board of Medical Examiners and the North Dakota Medical Association express some dislike of the bill. They sat down and worked with them and he thought they had made some good changes to the bill when they were on their first amendment and they still don't like it. In the mean time we worked with the Governor's office on the third amendment and they don't like that either.

Senator Andrist: Asked if the amendments improve what you are trying to do or are they something you just did as a concession.

Bryan: Said for the most part the amendments will allow them to do what they want to do, they still made some concessions. He said probably in the third amendment one of the areas is the random drug test we will have to work with prescribing physician on, we can work around it. I will have Tim explain the differences and you can see what one you like the most. The second or the third amendment would work for them.

Senator Schneider: Asked what of the sticking point with the American Medical Association.

Bryan: Said that the point was the philosophical difference the physician patient relationship they didn't want any agency telling them how to deal with their patients. We are a managed care organization so we do that all ready for surgeries and other things.

Tim Wahlin, Chief of Injury Services WFS and Insurance: He said to the extent that there is the amendment, 3001 that is the amendment that has been handed out to you. That is what the Director was talking about when he was referring to the third amendment. There is a second amendment as well that was basically put together with staff after meeting with both the board and the Medical Association. In addressing the third amendment and pointing out the areas of change. The most specific ones that will affect this is the thirty days before a plan had to come in about OPID treatment this amendment extends that to six weeks. After six weeks it will require a consultation with the board of medical specialties and a board eligible specialist in pain medicine. That language was derived and not drafted by staff. There is a question if the numbers will support enough available consultation, they don't know, haven't run the number to see how many are sitting at six weeks and would require those staffing. It is all out there within the medical specialties. The other area that has changed is the only time the organization is able to get involved in the process when the plan does not meet medically accepted therapeutic standards. That language again, he isn't sure how it came or how it applies, it seems significantly stricter than other language out there on are other manage care. The question would not be if it is in the patient's best interest but rather does this pain management depart from therapeutic standards out there. It looks like a fairly high burden for us to go into effect. That is a change in the third bill that has presented some concern. He said they don't know exactly how they are going to interpret that. With respect to the rest of the bill, while there are a number of language changes he doesn't know if there is a significant impact on how the bill will be effected other than those two areas. One that has been removed is subject to random drug screening on page three that has been struck in this amendment, however they retain the ability to have a prescribing physician administer a test. Does that mean the tests can't be random, does that mean that the test are only given with reasonable suspicion, don't know that will be settled in the court system because I don't believe the bill addresses that any longer with that random drug test taken out.

Senator Schneider: Asked if they could establish that through administrative rule.

Tim: He said that he thinks that is what they will try to do, is to try to use a rule making authority to clarify that particular area and work from there. Since it is out of the bill it is something you look at and say it was there and is not there so does that mean something.

Senator Andrist: Asked if he would have any problems if they didn't pass this amendment, 3001, is there anything of value to you that improves the bill.

Chairman Klein: Asked if they went back to the second version the one you had worked on extensively before this last version.

Tim: Said the third version here creates an ambiguity that gives me concern. I don't see the ambiguity in the second or in the engrossed bill before you. To the extent that I know what that engrossed bill is going to do and how I am going to implement it and to the extent that the second draft clarifies a couple of areas and makes it more tolerable, I still know how I

am going to enforce that. The third will take some more work from staff interpreting because it is not staff language.

Comments and Questions

Chairman Klein: Closed the hearing

2011 SENATE STANDING COMMITTEE MINUTES

Senate Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1054
March 29, 2011
Job Number 16153

☐ Conference Committee

Committee Clerk Signature Eva Liebelt

Explanation or reason for introduction of bill/resolution:

Relating to workers' compensation coverage of prescriptive drugs as part of pain therapy

Minutes: Discussion and Vote

Chairman Klein: Said committee let's go to 1054. We had some discussion; there were a lot of groups involved here. He said WSI is still trying to get to the crux of the problem.

Senator Andrist: Said he likes the bill and he is alarmed of the dimension of the social problem that goes well beyond WSI and in addition to helping WSI solve a problem we could be examining as a state the possible over exposure of our people to really hard drugs.

Chairman Klein: Said this is an area that the performance evaluators suggested we needed to look into. We are dealing with the managed care portion of this.

Senator Andrist: Said he feels it is appropriate to manage its care. He moved a do pass.

Senator Larsen: Seconded the motion.

Senator Schneider: Said that there may be a problem and the best ones to know would be the State Board of Medical Examiners. He said that managing care that puts WSI between a doctor and a patient, especially a patient that is in pain we should at least consider some of the amendments that got the two parties close together. This is a big bite, it does interfere with the doctor patient relationship and it does so with patients by and large are in chronic pain. He thinks a small step would be appropriate.

Senator Murphy: Said we are telling doctors how to practice without any criminal or any complaint being made officially is out of our purview. I am going to vote against the motion.

Senator Laffen: Said he went out and read a few things on this issue and it suggested that wherever pain clinics first move into states the use of OPIDS has exploded and the accidental death by middle age men has gone up along with it. When we look at this report it shows that where those clinics are the use of this drug has gone off the chart and that is the only two places in the state have those clinics. He said he feels WSI is trying to head

this off from what they know and what they've seen early and He wishes the medical board would have been on board with it.

Senator Schneider: Said that there never has been a complaint made to the medical board. He said anyone who feels aggrieved by a physician wrongly prescribing OPIDS can make a complaint to the medical board and that includes the state based workers' compensation agency. He said in regards to the number of OPIDS being prescribed by any one given doctor you are not seeing the percentage of this doctors practice that involves workers' comps claimants and without those numbers we need to be careful of the amount of stock we put into those statistics.

Senator Larsen: Said that during discussion today the individual said that amendment three they would have frustration with but the second amendment isn't as bad and they could live with that and there was just some word changing. It just comes back to the original bill and there is a problem with this. He talked about an experience he had driving around with the highway patrol and picking up a guy who had bought OPIDS from someone else who was getting prescribed three hundred OPIDS from somebody and selling half of them, so there is a huge problem with it.

Senator Andrist: Said that if you look at the charts, unless you don't believe WSI there is clearly a problem there and we have given the medical community every opportunity to work with us or WSI. He said he believes that it would be wrong to do nothing when they see a problem exists. He said that most of the objection came from the medical community about us injecting ourselves in their practice in their judgment. He said for ninety eight percent of the doctors in North Dakota we haven't injected anything in there because they aren't prescribing OPIDS. They are being prescribed here in Burleigh County and that is where we are injecting some controls. If we find out we don't need it we can repeal it in two years.

Senator Schneider: He said this bill will apply to the whole state and not just to Burleigh County.

Chairman Klein: We will call the roll for a do pass on engrossed House Bill 1054.

Roll Call Vote: Yes-5 No-2

Senator Andrist to carry the bill

Date: 3/29/11
Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1054

Senate Industry, Business and Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Senator Andrist Seconded By Senator Larsen

Senators	Yes	No	Senators	Yes	No
Chairman Jerry Klein	✓		Senator Mac Schneider		✓
VC George L. Nodland	✓		Senator Philip Murphy		✓
Senator John Andrist	✓				
Senator Lonnie J. Laffen	✓				
Senator Oley Larsen	✓				

Total (Yes) 5 No 2

Absent 0

Floor Assignment Senator Andrist

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1054, as engrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **DO PASS** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1054 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

HB 1054

TESTIMONY ATTACHMENT 1

2011 House Bill No. 1054
Testimony before the House Industry, Business, and Labor Committee
Presented by: Tim Wahlin, Chief of Injury Services
Workforce Safety & Insurance
January 10, 2011

Mr. Chairman, Members of the Committee:

My name is Tim Wahlin, Chief of Injury Services at WSI. I am here on behalf of WSI to convey support of this bill and to provide information to the Committee to assist in making its determination.

This bill originates from the interim Legislative Workers' Compensation Review Committee.

During the last two years, WSI staff has been monitoring the prescriptive practices of North Dakota physicians regarding opioid treatment therapies for injured employees. Recently, WSI acquired more detailed methods of critically analyzing these trends, which lead to serious concerns.

These concerns were made an issue in the latest Performance Evaluation completed by the independent firm, Sedgwick CMS. Numerous findings confirmed WSI's observations regarding the frequency and pervasiveness of opioid therapeutics.

I will walk the Committee through those numbers with the appended presentation.

It is apparent from the numbers and comparisons of neighboring jurisdictions that the ever increasing tolerance is requiring higher and more frequent dosages or many of the prescribed opioids are being redirected.

In either circumstance, additional control must be asserted to safeguard the citizens of North Dakota.

In reviewing other models and legislative approaches, the organization has drafted HB1054 for your consideration.

The bill would simply regulate payment for opioid prescriptions under two methods; acute stage coverage and long-term coverage.

Acute stage would include prescriptions within six weeks of an initial injury or discharge. This class of prescriptions would be unaltered from current practice within the first thirty days. After thirty days, the provider would be required to complete a treatment plan which is a slightly more in depth screening tool for the benefit of WSI, the injured employee, and also the medical provider.

Beyond six weeks, WSI would cover opioid prescriptions only when the patient qualifies for long term opioid therapy coverage.

Long-term therapy would require increased justification including documentation of greater function, a diagnosis of chronic pain, and a treatment agreement with the prescriber. The patient must be subject to random screens for the presence of the prescribed medication as well as the absence of unprescribed medications and ongoing review and documentation of the therapy's effectiveness.

Prescribers will be required to complete this documentation in a treatment plan which includes providing the employee with information regarding chemical dependency programs, a plan for discontinuation should that ever become necessary, review of personal risk factors, and a history of treatment that documents conservative care measures that have been ineffective in controlling pain.

The bill also sets forth other requirements for prescribers including the requirement to respond to an organization's request to alter dosages. The bill requires that upon request to reduce dosage, the provider either provide reasons why this would not be in a patient's best interest or make the adjustment. This requires a responsive dialog regarding dosages. Absent this requirement, experience shows this dialog will not occur.

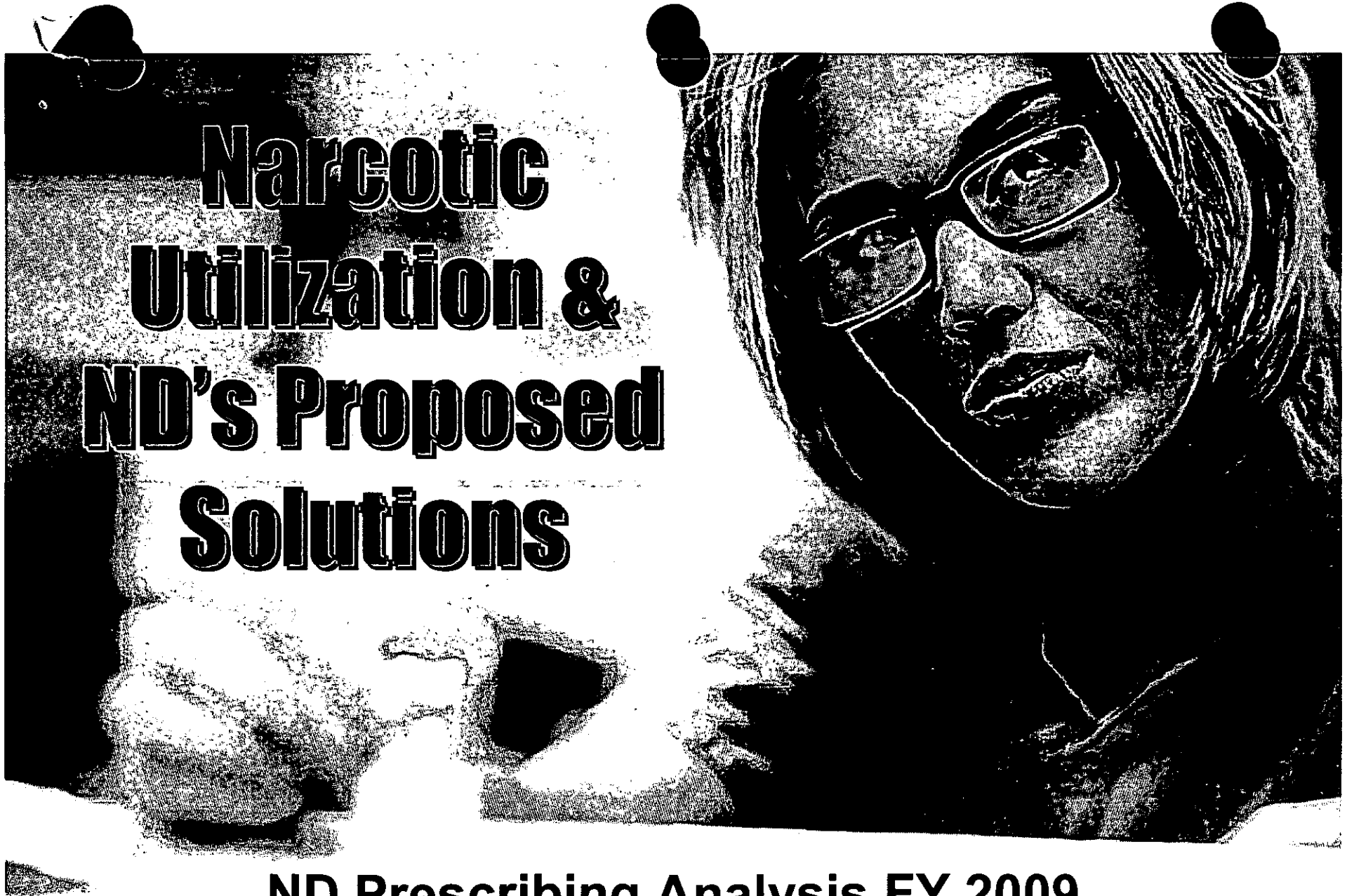
The bill before you contains a typographical error. On page two, line 23, the word "lesion" should be "lessening with acute stage opioid therapy." I would offer the amendment to correct that error.

This concludes my testimony. I would be happy to answer any questions at this time.

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1054

Page 2, line 23, replace "lesion" with "lessening with acute stage opioid therapy"

Renumber accordingly.



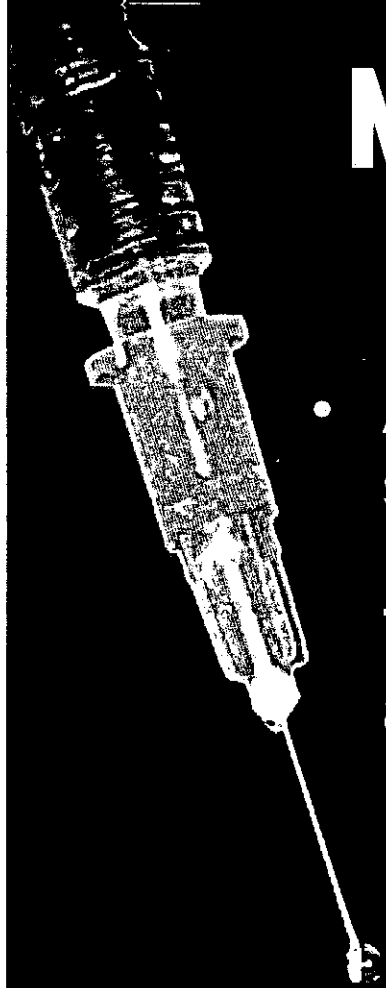
ND Prescribing Analysis FY 2009

Timothy J. Wahlin, Chief of Injury Services

2011 HB 1054

Significant assistance has been provided by:

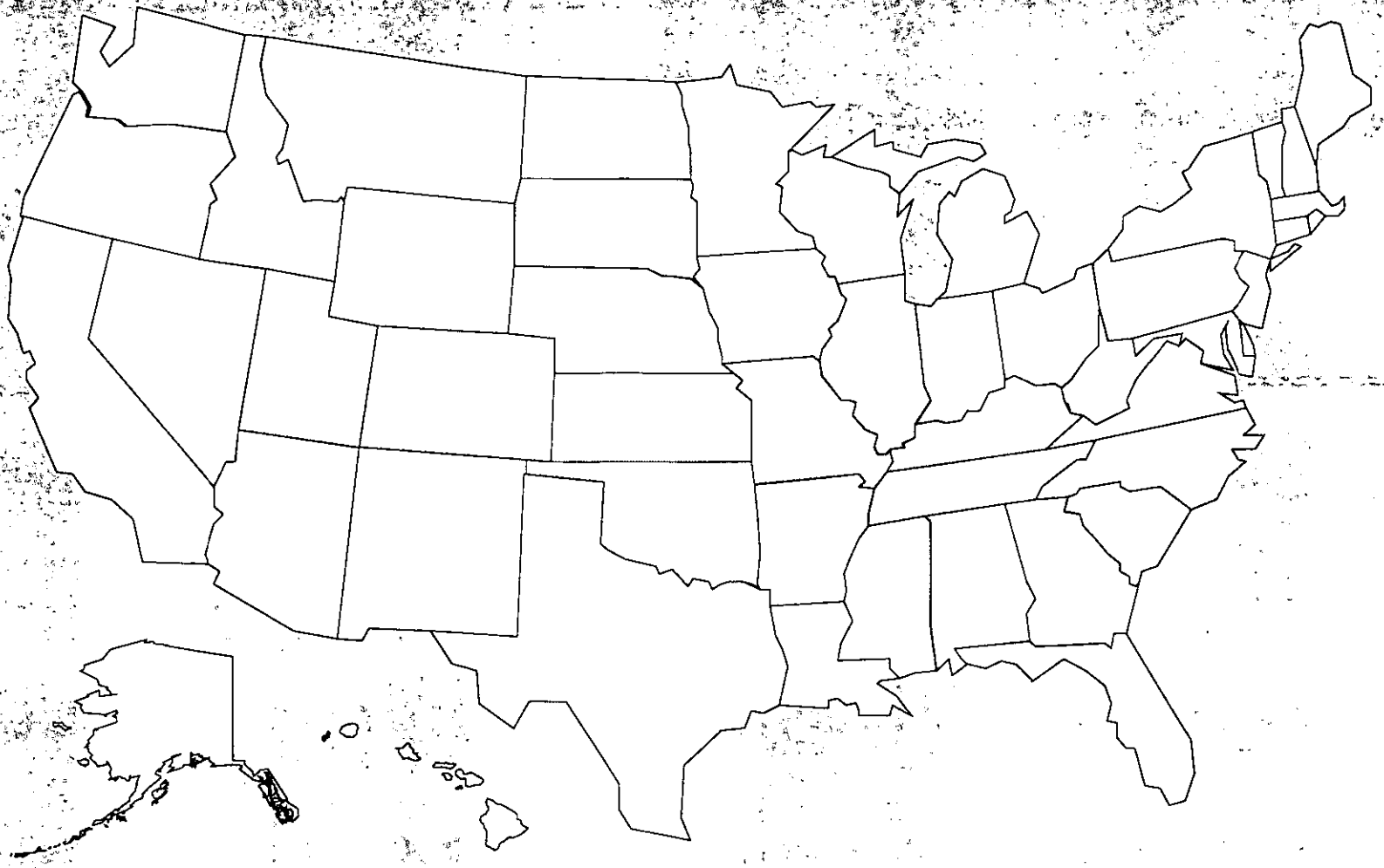
- **Harvey Hanel, PharmD, R.Ph.**
  WSI's Pharmacy Director
- **US Script**
  WSI's Pharmacy Benefit Mgr since 2004



NCCI presented an Opioid cost analysis in 2009

- Average claim costs of workers receiving seven or more scripts for opioids were 3x higher than those receiving zero or one. These workers were 2.7x more likely to have a time-loss, and had 4.7x more lost days
  - Since 2005 Schedule II narcotics costs have increased 521% and the number of scripts have increased 414% in CA
- Opioid cost average about 23% total drug spend
- In ND 41.5%
- As you all already know ND is similar to CA

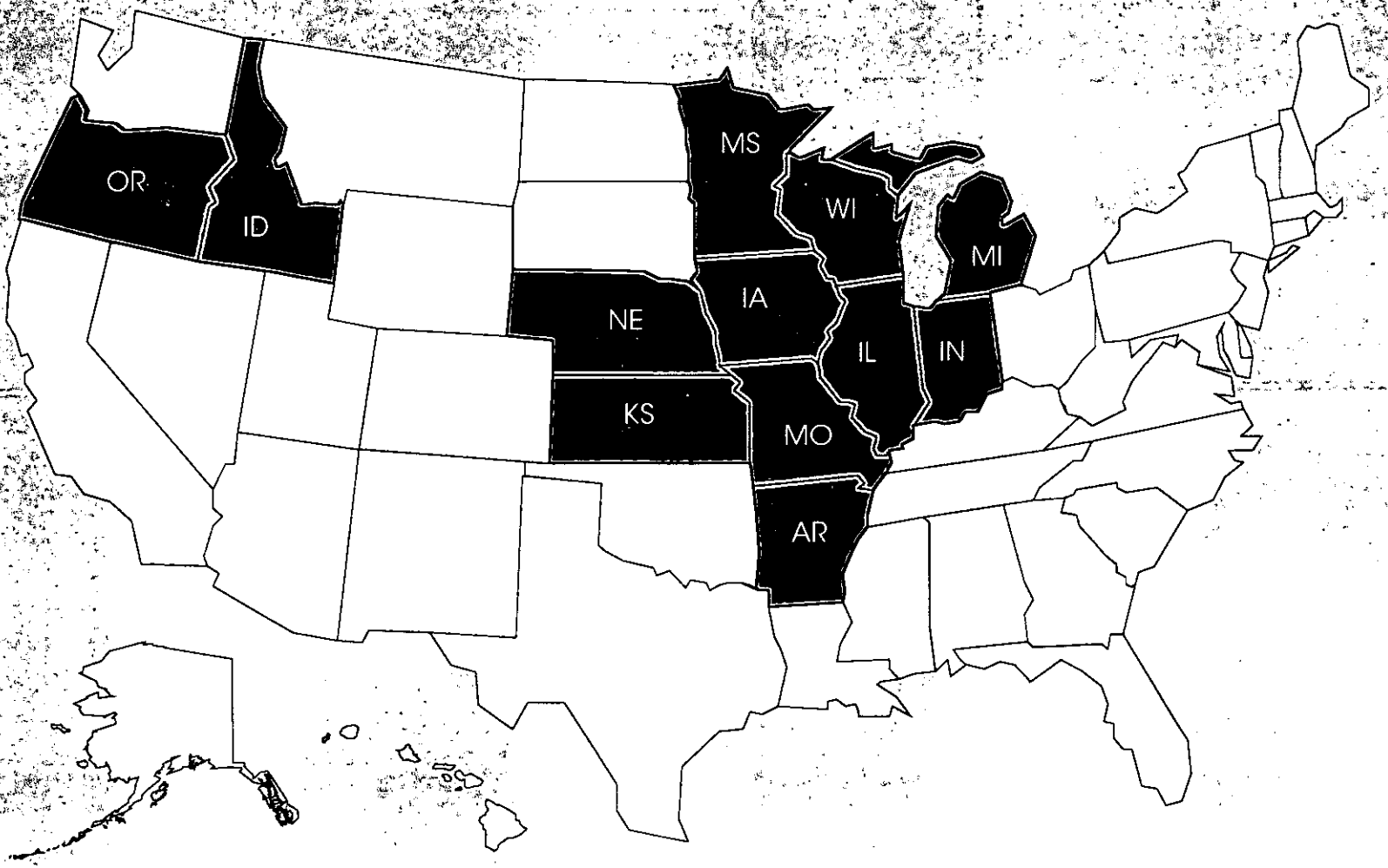
WC Narcotics Costs per Medical Claim



Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

WC Narcotics Costs per Medical Claim

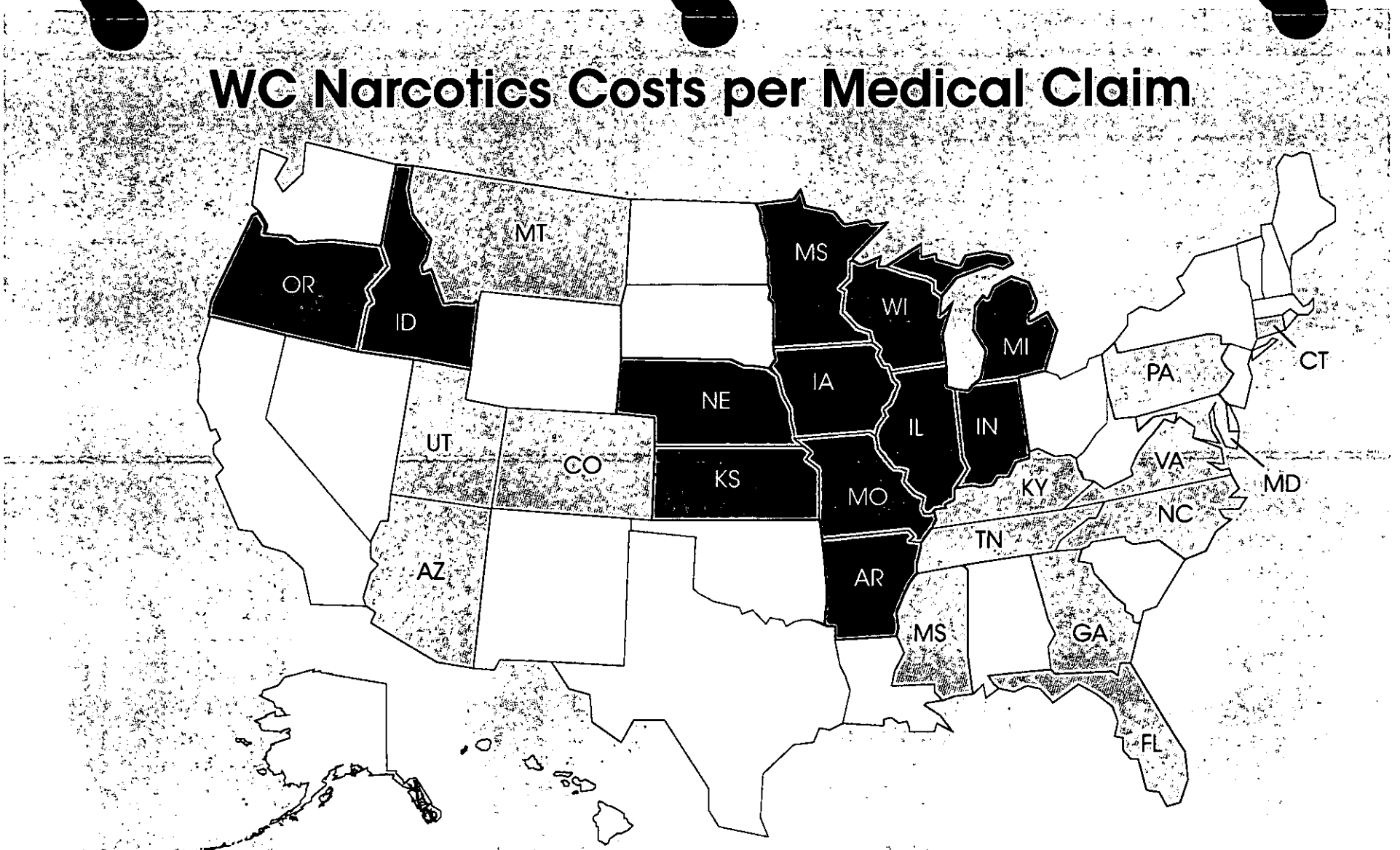


Below Average
(≤ $15 per claim)

Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

WC Narcotics Costs per Medical Claim



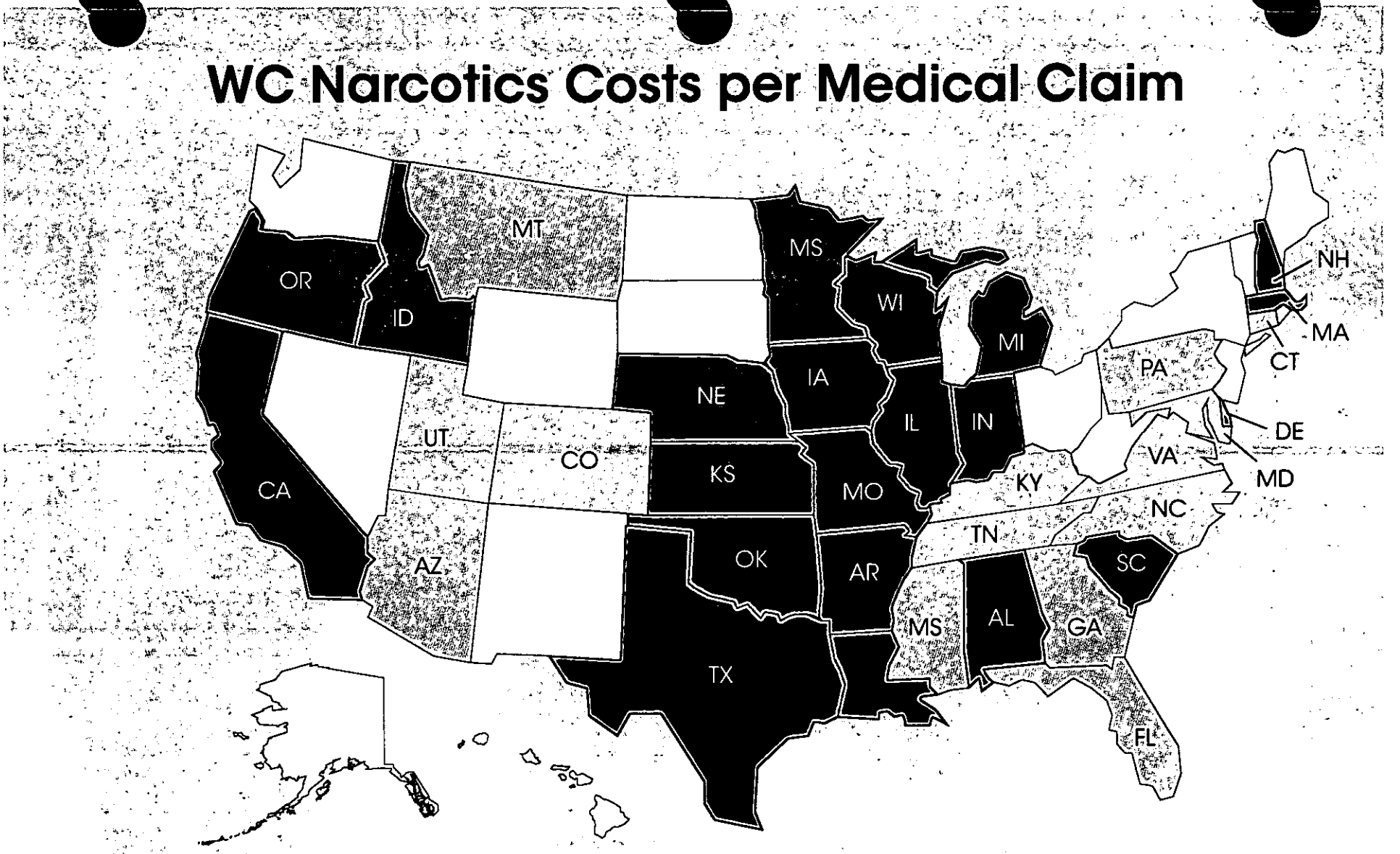
Below Average

Average
($15 - $30 per claim)

Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

WC Narcotics Costs per Medical Claim



Below Average

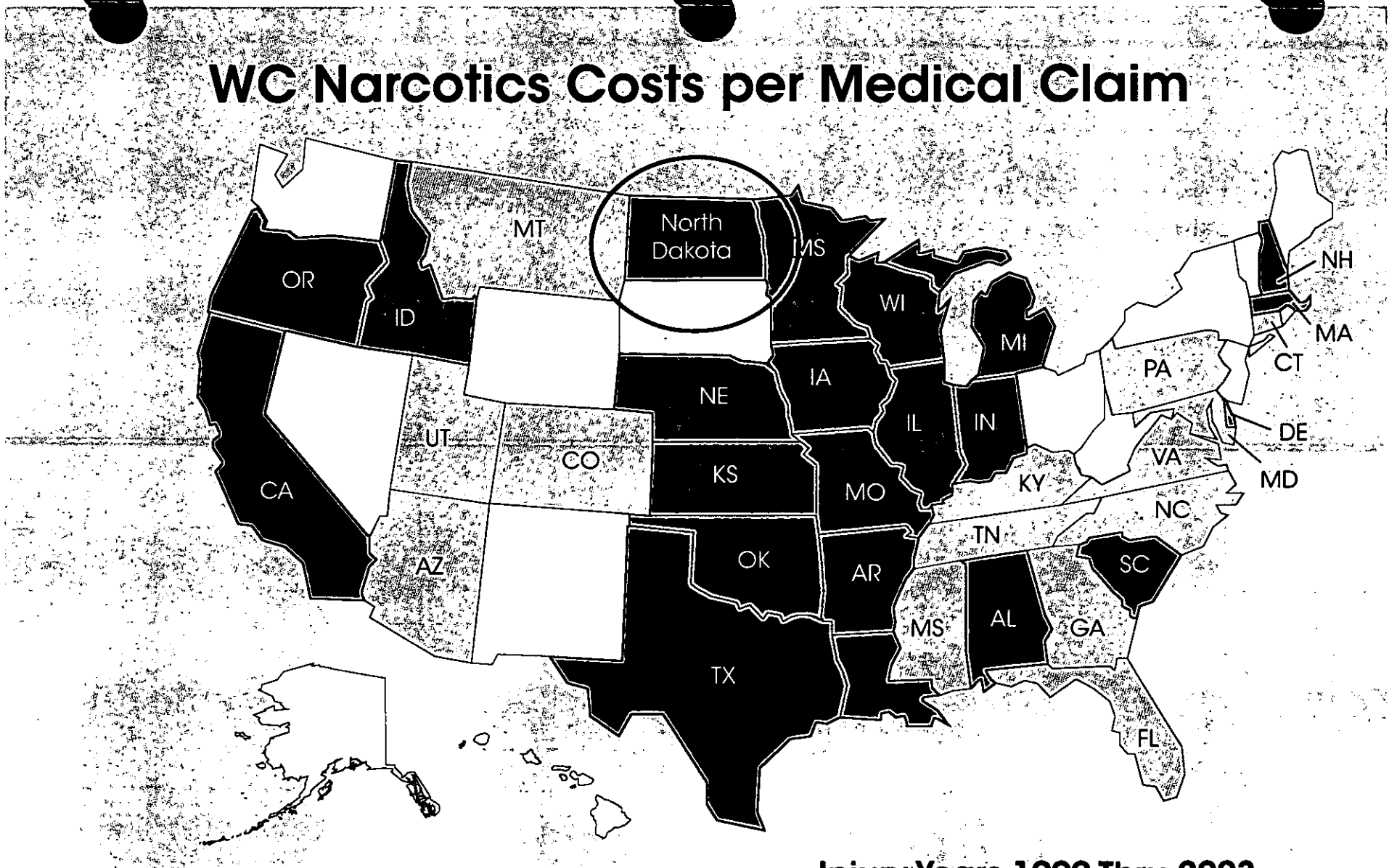
Average

Above Average
(≥ $30 per claim)

Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

WC Narcotics Costs per Medical Claim



Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

FY 2009 Pharmacy Data

Total Prescriptions: 86,108

Total Drug Spend: $6,754,324

Total Narcotic Spend: $2,801,773

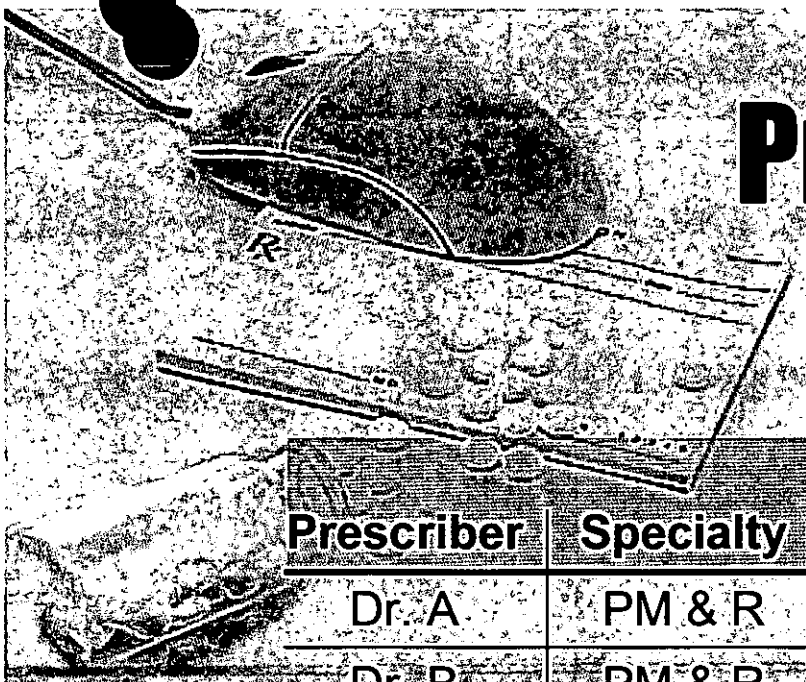
- Burleigh County: $1,575,102 (56.2%)
- Cass County: $226,304 (8.1%)
- Grand Forks County: $162,391 (5.8%)

ND Narcotic Spend: $2,297,310

- Burleigh County: (68.6%)
- Cass County: (9.9%)
- Grand Forks County: (7.1%)

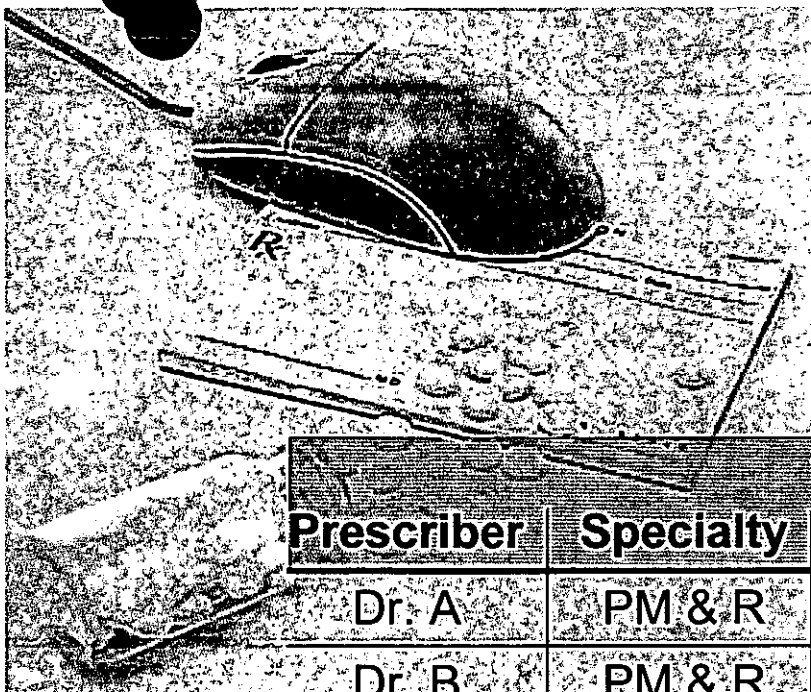
North Dakota
Workforce Safety
& Insurance
Putting safety to work

WSI



Prescribing by Total Narcotic Spend

Prescriber	Specialty	City	Clinic	Narcotic Spend	% of Total
Dr. A	PM & R	Bismarck	Clinic A	$888,048	31.62%
Dr. B	PM & R	Bismarck	Clinic B	$248,625	8.87%
FNP A	FNP	Bismarck	Clinic B	$119,725	4.27%
Dr. C	Anesth	Bismarck	Clinic C	$78,097	2.79%
Dr. D	Anesth	Bismarck	Clinic C	$72,878	2.60%
FNP C	FNP	Bismarck	Clinic C	$55,278	1.97%
Dr. G	FP	GF	Clinic E	$48,514	1.73%
Dr. E	PM & R	Fargo	Clinic D	$40,601	1.45%
Dr. I	Anesth	Fargo	Clinic F	$38,012	1.36%
FNP B	FNP	Fargo	Clinic D	$37,251	1.33%

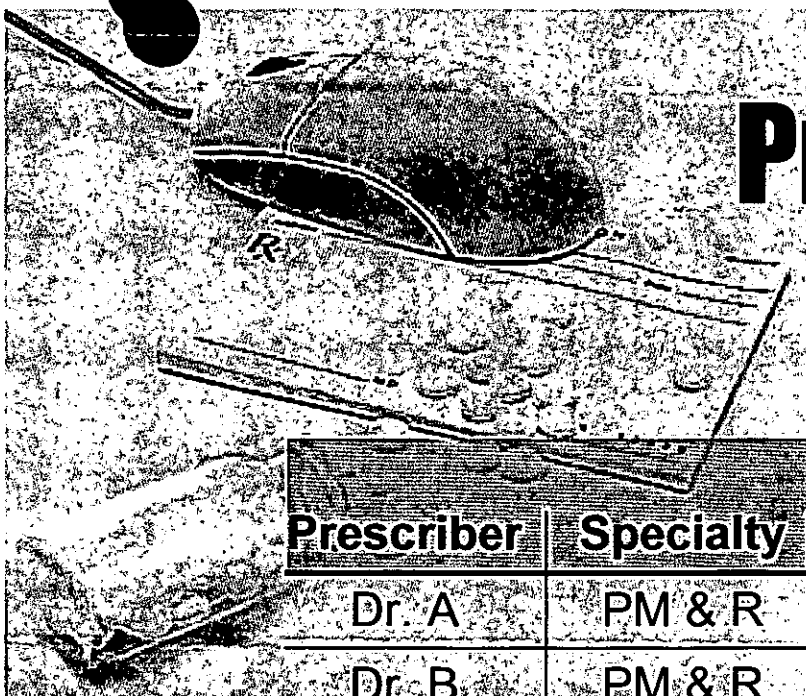


Prescribing by Total Spend

Prescriber	Specialty	City	Clinic	Drug Spend	% of Total
Dr. A	PM & R	Bismarck	Clinic A	$1,389,881	19.52%
Dr. B	PM & R	Bismarck	Clinic B	$545,637	7.66%
Dr. C	Anesth	Bismarck	Clinic C	$226,082	3.17%
Dr. D	Anesth	Bismarck	Clinic C	$224,188	3.15%
FNP A	FNP	Bismarck	Clinic B	$188,590	2.65%
Dr. E	PM & R	Fargo	Clinic D	$114,866	1.61%
Dr. F	PM & R	GF	Clinic E	$95,744	1.34%
FNP B	FNP	Fargo	Clinic D	$93,021	1.31%
Dr. G	FP	GF	Clinic E	$90,777	1.27%
Dr. H	PM & R	Bismarck	Clinic C	$67,541	0.95%

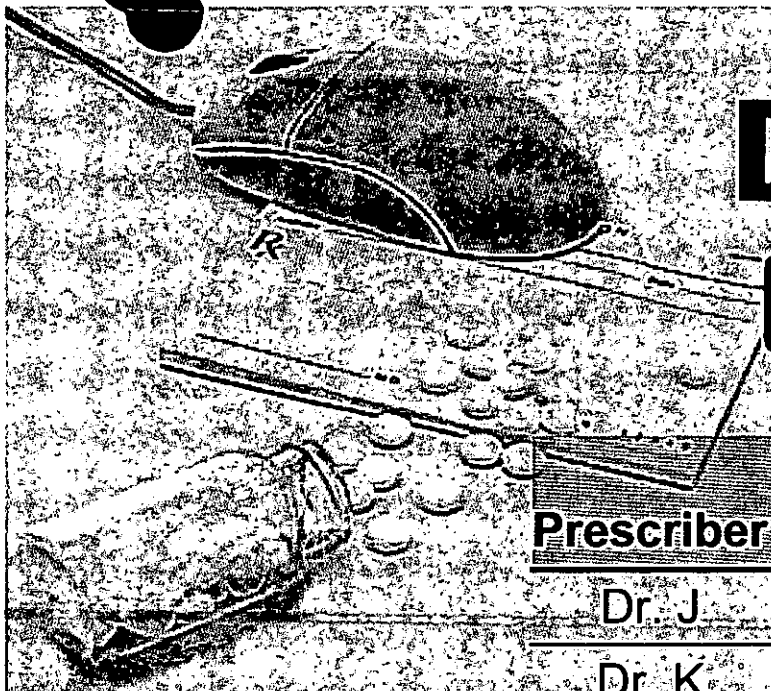
North Dakota Workforce Safety & Insurance

WSI



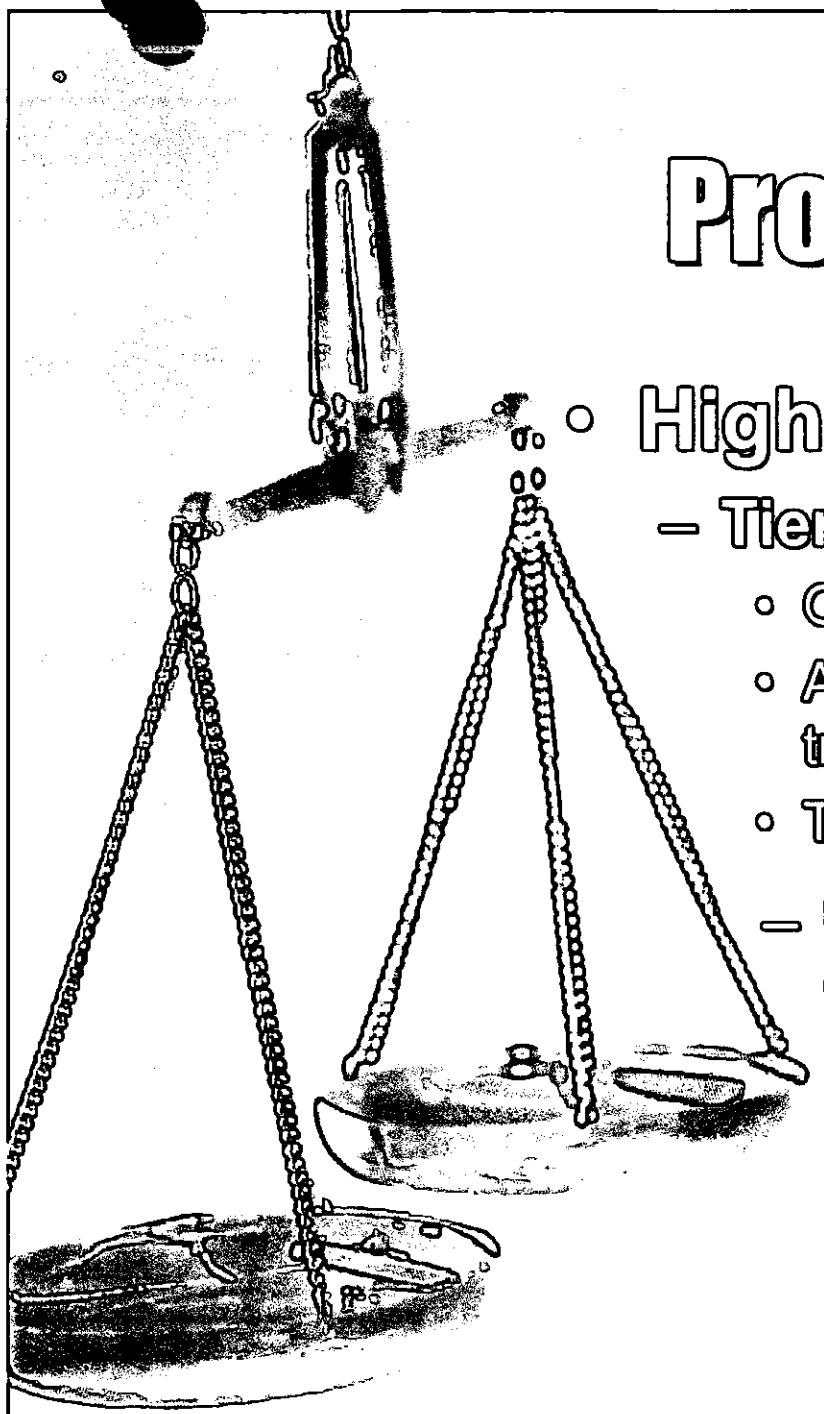
Prescribing by Total Number of Rxs

Prescriber	Specialty	City	Clinic	Number of Rxs	% of Total
Dr. A	PM & R	Bismarck	Clinic A	9073	10.51%
Dr. B	PM & R	Bismarck	Clinic B	5462	6.33%
Dr. D	Anesth	Bismarck	Clinic C	2490	2.88%
Dr. C	Anesth	Bismarck	Clinic C	2075	2.40%
FNP A	FNP	Bismarck	Clinic B	1770	2.05%
Dr. G	FP	GF	Clinic E	1594	1.85%
Dr. E	PM & R	Fargo	Clinic D	1010	1.17%
FNP B	FNP	Fargo	Clinic D	961	1.11%
Dr. F	PM & R	GF	Clinic E	867	1.00%
Dr. I	Anesth	Fargo	Clinic F	766	0.89%



Dispense As Written (DAW1) Prescribing

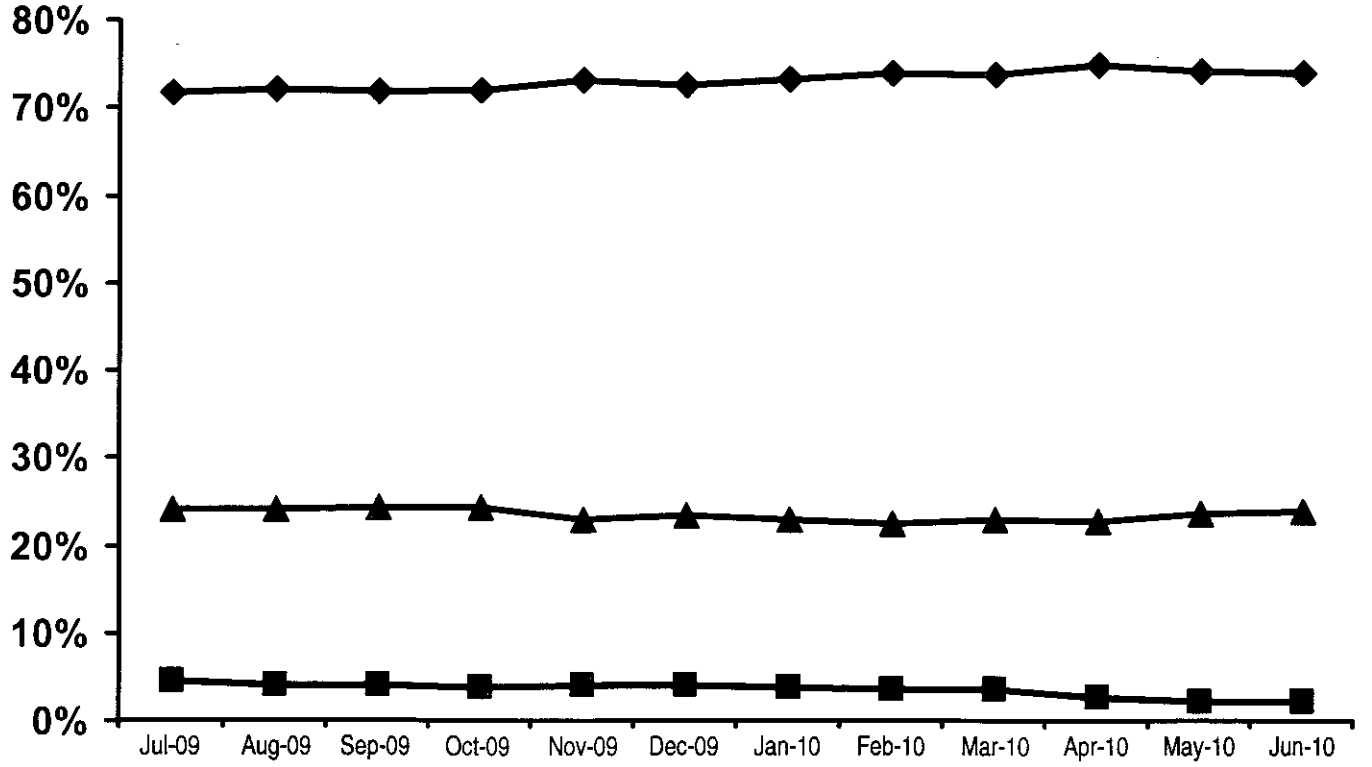
Prescriber	Specialty	City	Clinic	% of DAW_1
Dr. J	PM & R	Rapid City	Clinic G	25.00%
Dr. K	FP	Bismarck	Clinic C	23.66%
Dr. L	Rheum	Fargo	Clinic H	10.66%
Dr. A	PM & R	Bismarck	Clinic A	10.20%
FNP D	FNP	Bismarck	Clinic B	6.78%
Dr. M	FP	Jamestown	Clinic I	6.23%
FNP E	FNP	Fargo	Clinic D	5.13%
Dr. H	PM & R	Bismarck	Clinic C	4.95%
Dr. C	Anesth	Bismarck	Clinic C	4.63%
FNP B	FNP	Fargo	Clinic D	4.16%



Proposed Legislation

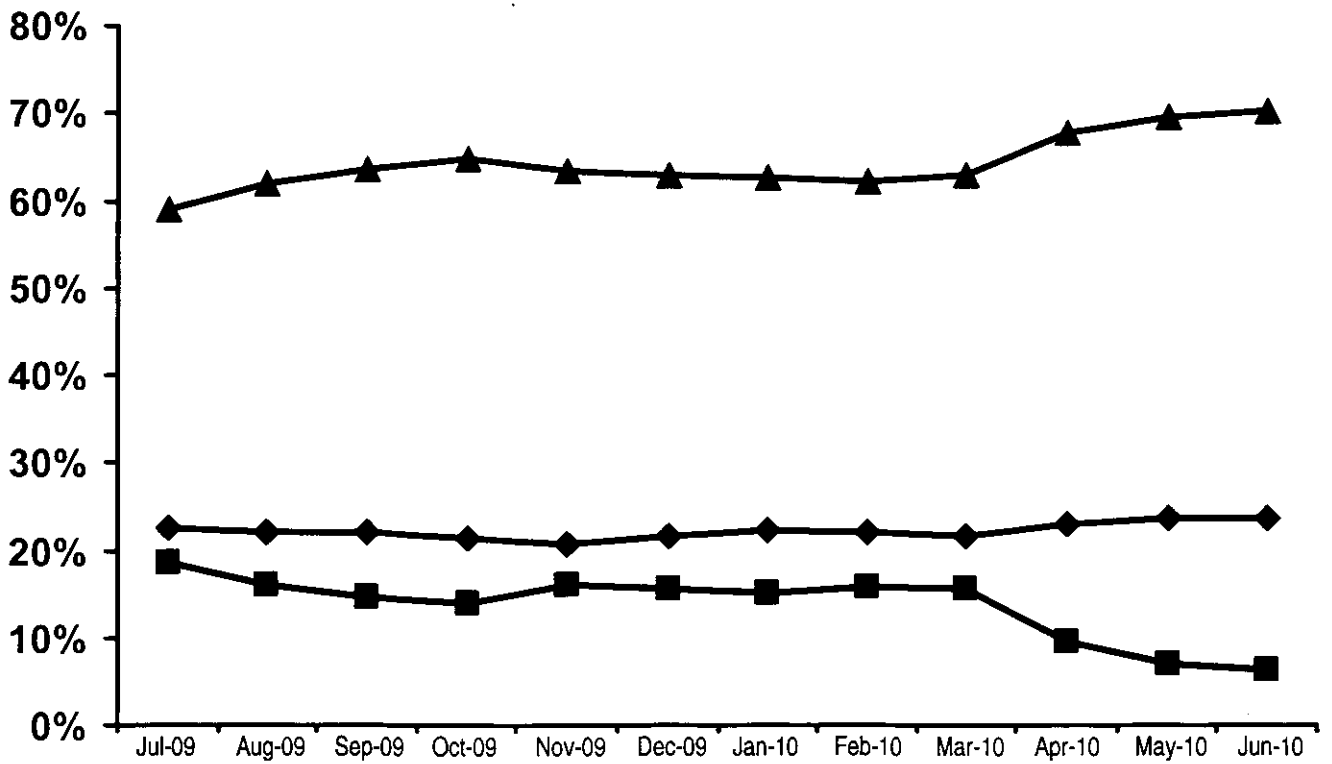
- Highlights
  - Tiered approach to opioids
    - Outpatient cover 30 days
    - After 30 days require prescribers treatment plan
    - Then coverage only up to 6 months
  - Beyond 6 months IW qualify "Long-term Therapy"
    - Require treatment plan
    - Testing at WSI or prescribers request
    - Requirements for increased justification and documentation
    - Include a titration plan

Rx Percent Utilization



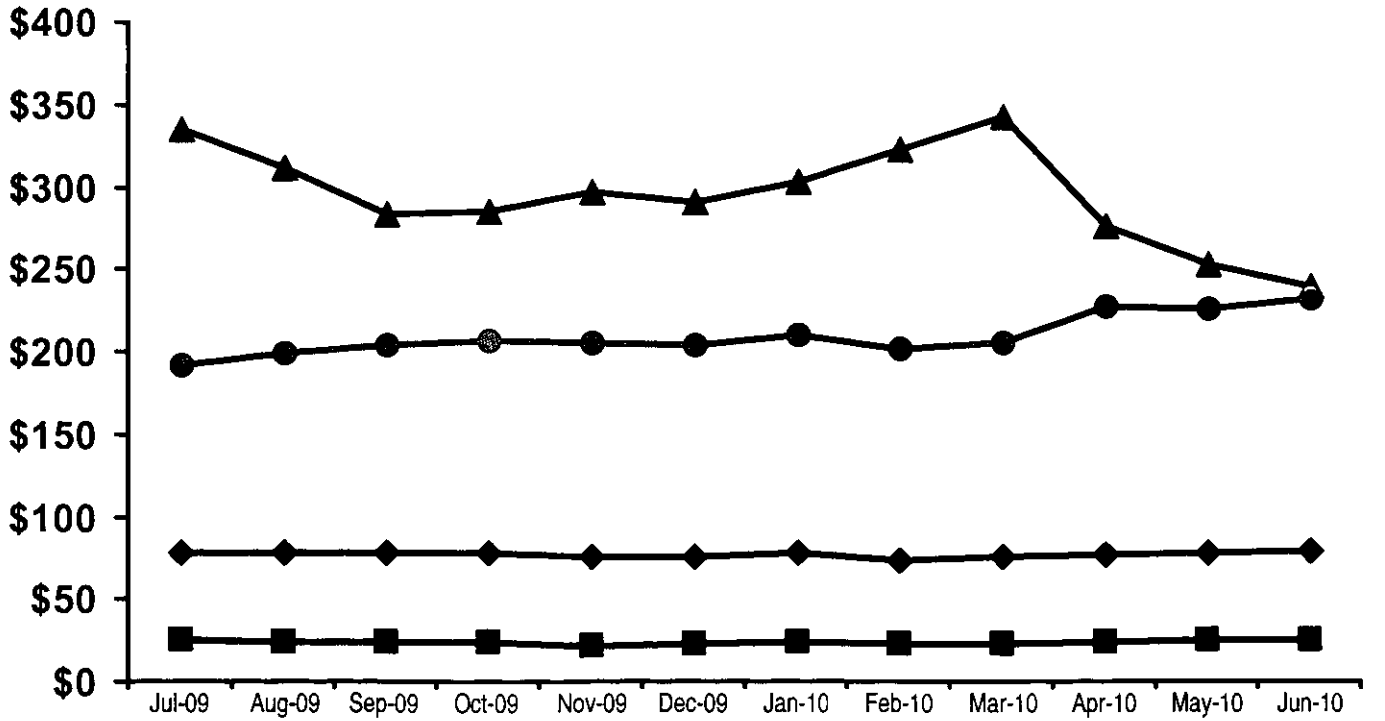
	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Ave/Generic	71.73%	72.03%	71.61%	71.51%	73.08%	72.71%	73.26%	74.06%	73.69%	74.97%	74.26%	74.02%
Ave/DAW1	4.28%	3.96%	3.99%	3.78%	3.98%	4.04%	3.81%	3.53%	3.37%	2.57%	2.08%	2.07%
Ave/Brand	23.99%	24.01%	24.36%	24.30%	22.94%	23.26%	22.93%	22.41%	22.93%	22.56%	23.65%	23.91%

Percent Cost per Category



	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
% Cost/Generic	22.53%	22.02%	21.90%	21.26%	20.69%	21.58%	22.22%	22.04%	21.53%	22.80%	23.58%	23.49%
% Cost/DAW1	18.45%	16.04%	14.48%	13.96%	15.87%	15.57%	15.06%	15.74%	15.50%	9.41%	6.98%	6.27%
% Cost Brand	59.03%	61.93%	63.62%	64.78%	63.44%	62.86%	62.72%	62.23%	62.97%	67.78%	69.53%	70.24%

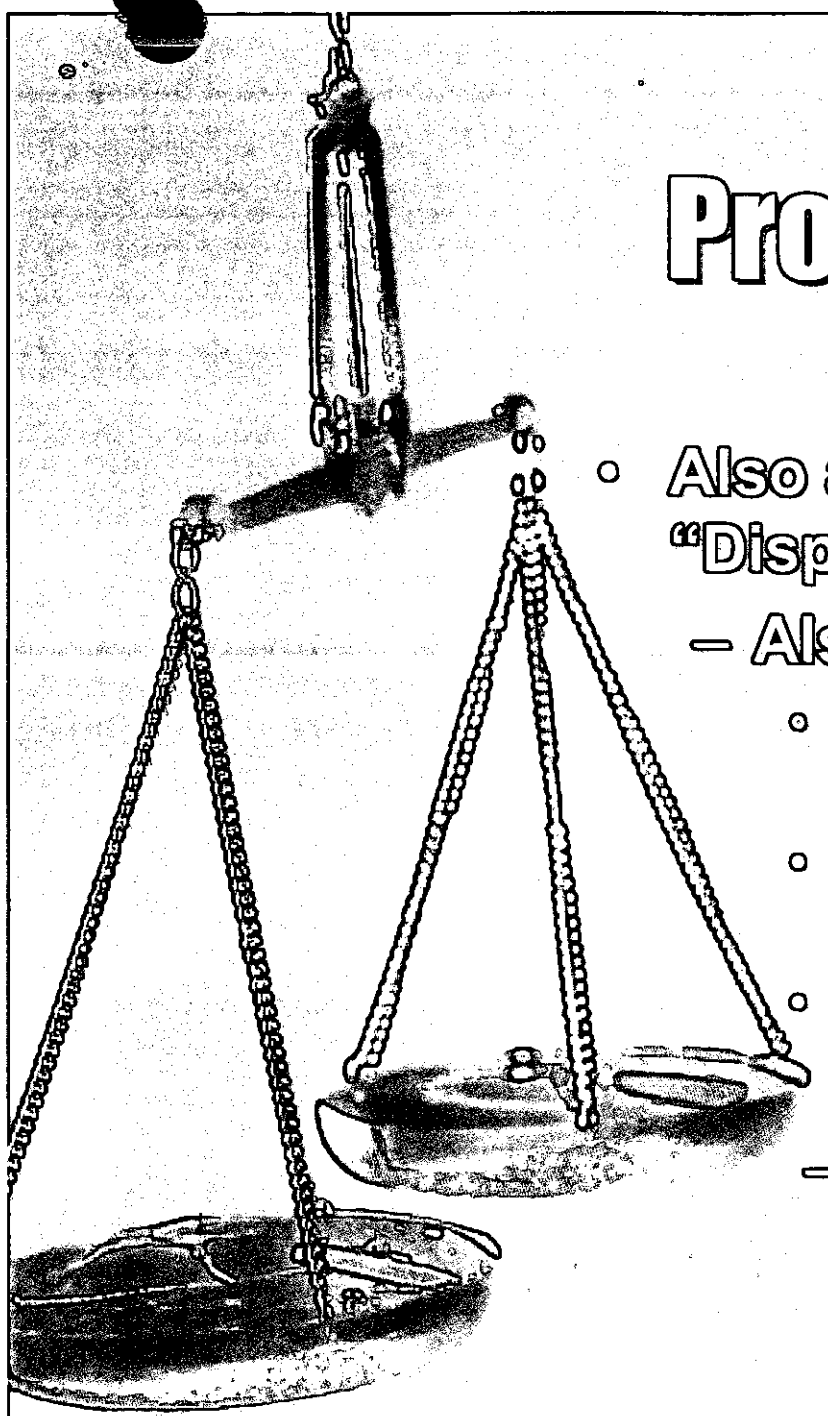
Average Cost per Rx



	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Ave/Rx	$77.61	$77.09	$77.81	$77.29	$74.29	$75.30	$76.83	$72.44	$74.42	$75.54	$76.76	$79.01
Ave/Generic	$24.44	$23.57	$23.78	$22.35	$21.01	$22.35	$23.30	$21.55	$21.74	$23.01	$24.47	$26.07
Ave/DAW1	$335.49	$312.15	$283.28	$285.11	$296.46	$291.01	$303.35	$322.68	$342.11	$276.38	$252.65	$239.73
Ave/Brand	$191.45	$198.85	$203.19	$206.00	$205.29	$203.45	$210.15	$201.18	$204.32	$226.96	$225.70	$232.10

FY 2010 DAW1 to Generic Comparison

Description	DAW1 Amt	Generic Amt	Difference	% of DAW1	% of Total
Cardiovascular Drugs	$4,812.94	$1,235.61	$3,577.33	25.67%	1.25%
GI Drugs	$6,579.27	$731.17	$5,848.10	11.1%	1.71%
Antianxiety Agents	$14,976.08	$763.95	$14,212.13	5.1%	3.89%
Antidepressants	$21,800.74	$1820.49	$19,980.25	8.4%	5.66%
Hypnotics	$14,232.03	$455.88	$13,776.15	3.2%	3.70%
Stimulants	$2,203.43	$116.38	$2,087.05	5.3%	0.57%
Opioid Analgesics	$250,628.55	$59,407.57	$191,220.98	23.7%	65.10%
Other Analgesics	$829.50	$125.82	$703.68	15.2%	0.22%
Anticonvulsants	$45,648.50	$7695.14	$37,953.36	16.9%	11.86%
Muscle Relaxants	$22,076.44	$768.82	$21,307.62	3.5%	5.73%
Misc. Agents	$1,189.35	$413.36	$775.99	34.76%	0.31%
Totals	$384,976.83	$75,534.19	$311,442.64	19.1%	



Proposed Legislation

- Also address "Dispense as Written Overrides"
  - Also will address the DAW1
    - Pay pharmacy fills to the extent available generic
    - Only override if "life-threatening side effect(s)"
    - Amend to override if "allergic reaction"
  - Significant cost driver
    - Especially in Opioids (resale)

Questions?

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TESTIMONY ATTACHMENT 2

House Industry, Business & Labor Committee

HB 1054

January 10, 2011

Testimony of Duane Houdek, Executive Secretary
North Dakota State Board of Medical Examiners

Chairman Keiser and members of the House IBL Committee, my name is Duane Houdek, Executive Secretary of the North Dakota State Board of Medical Examiners. By statute, the Board is responsible for regulating the practice of medicine in North Dakota. On behalf of the board, which is composed of 10 physicians and two public members from throughout the state, I speak in opposition to HB 1054 and offer an alternative approach to the issue of regulating opioid prescribing for WSI claimants.

I have attached an analysis of the bill I've received from board members, but let me summarize it in my comments by saying that, with all due respect, this bill reflects a misunderstanding of the medical management of pain and represents an extreme intrusion into the patient-physician relationship. For example, the provisions that allow someone who is not required to be a physician, who does not know the patient and who has never met the patient to recommend a change in dosage of pain medication or mandate a titration plan illustrates the extent of the problem this bill presents. We have prosecuted doctors for attempting to prescribe in such circumstances.

There is a much better way to address this issue. The issue presented to you, to the extent that it may reflect a problem with prescribing, involves a handful of

physicians and nurse-practitioners working with those physicians. prepared by WSI indicates that prescribing by just two physicians repr 40% of the entire narcotic prescribing to claimants in the state, if m dollars spent. I am not saying there is a problem with their prescribing; itself, does not tell you anything about the quality of the practice. But th you that the perceived problem resides with a very small number of pra

I propose that, if there are legitimate grievances with opioid involving a small number of practitioners, WSI refer those physicians to u jurisdiction over the practice of physicians, both in their direct prescribing extent they may have collaborative agreements with nurse-practitione clinics.

Within the past two years, we have investigated such complaint from law enforcement and from the Medicare Office of Inspector Gene recent case, we revoked the physician's license entirely for improperly p controlled substances; in another, we removed the ability of the ph prescribe controlled substances and required the physician to surrend registration.

The legislature has given us the authority and the tools–suc Prescription Drug Monitoring Program–to investigate such claims an decisive action where warranted. Our history shows we take that resp seriously. Last year, an independent watch-dog organization ranked t Dakota board second in the nation in the per capita number of serious di actions taken against physicians.

We have the ability to subpoena records and witnesses, employ ex

thoroughly investigate claims of inappropriate practice by physicians and we do so every day. There is no reason we should not be called on to do so in the instances brought to you by WSI.

This would be a much better practice than imposing very questionable requirements on all physicians when it is admitted that the problem–if it is a problem–resides with very, very few.

Thank you. I would be happy to try to answer any questions you may have.

Summary analysis of HB 1054

Section 1. General opioid therapy acute stage coverage

The default position of the bill is to deny coverage for a compensable condition just because it extends beyond an arbitrary number of days. It is contrary to most authorities who define chronic pain as pain lasting three to six months from the initial injury.

The requirement for submission of "an objectively supportable treatment plan", as well as "prequalification requirements", at the very least, will delay and may well deny patients access to treatment for compensable conditions.

Section 2. Long-term opioid therapy coverage

This fails to recognize that it may take time to arrive at the correct drug and dose that works for each individual patient. Furthermore, patients may require long-term opioid therapy just to achieve a very basic gain in quality of life and living.

Subsections 4-7 constitute a direct intrusion by a third party in the patient-physician relationship. It is an unnecessary attempt to legislate the practice of medicine and will put patients at risk for under-treatment, which leads to an increase in co-morbidities, while increasing the utilization of already compromised and limited resources such as physician offices and emergency departments.

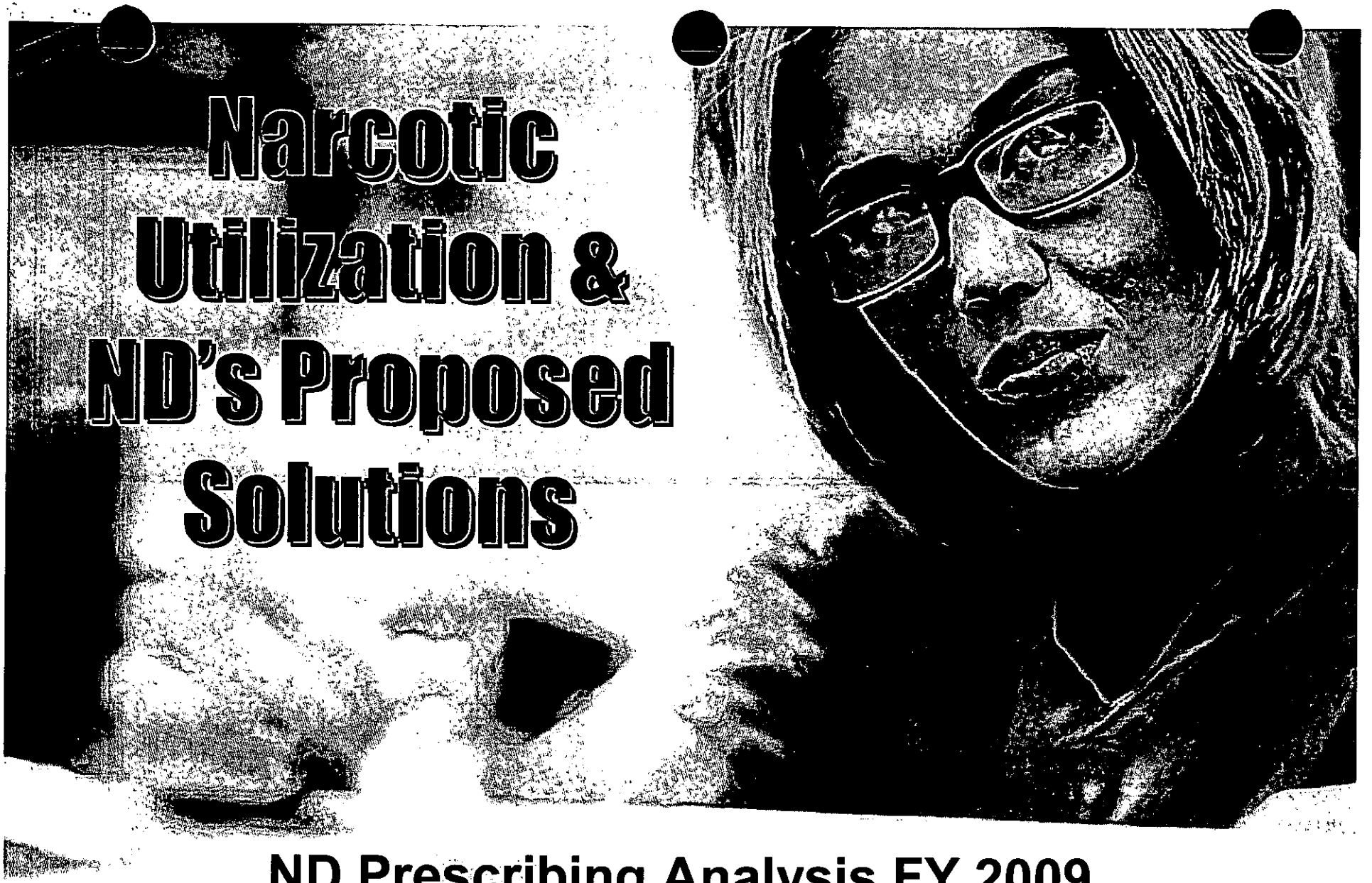
Section 3. Prescribers of long-term opioid therapy coverage

This is the practice of medicine. The requirements here go to the essence of the practice of medicine and can not and should not be done by a third party who is not involved in the care and treatment of the patient.

Section 4. Prescriber treatment plans for treatment of nonmalignant pain with

opioids.

Again, this is the practice of medicine. Furthermore, elements of this mandate may not apply in each case.

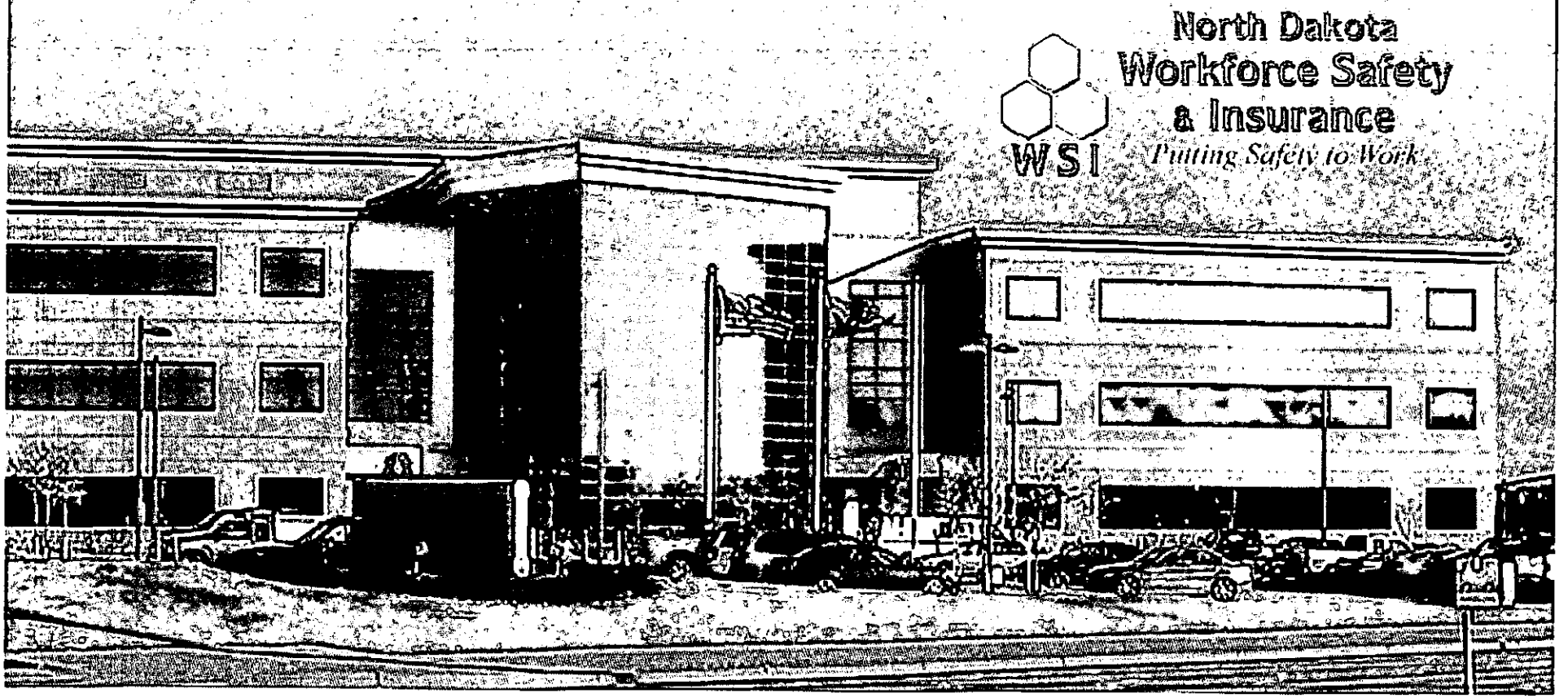


ND Prescribing Analysis FY 2009

Timothy J. Wahlin, Chief of Injury Services

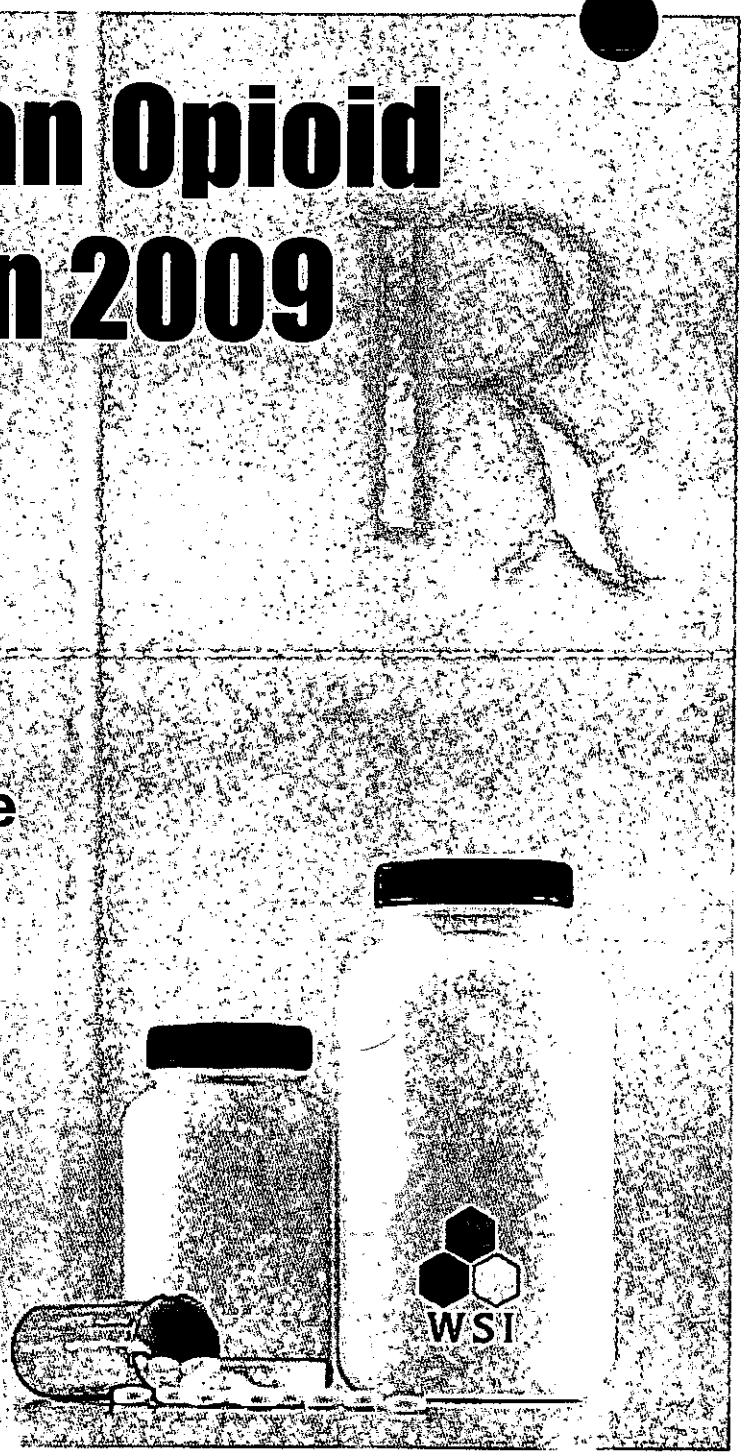
Significant assistance has been provided by:

- **Harvey Hanel, PharmD, R.Ph.**
  WSI's Pharmacy Director
- **US Script**
  WSI's Pharmacy Benefit Mgr since 2004

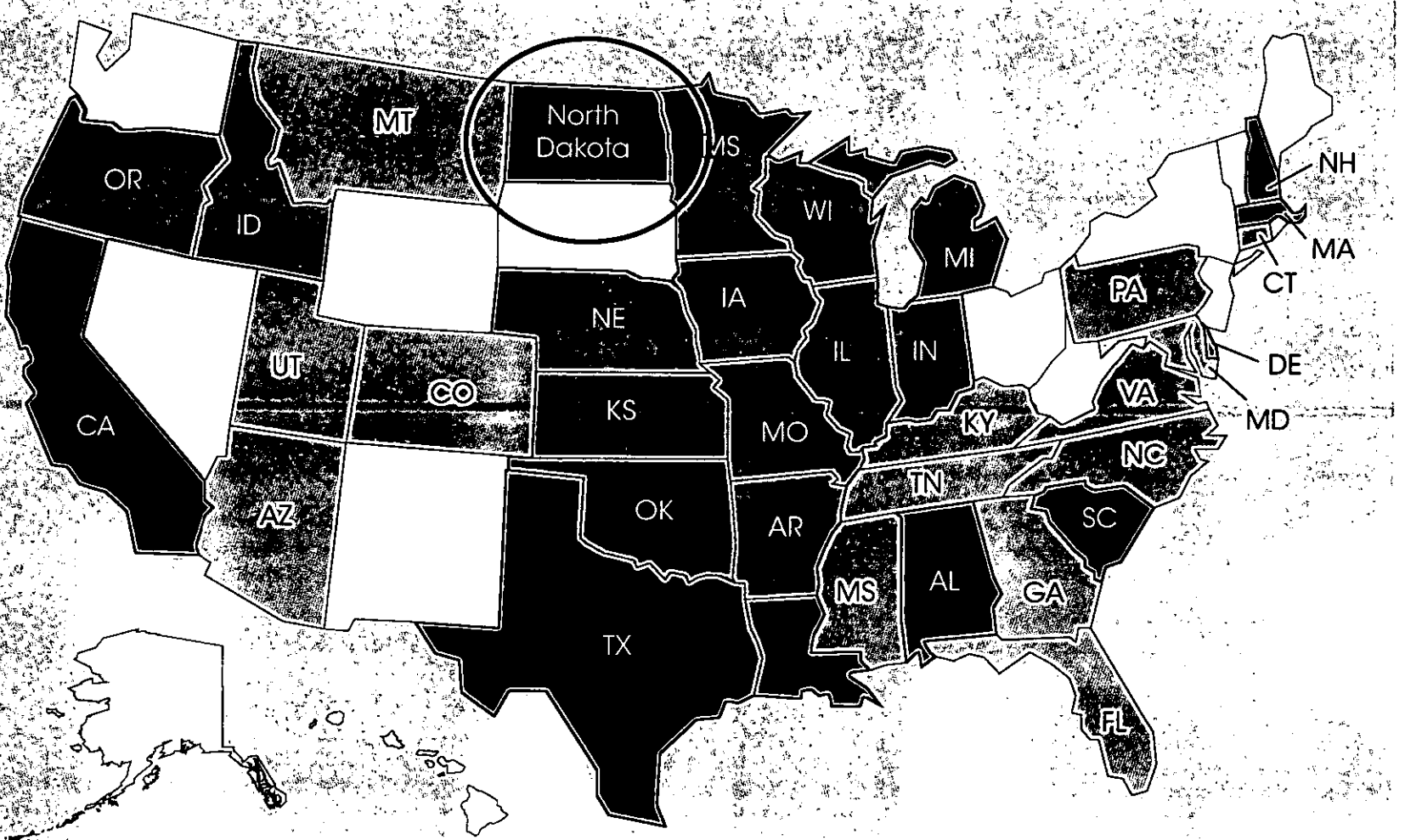


NCCI presented an Opioid cost analysis in 2009

- Opioid cost nationally average about 23% total drug spend
- In ND 41.5%
- Since 2005 Schedule II narcotics costs have increased 521% and the number of scripts have increased 414% in CA
- IW receiving multiple opioid scripts were 2.7x more likely to have a time-loss, and had 4.7x more lost days



WC Narcotics Costs per Medical Claim



Below Average (≤ $15/claim)

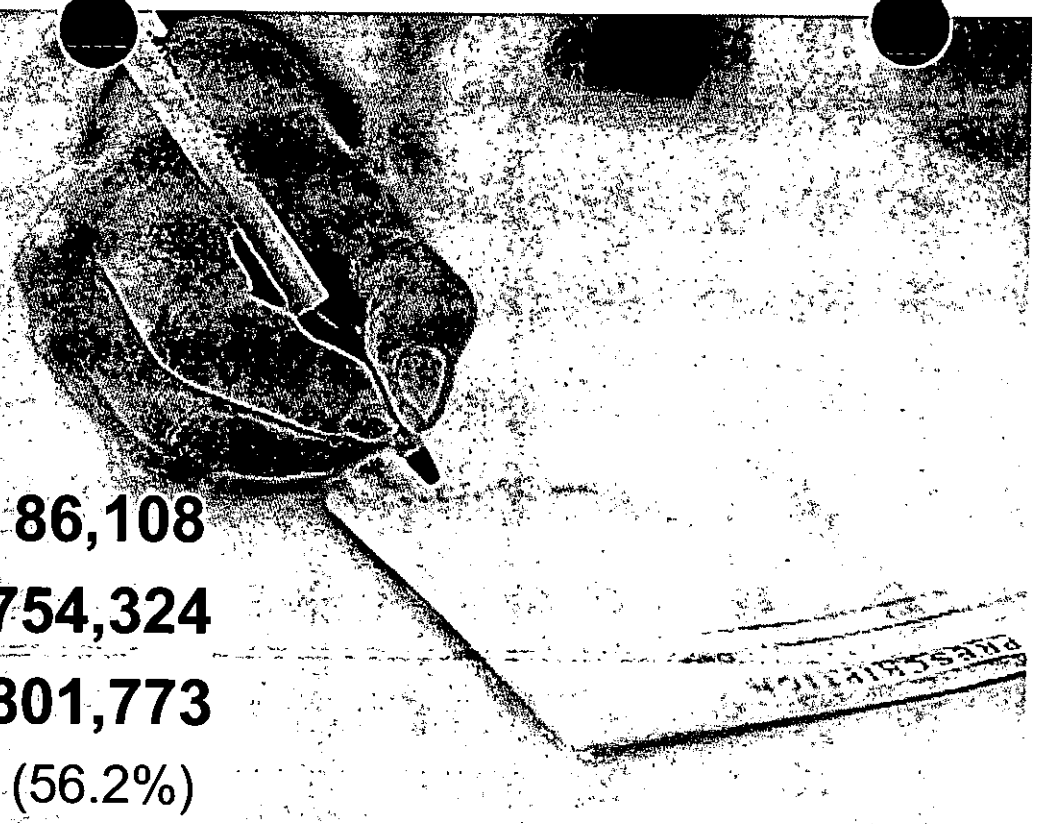
Average ($15 - $30/claim)

Above Average (≥ $30/claim)

Injury Years 1999 Thru 2003
Relative Service Years 1 Thru 5

Source: NCCI Research Brief

FY 2009 Pharmacy Data



Total Prescriptions: 86,108

Total Drug Spend: $6,754,324

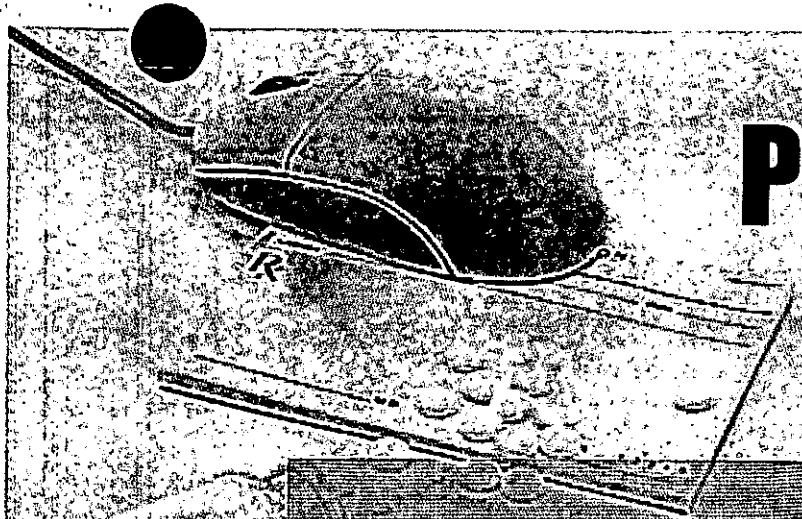
Total Narcotic Spend: $2,801,773

- Burleigh County: $1,575,102 (56.2%)
- Cass County: $226,304 (8.1%)
- Grand Forks County: $162,391 (5.8%)

ND Narcotic Spend: $2,297,310

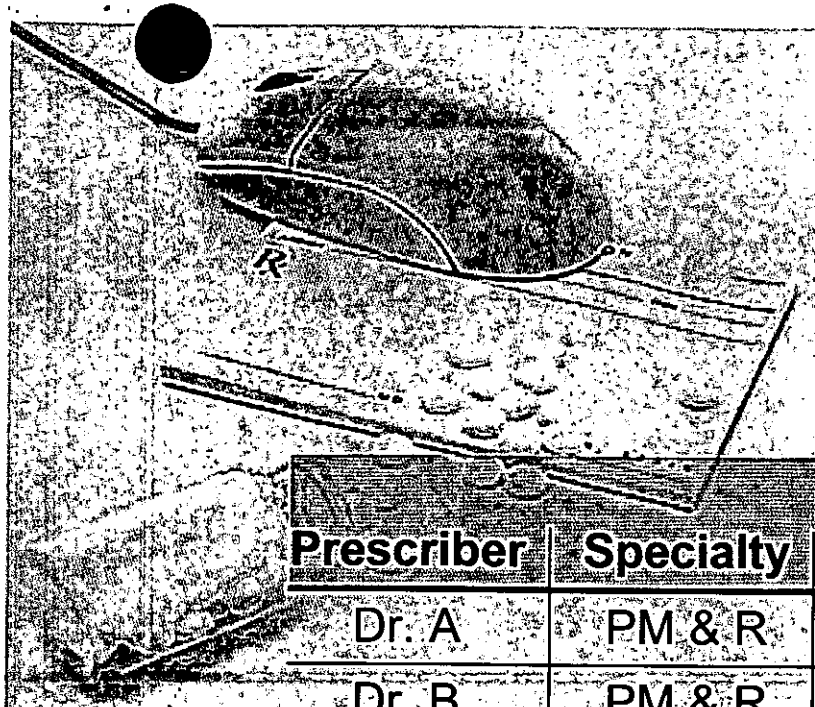
- Burleigh County: (68.6%)
- Cass County: (9.9%)
- Grand Forks County: (7.1%)

North Dakota Workforce Safety & Insurance
WSI
Putting Safety to Work



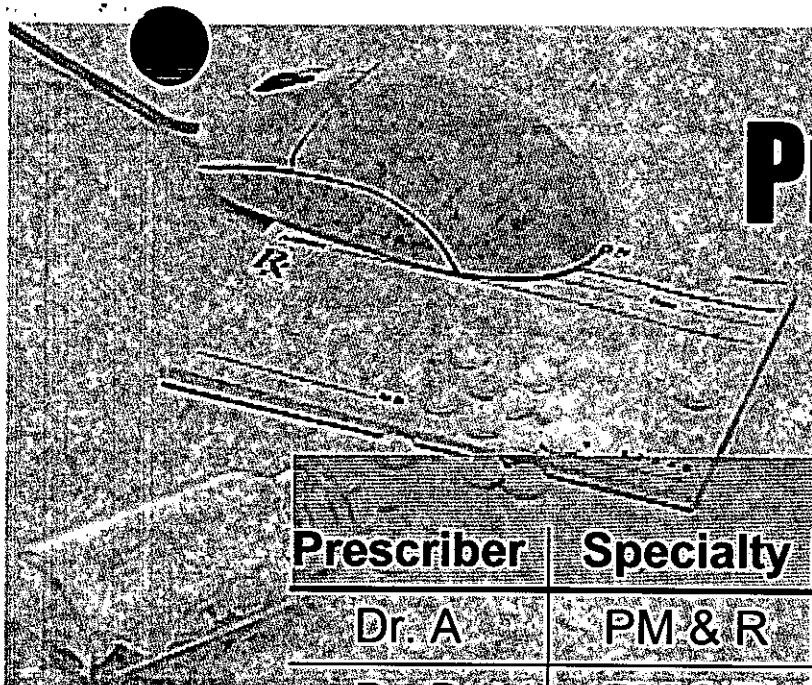
Prescribing by Total Narcotic Spend

Prescriber	Specialty	City	Clinic	Narcotic Spend	% of Total
Dr. A	PM & R	Bismarck	Clinic A	$888,048	31.62%
Dr. B	PM & R	Bismarck	Clinic B	$248,625	8.87%
FNP A	FNP	Bismarck	Clinic B	$119,725	4.27%
Dr. C	Anesth	Bismarck	Clinic C	$78,097	2.79%
Dr. D	Anesth	Bismarck	Clinic C	$72,878	2.60%
FNP C	FNP	Bismarck	Clinic C	$55,278	1.97%
Dr. G	FP	GF	Clinic E	$48,514	1.73%
Dr. E	PM & R	Fargo	Clinic D	$40,601	1.45%
Dr. I	Anesth	Fargo	Clinic F	$38,012	1.36%
FNP B	FNP	Fargo	Clinic D	$37,251	1.33%



Prescribing by Total Spend

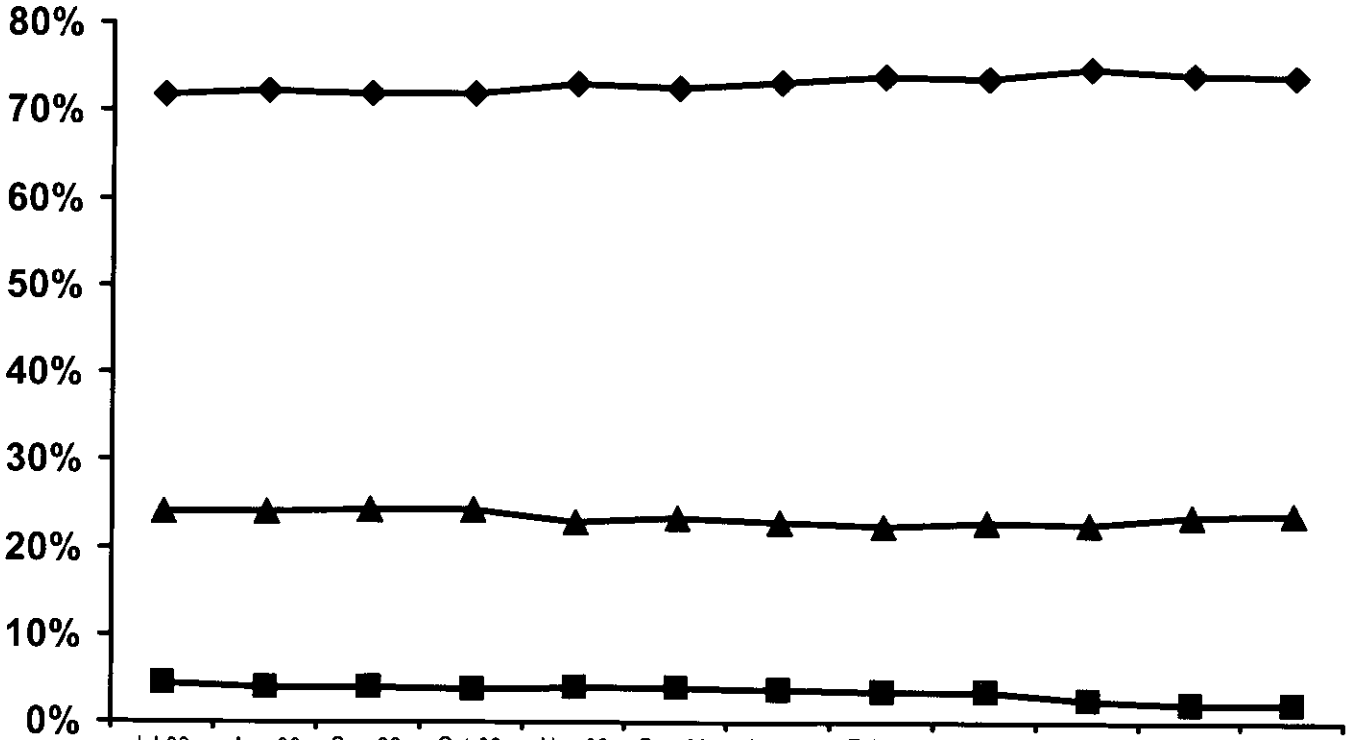
Prescriber	Specialty	City	Clinic	Drug Spend	% of Total
Dr. A	PM & R	Bismarck	Clinic A	$1,389,881	19.52%
Dr. B	PM & R	Bismarck	Clinic B	$545,637	7.66%
Dr. C	Anesth	Bismarck	Clinic C	$226,082	3.17%
Dr. D	Anesth	Bismarck	Clinic C	$224,188	3.15%
FNP A	FNP	Bismarck	Clinic B	$188,590	2.65%
Dr. E	PM & R	Fargo	Clinic D	$114,866	1.61%
Dr. F	PM & R	GF	Clinic E	$95,744	1.34%
FNP B	FNP	Fargo	Clinic D	$93,021	1.31%
Dr. G	FP	GF	Clinic E	$90,777	1.27%
Dr. H	PM & R	Bismarck	Clinic C	$67,541	0.95%



Prescribing by Total Number of Rxs

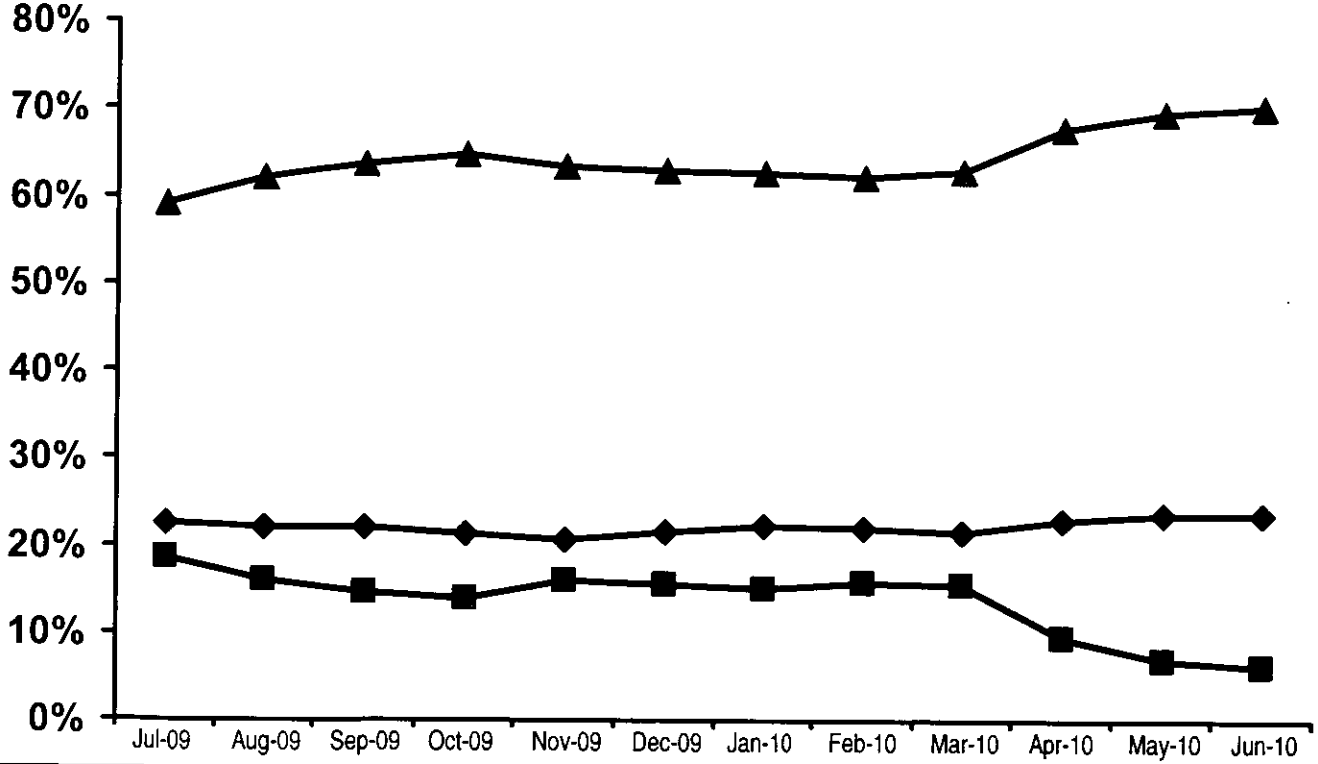
Prescriber	Specialty	City	Clinic	Number of Rxs	% of Total
Dr. A	PM & R	Bismarck	Clinic A	9073	10.51%
Dr. B	PM & R	Bismarck	Clinic B	5462	6.33%
Dr. D	Anesth	Bismarck	Clinic C	2490	2.88%
Dr. C	Anesth	Bismarck	Clinic C	2075	2.40%
FNP A	FNP	Bismarck	Clinic B	1770	2.05%
Dr. G	FP	GF	Clinic E	1594	1.85%
Dr. E	PM & R	Fargo	Clinic D	1010	1.17%
FNP B	FNP	Fargo	Clinic D	961	1.11%
Dr. F	PM & R	GF	Clinic E	867	1.00%
Dr. I	Anesth	Fargo	Clinic F	766	0.89%

Rx Percent Utilization



	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Ave/Generic	71.73%	72.03%	71.91%	71.91%	73.08%	72.71%	73.26%	74.06%	73.69%	74.87%	74.26%	74.02%
Ave/DAW1	4.28%	3.96%	3.98%	3.78%	3.98%	4.03%	3.81%	3.53%	3.37%	2.57%	2.09%	2.07%
Ave/Brand	23.99%	24.01%	24.36%	24.30%	22.94%	23.26%	22.93%	22.41%	22.93%	22.56%	23.65%	23.91%

Percent Cost per Category



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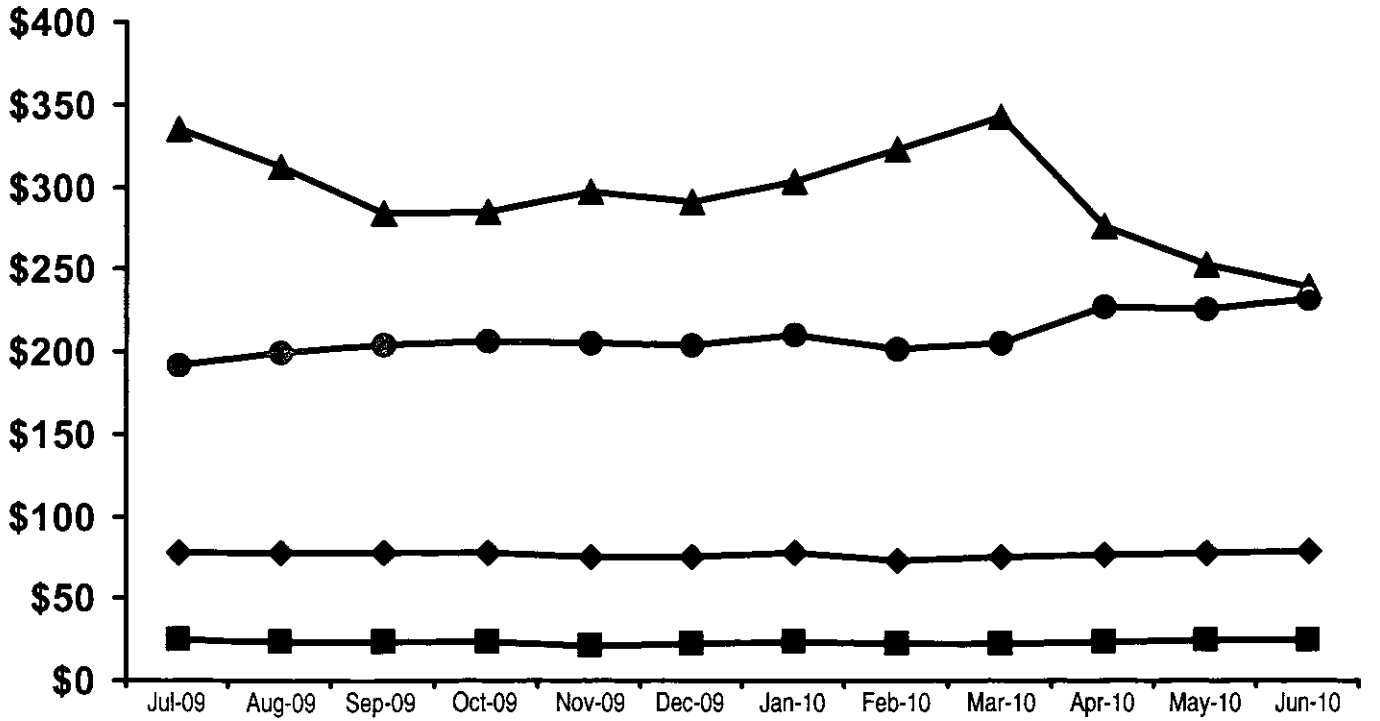
% Cost Brand	59.03%	61.93%	63.62%	64.78%	63.44%	62.86%	62.72%	62.23%	62.97%	67.78%	69.53%	70.24%

Average Cost per Rx



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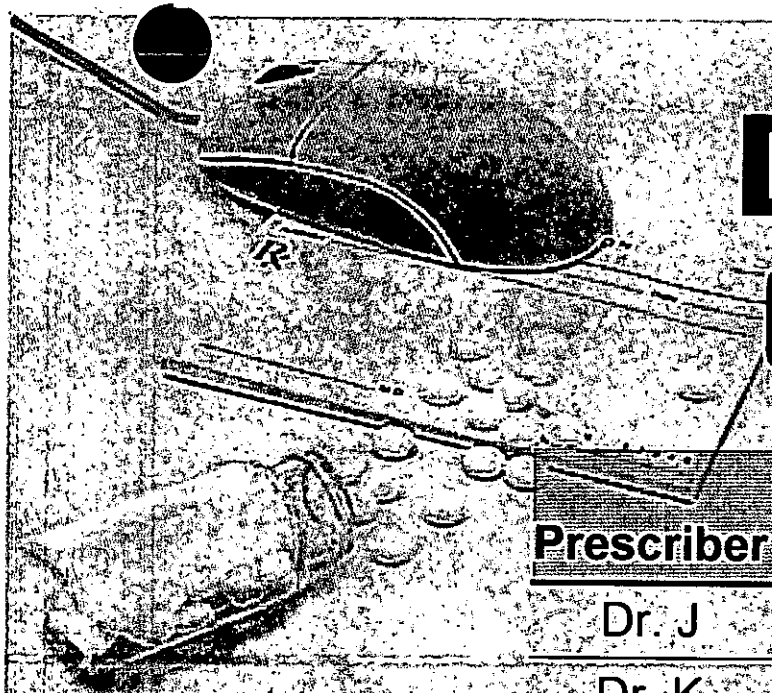
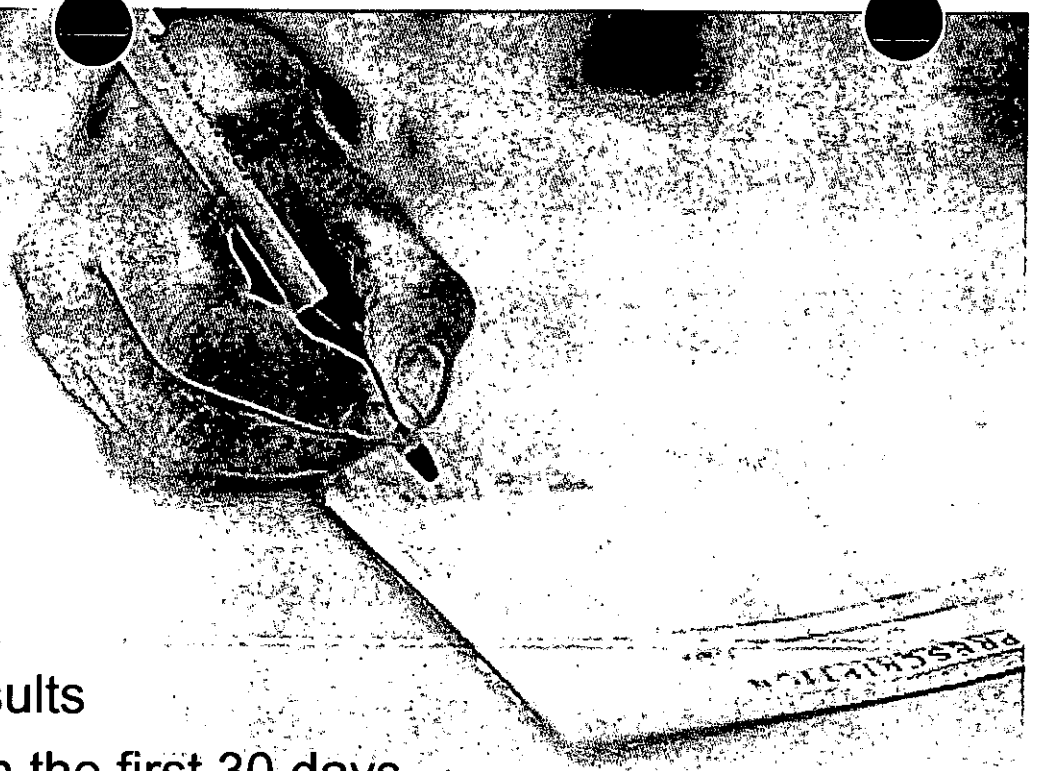


Dispense As Written (DAW1) Prescribing

Prescriber	Specialty	City	Clinic	% of DAW$_1$
Dr. J	PM & R	Rapid City	Clinic G	25.00%
Dr. K	FP	Bismarck	Clinic C	23.66%
Dr. L	Rheum	Fargo	Clinic H	10.66%
Dr. A	PM & R	Bismarck	Clinic A	10.20%
FNP D	FNP	Bismarck	Clinic B	6.78%
Dr. M	FP	Jamestown	Clinic I	6.23%
FNP E	FNP	Fargo	Clinic D	5.13%
Dr. H	PM & R	Bismarck	Clinic C	4.95%
Dr. C	Anesth	Bismarck	Clinic C	4.63%
FNP B	FNP	Fargo	Clinic D	4.16%

So How Can We Address This Crisis?



- We know that dependency and addiction arise quickly
- Literature and professional consults recommend "intervention" within the first 30 days
- Most agree opioids are appropriate to lower pain during healing
- Long term usage increases tolerance leading to increased dosages
- With increased dosage comes increased side effects
- General consensus that long term usage is rarely appropriate
- When dependencies arise, users will seek those long term therapies

Our answer is to require additional documentation and justification for longer term therapies.

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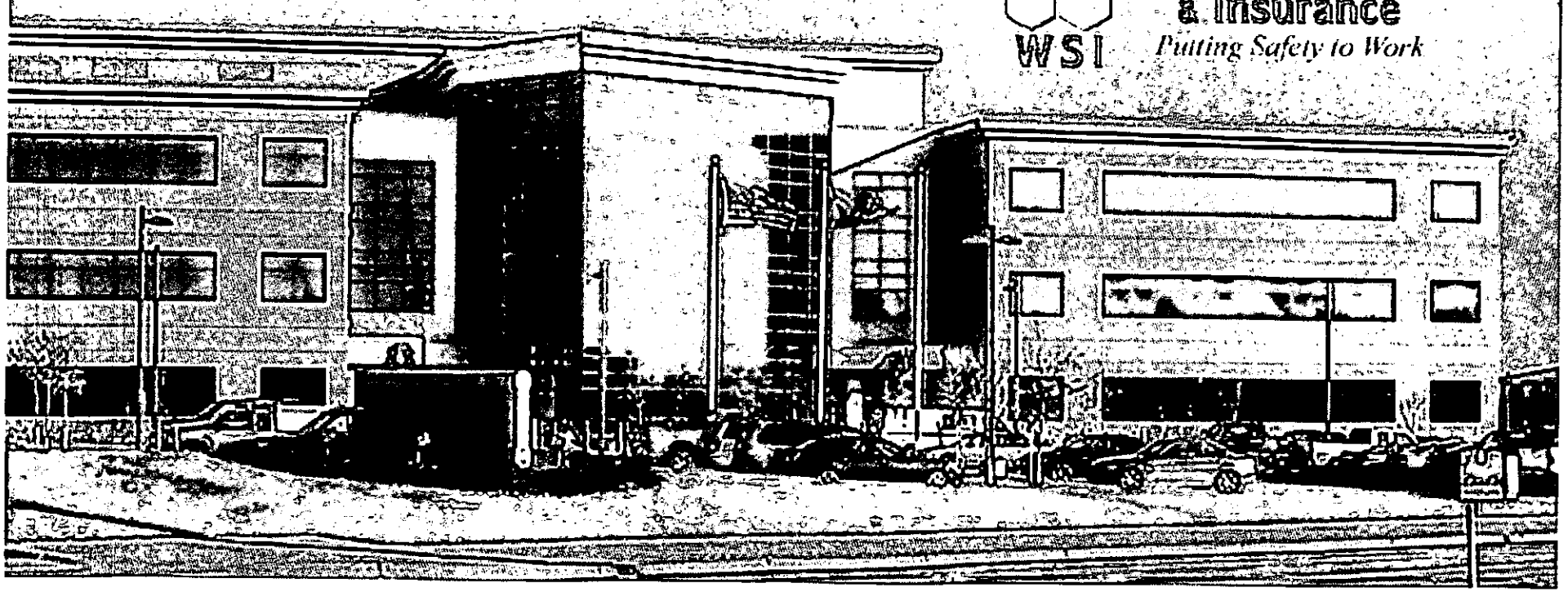
Proposed Legislation

- **Highlights**
  - **Tiered approach to opioids**
    - Outpatient cover 30 days
    - After 30 days require prescribers treatment plan
    - Then coverage up to 6 months
  - **Beyond 6 months IW qualify "Long-term Therapy"**
    - Require treatment plan
    - Testing at WSI or prescribers request
    - Requirements for increased justification and documentation
    - Include a titration plan

Questions?



North Dakota
Workforce Safety
& Insurance
Putting Safety to Work

WSI

2011 Engrossed House Bill No. 1054
Testimony before the Senate Industry, Business, and Labor Committee
Presented by: Tim Wahlin, Chief of Injury Services
Workforce Safety & Insurance
March 7, 2011

Mr. Chairman, Members of the Committee:

My name is Tim Wahlin, Chief of Injury Services at WSI. I am here on behalf of WSI to convey support of this bill and to provide information to the Committee to assist in making its determination.

This bill originates from the Interim Legislative Workers Compensation Review Committee.

During the last two years, WSI staff has been monitoring the high levels in the prescriptive practices of North Dakota physicians regarding opioid treatment therapies for injured employees. Recently, WSI acquired more detailed methods of critically analyzing these trends, which leads to serious concerns.

These concerns were made an issue in the latest Performance Evaluation completed by Sedgwick CMS. Numerous findings confirmed staff's observations regarding the disturbing frequency and pervasiveness of opioid therapeutics.

I will walk the Committee through those numbers with the appended presentation.

It is apparent from the numbers and comparisons of neighboring jurisdictions that the ever increasing tolerance is requiring higher and more frequent dosages or many of the prescribed opioids are being redirected.

I have included just a short listing of our North Dakota headlines from the past two years regarding the illegal use of prescription drugs in North Dakota. At least two of these headlines involve injured employees. In fact, over the past two years, roughly 25% of all our injured employee fraud investigations involved allegations of medication misuse or abuse.

These numbers are an example of what is going wrong. Realistically, by the time an injured employee develops these long term dependencies, it is too late. We have failed them.

This legislation is intended and targeted at early intervention. At the thirty-day mark, a provider will be required to develop a treatment plan and address with the worker timelines, dependency issues, as well as set expectations for treatment. Presently, when this does occur, it will rarely take place to the extent necessary. WSI, under this statutory scheme, will ensure these discussions occur and will specifically compensate physicians for that work. Regardless of the form, additional control must be asserted to safeguard the North Dakotans.

In the process of developing this legislation, many models and legislative approaches were reviewed. The organization, in conjunction with your Interim Legislative Workers Compensation Review Committee, settled on the language in Engrossed HB1054 and present this for your consideration.

The bill simply regulates payment for opioid prescriptions under two methods; acute stage coverage and long-term coverage.

Acute stage includes prescriptions within six weeks of an initial injury, or discharge. This class of prescriptions would be unaltered from current practice within the first thirty days. After thirty days, the provider would be required to complete a treatment plan which is a slightly more in depth screening tool for the benefit of WSI, the injured employee and also the provider.

Beyond six weeks, WSI would cover opioid prescriptions only when the patient qualifies for long-term opioid therapy coverage.

Long-term therapy would require increased justification that includes documentation of greater function, a diagnosis of chronic pain, and a treatment agreement with the prescriber. In addition, the patient must be subject to random screens for the presence of the prescribed medication, as well as the absence of un-prescribed medications, and ongoing review and documentation of the therapy's effectiveness.

Prescribers will be required to complete this documentation in a treatment plan that includes providing the employee with information regarding chemical dependency programs; a plan for discontinuation should that become necessary; review of personal risk factors; and a history of treatment that includes conservative care measures that have been ineffective in controlling pain.

Finally, I would draw your attention to a sheet of Frequently Asked Questions the organization has developed in an attempt to clarify any questions that may arise in the process of consideration of this legislation.

This concludes my testimony. I would be happy to answer any questions at this time.

North Dakota Headlines

8 arrested in Stark County drug bust (February 24, 2011)
http://www.thedickinsonpress.com

LATEST: Police investigation shows one West Fargo student providing prescription meds at high school (February 2, 2011)
http://www.westfargopioneer.com

WFHS investigating alleged 'misuse of prescription medications' by students (February 2, 2011)
http://www.westfargopioneer.com

Devils Lake woman to plead guilty in prescription drug case (January 3, 2011)
http://www.devilslakejournal.com

Soehren drug case set for trial, others postponed (November 23, 2010)
http://www.thedickinsonpress.com

Prescription drug abuse increasing in North Dakota (November 19, 2010)
http://www.thedickinsonpress.com

Eleven month investigation leads to 16 arrests - so far (November 4, 2010)
http://www.devilslakejournal.com

Run down of people involved in drug bust (July 31, 2010)
http://www.thedickinsonpress.com

Law Works on sting since January (July 30, 2010)
http://www.thedickinsonpress.com

North Dakota teens engage in risky behaviors (June 5, 2010)
http://www.inforum.com/

Larimore officials say student overdosed (February 6, 2009)
http://www.bismarcktribune.com

National Headlines

Jailed Anesthesiologist Pays $830,000 in Restitution to Ohio Workers Comp Board (February 18, 2011)
http://workerscompgazette.com/jailed-anesthesiologist-pays-830000-in-restitution-to-ohio-workers-comp-board/

Louisiana: Comp drugs costs 75 percent higher than study states (June 14, 2010)
http://www.riskandinsurance.com/story.jsp?storyId=452521602

Narcotics Abuse in Workers' Compensation (November 4, 2010)
http://www.workcompwire.com/2010/11/narcotics-abuse-workers-compensation/

Industry Reports

National Institute on Drug Abuse - *Monitoring the Future: National Results on Adolescent Drug Use 2010* (2/2011)

- Monitoring the Future (MTF) is a long-term study of American adolescents, college students, and adults through age 50
- The proportion of 12th graders in 2010 reporting use of psychotherapeutic ***prescription drugs*** (amphetamines, sedatives, tranquilizers, and narcotics other than heroin) without medical supervision in the prior year was 15.0%, up slightly from 14.4% in 2009 but a bit lower than in 2005, when it was 17.1%.
    - Lifetime prevalence for the use of any of these drugs without medical supervision in 2010 was 21.6%
- OxyContin use increased some in all grades from 2002 (when it was first measured) through 2010, though the trend lines have been irregular.
    - 2010 annual prevalence rates were 2.1%, 4.6%, and 5.1% in grades 8, 10, and 12
- Use of Vicodin, has remained fairly steady at somewhat higher levels since 2002, though use among 12th graders declined significantly in 2010.
    - 2010 annual prevalence rates were 2.7%, 7.7%, and 8.0% in grades 8, 10, and 12

Quest Diagnostics - *U.S. Worker Use of Prescription Opiates Climbing, Shows Quest Diagnostics Drug Testing Index(TM)* (9/16/2010)

- 5.5 million urine drug tests reveal an 18% jump in opiate positives in general US workforce in a single year (2008 to 2009), more than 40% jump from 2005 to 2009
- 2009 post-accident drug tests found opiates up to four times more often than pre-employment tests (3.7% in post-accident as compared to 0.78% in pre-employment tests in the case of hydrocodone), suggesting that these drugs may be playing a role in workplace accidents
- Consistent with a June report from the Drug Abuse Warning Network (DAWN), part of the U.S. Department of Health & Human Services
    - DAWN study reported a 111% increase in the estimated number of emergency department visits for nonmedical use of opioid analgesics from 2004-2008 and a 29% jump from 2007-2008
    - Highest numbers of emergency department visits were recorded for oxycodone, hydrocodone and methadone
    - Note: More data from DAWN study next under Centers for Disease Control and Prevention

Centers for Disease Control and Prevention - *Emergency Department Visits Involving Nonmedical Use of Selected Prescription Drugs --- United States, 2004—2008* (6/18/2010)

- Estimated number of emergency department (ED) visits for nonmedical use of opioid analgesics increased 111% during 2004--2008 (from 144,600 to 305,900 visits) and increased 29% during 2007—2008
- Highest numbers of ED visits were recorded for oxycodone, hydrocodone, and methadone
    - Oxycodone increased from 41,700 to 105,200, and rates increased from 14.2 per 100,000 to 34.6 per 100,000, an increase of 144%
- ED visits involving nonmedical use of benzodiazepines increased from 143,500 in 2004 to 271,700 in 2008, and rates increased from 49.0 to 89.4 per 100,000, an increase of 82%
- Number of ED visits involving nonmedical use of prescription or over-the-counter drugs increased rapidly during 2004--2008, and by 2008 matched the number of ED visits involving illicit drugs

National Council on Compensation Insurance (NCCI) - *Narcotics in Workers Compensation* (12/2009)

- Data used in this study was consolidated from a sample of claims data provided by select carriers for injuries that occurred from 1994 to 2007, and services provided from 1996 to 2007, evaluated as of July 1, 2008.
- Narcotics account for nearly one quarter of all workers' compensation prescription costs
- The narcotics share of drug costs increases as claims age
- Narcotics costs per claim vary by state with apparent regional differences
- Narcotics are used mostly for back injuries in WC
- Narcotics used early in the life of claims is increasing
- Narcotics use can persist for many years
- Heavy narcotics use for WC injuries is related to substance-abuse treatments

US Department of Justice - *Methadone Diversion, Abuse, and Misuse: Deaths Increasing at Alarming Rates* (11/2007)

- Methadone poisoning deaths increased from 786 in 1999 to 3,849 in 2004, an increase of 390%
    - exceeds the percentage increase in "other opioid" (including oxycodone, morphine, hydromorphone, and hydrocodone) deaths during the same period
    - Other opioid deaths increased 90 percent (2757 deaths in 1999 to 5242 deaths in 2004) and accounted for a much larger percentage of total opioid-related deaths
- Most methadone deaths are the result of methadone diverted from hospitals, pharmacies, practitioners, pain management physicians and, to a much lesser extent, narcotic treatment programs (NTPs) and used in combination with other drugs and/or alcohol.
- Some methadone deaths and nonfatal overdoses are the result of misuse of legitimately prescribed methadone by individuals who may not have been properly counseled by their physicians about the dangers of taking the drug in ways other than those prescribed, including in combination with other drugs and/or alcohol.
- Total amount of methadone legitimately distributed to businesses increased from 2001 through 2006; the greatest percentage change occurred at the practitioner level, indicating that pain management and general practitioners are dispensing the drug more frequently in the management of pain.

Engrossed HB 1054

What does this bill do?
This bill regulates when WSI will pay the cost of opioid prescriptions for injured employees. It establishes criteria for documentation supporting opioid prescriptions after thirty days.

Why is this important?
Opioid pharmaceuticals are powerful, effective, pain control agents. They act on the nervous system to impair pain sensations. They are also addictive and can be used to create sensations of euphoria. As a result, they have become increasingly popular drugs of abuse in ND. This has increased the likelihood they will be re-sold for profit or to fund continued drug abuse.

What would WSI require in order to pay these prescriptions?
No additional documentation is required for the initial thirty days.

For continued payment after the first thirty days, WSI will require the provider to:

- Provide estimated timelines for the treatment
- Document a screen for abuse factors
- Provide a plan for ultimately withdrawing the injured employee from the medication
- Enter into an opioid treatment agreement which documents the risks of the medication, as well as limiting the sources the injured employee may solicit treatment from, and
- Document the overall improvements the medication provides.

Prescriptions lasting longer than six months will qualify for coverage only if the following criteria are met:

- Documentation of increased function
- Diagnosis of chronic pain
- Treatment agreement with the prescriber, and
- Ongoing review and documentation of the therapy's effectiveness.

In order to prevent diversion, the injured employee is subject to random screens for the presence of the prescribed medication, as well as the absence of un-prescribed medications. This is the only effective check and balance which prevents the redirection of these medications.

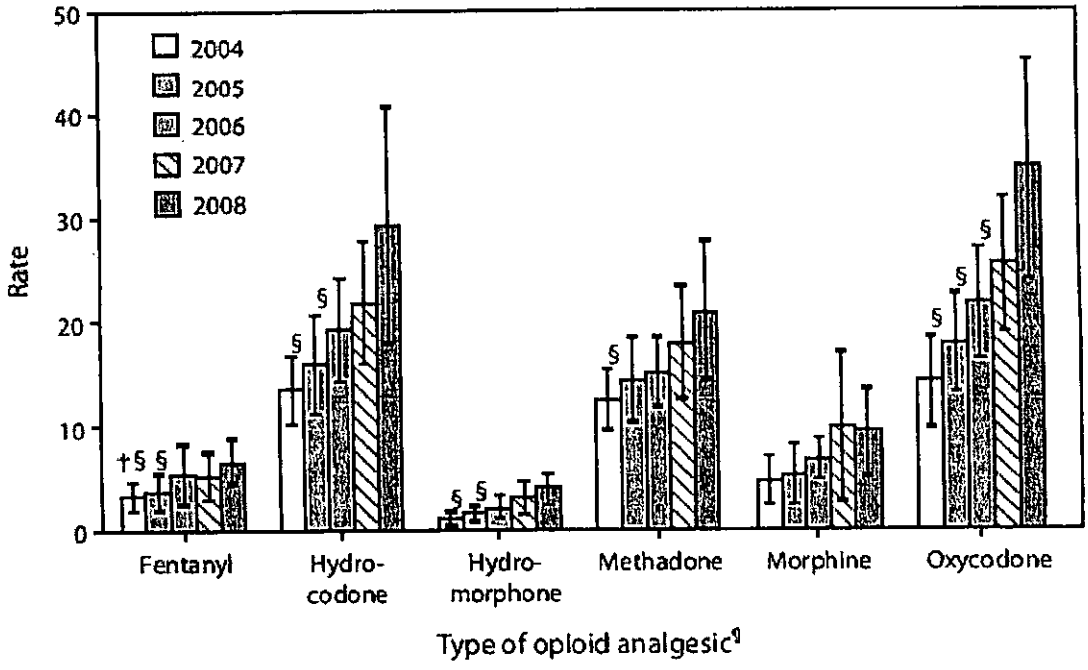
Currently, what effects does WSI see from misuse of these medications?
In the past two years, fully 25% of all injured employee fraud investigations have involved allegations of narcotic misuse or diversion. Almost half of WSI's total drug expenditure is on opioid therapies; this is significantly higher than any of our neighbors. These numbers fail to quantify the societal impacts that North Dakota absorbs when a parent or a loved one becomes addicted.

Why is the thirty day window so important?
Literature indicates that dependency issues tend to arise at the thirty day mark. Intervention and information must occur in this window in order to effectively deter the dependency spiral.

Doesn't the North Dakota Board of Medical Examiners handle these issues?
The North Dakota Medical Board of Medical Examiners addresses areas of discipline such as unprofessional conduct, patterns of inappropriate care, lack of appropriate documentation, and distribution of controlled substances for other than medically accepted therapeutic purposes. Generally, the cases they investigate are those exhibiting a pattern of inappropriate care. This bill is intended to establish criteria for opioid usage among North Dakota injured employees. The bill does not regulate prescriber conduct. This bill requires documentation and ongoing attention, along with verification, for individual injured employees.

How big of a problem is drug-related morbidity?

Rates of emergency department (ED) visits* for nonmedical use of selected opioid analgesics, by type --- United States, 2004--2008



Source: Substance Abuse and Mental Health Services Administration (SAMHSA)'s Drug Abuse Warning Network (DAWN), 2004--2008. Additional information available in appendix C at http://dawninfo.samhsa.gov/files/ed2007/dawn2k7ed.pdf.

* Per 100,000 population.
† 95% confidence interval.
§ Rate significantly less than the rate in 2008, by two-sided *t* test ($p<0.05$).
¶ Drug types include combination products (e.g., combinations of oxycodone and aspirin).

Source-Centers for Diseases Control and Prevention-- June 18, 2010/59(23);705-709

House Bill 1054 Against

Shelley Killen MD

1. Under Section 1 requiring a "objectively supportable" treatment plan after 30 days for the first surgery and 6 weeks for a 2nd surgery this seems punitive for both the surgeon and the injured worker. To avoid the prequalification and extra paperwork the surgeon may either prescribe no further pain medications or transfer care to a pain specialist. In either case it further calls this long-term opioid therapy, which it is not. This is normal post-operative care. This could significantly increase ER visits and most certainly decrease the quality of care provided to injured workers.
2. Under both general and long-term opioid therapy documentation as required by the organization is referenced but nowhere is this defined or clarified and are samples of the forms provided. Exactly how much more paperwork does the organization realistically think physicians can complete especially when it is not provided here as part of this bill. This will only cause even more physicians to refuse to care for injured workers.
3. Under long-term opioid therapy section C. each injured worker shall be evaluated annually by the organization to determine the need for continuing the therapy. By what criteria are they being evaluated and by who in the organization. By someone with a medical background in chronic pain management or by the analyst who may not have any medical background at all.
4. Under the section dealing with prescribers the organization requesting a drug screen negates the very idea of a random drug screen and in my experience the patients can then take what ever they need to have the test go their way.
5. Under the section dealing with prescribers who at the organization is qualified to determine if, when or how an injured worker medications should be reduced or by what extent. .
6. To have an opioid agreement renewed every 6 months is not the standard of care. Once it is agreed upon and signed it is good until broken or one of the parties cancels it.
7. This appears to be written solely for the benefit of the organization and not for the benefit or protection of the injured worker.

Testimony in opposition to House Bill No. 1054
Trina Kaiser, Nurse Practitioner

In general, I support the use of clinical guidelines for chronic opioid therapy. Establishing practices that help to identify which individuals may be more appropriate for long-term opioid treatment can help balance the potential benefits of opioid use (improved pain control, improved ability to function) with the potential risks of treatment (eg. Abuse, addiction, diversion, side effects). However, House Bill No. 1054 has several provisions that are too broad, allowing for too much subjectivity on the part of Workforce Safety and Insurance to make medical decisions.

Here are some specific issues of concern:

1. Inconsistent definition of chronic pain
   Example: Page 1 – Time frame 30 days (Line 12) versus 6 weeks (Line 15). Contrast with the definition of "chronic" pain provided on page 2 (Line 4-6). Most sources do not consider pain to be chronic before a minimum of 3 months post-injury.

2. Poorly defined roles of who exactly will decide if an injured employee will qualify for chronic opioid therapy or what criteria will be used to render this decision
   - The bill contains no language identifying if decisions regarding chronic opioid therapy will be made by one specific individual or a group.
   - Example: Page 3 (Lines 26-28): "Upon request of the organization, the prescriber shall reduce the prescription levels or provide objective justification why such a reduction is not in the injured employee's best interest." If the injured employee is receiving long-term opioid treatment, this would assume that pre-authorization has already been obtained from the organization based on submitted documentation. Under what circumstances should the organization request changes in prescription levels when the treatment plan was agreed upon previously?

3. Absence of a defined appeals process
   - North Dakota Century Code 65-05-07 #3 states "The doctor or health care provider may appeal adverse decisions of the organization in accordance with the medical aid rules adopted by the organization."
   - If an appeals process is not clearly defined, it may result in the organization making medical decisions, based solely on documentation, that deny an injured employee access to an entire class of medications for pain management. This would allow too

much authority by the organization to dictate medical care if decisions are final. Addition of a statement indicating that a standard appeals process will be observed may be appropriate.

Potential negative consequences from House Bill 1054:

- Decreased quality of patient care if access to chronic opioid therapy is inappropriately denied

- Limited access to timely medical care for chronic pain, as primary care providers may not be willing to treat injured workers with chronic pain due to the new documentation requirements. This will likely result in more referrals to pain specialists. Access in the Bismarck area for pain management is already difficult.

- Increased cost

  Greater number of specialty referrals and increased length of provider office visits

  Drug Screens: Refer to Page 3 (Lines 7-11).

Drug screens are one important tool for monitoring compliance with opioid therapy in combination with other monitoring strategies. However, the type of testing required to best determine if an individual is compliant with opioid therapy is quite costly and subject to erroneous interpretation due to metabolic pathways, cross-reactivity, and a minimum level necessary for detection. "Failure of the screen" is not clearly defined and misinterpretation may result in unjustified termination of opioid therapy.

Items that should be more clearly defined include:

- What is the time frame for considering opioid therapy to be "long-term maintenance analgesia therapy"
- Who will make the decision whether or not to preauthorize long-term opioid therapy?
- What document or forms will be utilized to facilitate this process for the prescriber and for the organization?
- What is the process to appeal a decision?
- How is "Failure of the screen" determined if results are indeterminate?

(4)

Senate Industry, Business & Labor Committee

HB 1054

March 7, 2011

Testimony of Duane Houdek, Executive Secretary
North Dakota State Board of Medical Examiners

Chairman Klein and members of the Senate IBL Committee, my name is Duane Houdek, Executive Secretary of the North Dakota State Board of Medical Examiners. By statute, the Board is responsible for regulating the practice of medicine in North Dakota. On behalf of the board, which is composed of 10 physicians and two public members from throughout the state, I speak in opposition to HB 1054 and offer an alternative approach to the issue of regulating opioid prescribing for WSI claimants.

With all due respect, this bill reflects a misunderstanding of the medical management of pain and represents an extreme intrusion into the patient-physician relationship. For example, the provisions that allow someone who is not required to be a physician, who does not know the patient and who has never met the patient to recommend a change in dosage of pain medication or mandate a titration plan illustrates the extent of the problem this bill presents. We have prosecuted doctors for attempting to prescribe in such circumstances. There is already a shortage of physicians who are willing to treat WSI patients–this type of interference and second-guessing will only make that problem worse.

There is a much better way to address this issue. The issue presented to you, to the extent that it may reflect a problem with prescribing, involves a handful of

thoroughly investigate claims of inappropriate practice by physicians and we do so every day. There is no reason we should not be called on to do so in the instances brought to you by WSI.

This would be a much better practice than imposing questionable requirements on all physicians when it is admitted that the problem–if it is a problem–resides with very, very few.

Thank you. I would be happy to try to answer any questions you may have.

(5)

Physicians Dedicated to the Health of North Dakota

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Testimony in Opposition to HB 1054
Senate Industry Business and Labor Committee
March 7, 2011

Chairman Klein and Committee Members, I'm Courtney Koebele and I serve as Director of Advocacy for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

The Association opposes HB 1054 for the following reasons:

1. This bill is inconsistent with public policy for good pain management. There is a general medical and regulatory consensus that opioid analgesics are necessary to maintain public health; they often are the mainstay of treatment, particularly if pain is severe. The burdens that this bill places on this type of treatment jeopardize the appropriate use of the opioids for good pain management.
2. Chapter 19-03.3 of the North Dakota Century Code, also known as the Intractable Pain Treatment Act, governs controlled substances for care and treatment. This act, adopted in 1995, states the intention and policy of the state for pain management. The act was updated in 2005. HB 1054 is inconsistent with that act because of the extra burdens it puts on the physician prescriber. This bill places severe burdens on the physician, when there are already protocols in the law to rectify any misuse. Current law provides for discipline action against the license of any physician who prescribes or administers a drug or treatment that is nontherapeutic in nature. This bill is not necessary.
3. This bill will have a chilling effect on physicians treating injured workers. Placing these onerous series of protocols and prior authorizations on physicians only for injured workers receiving WSI benefits may result in physicians being less willing to treat such patients.

Thank you for the opportunity to present the views of the North Dakota Medical Association. NDMA urges the Committee to vote a "DO NOT PASS" on HB 1054.

11.0240.03001
Title.

Prepared by the Legislative Council staff for
Senator Klein
March 25, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1054

Page 1, line 1, replace "four" with "three"

Page 1, line 11, replace "does not" with "may"

Page 1, line 12, replace "thirty days" with "six weeks"

Page 1, line 13, replace ", unless" with "if"

Page 1, line 13, remove "submits an objectively"

Page 1, replace lines 14 through 18 with "of the opioids seeks consultation with an American board of medical specialties board-certified or eligible specialist that has undergone subspecialty training in pain medicine. The consultation must establish, along with the referring physician, a pain management treatment plan. Such treatment plan must be documented in the injured employee's medical records."

Page 1, line 19, remove "Qualification for coverage beyond the coverage provided for under subsection 2"

Page 1, replace lines 20 and 21 with "The organization may require consultation with an alternate pain management specialist if the organization, after reviewing the pain treatment plan or the prescribing done pursuant to that plan, renders an opinion that the treatment plan or the prescribing of opioids done pursuant to that plan does not meet medically accepted therapeutic standards."

Page 2, line 2, after the underscored period insert "The organization may not pay for an opioid therapy prescribed on an outpatient basis extending beyond twelve weeks following an initial injury or initial discharge or following a subsequent operative procedure, unless the therapy qualifies as a long-term opioid therapy.

2."

Page 2, line 7, replace "2." with "3."

Page 2, line 11, replace "3." with "4."

Page 2, line 14, replace "4." with "5."

Page 2, line 16, after the underscored semicolon insert "and"

Page 2, line 17, replace "; and" with an underscored period

Page 2, remove lines 18 and 19

Page 2, line 20, replace "5." with "6."

Page 2, remove lines 24 through 28

Page 3, line 1, remove "Every thirty days during the first three months and every sixty days during the"

Page 3, line 2, replace "next six months, progress" with "Progress"

Page 3, line 7, replace "At the prescriber's or organization's" with "The organization may"

Page 3, line 7, replace ", every" with "the results of any drug screening test that a prescriber ordered or may order for an"

Page 3, line 8, remove "is subject to random drug screens for the"

Page 3, remove lines 9 and 10

Page 3, line 11, remove "analgesia therapy"

Page 3, remove lines 12 through 19

Page 3, line 20, remove "a."

Page 3, remove lines 23 through 30

Page 4, remove lines 1 through 3

Page 4, line 4, replace "2." with "8."

Page 4, line 4, after the first "the" insert "organization finds the"

Page 4, line 12, remove "Within the first thirty days of treatment of an injured employee under an opioid"

Page 4, line 13, replace "maintenance analgesia therapy," with "The organization may require"

Page 4, line 13, replace "shall" with "to"

Page 4, line 13, remove "to"

Page 4, line 14, remove "the organization"

Page 4, line 14, after the underscored period insert "The treatment plan must restrict treatment access and limit opioid prescription to an identified single prescriber."

Page 4, line 15, replace "Time-limited goals" with "Anticipated length of opioid therapy"

Page 4, remove lines 26 through 31

Page 5, line 1, replace "presriber" with "prescriber"

Renumber accordingly

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1054

Page 1, line 11, replace "does not cover an" with "may require prescribers to submit an objectively supportable treatment plan for"

Page 1, line 11, replace "therapy" with "therapies"

Page 1, line 13, replace the comma with a period

Page 1, line 13, remove "unless the prescriber submits an objectively"

Page 1, line 14, remove " supportable required prescriber's treatment plan."

Page 1, line 14, replace "does not cover an" with "may not pay for"

Page 1, line 15, replace "therapy" with "therapies" and replace "six" with "twelve"

Page 1, line 17, replace "prescriber prequalifies the injured employee for" with "therapy qualifies as a"

Page 1, line 18, remove "coverage"

Page 2, line 27, replace "prior authorization from the organization. An authorization request under this" with "a consultation with a provider that has undergone subspecialty training in pain medicine and will require organization preauthorization."

Page 2, line 28, remove "subsection must include documentation as required by the organization."

Page 3, line 1, remove "Every thirty days during the first three months and every sixty days during the"

Page 3, line 2, replace "next six months, progress" with "Progress" and replace "on forms provided" with "in a format and on a frequency as requested"

Page 3, line 4, remove "every" and replace "employee" with "employees"

Page 3, line 7, remove "every" and replace "employee" with "employees"

Page 3, line 8, replace "is" with "are"

Page 3, line 9, replace "illegal" with "unprescribed"

Page 3, remove lines 12 through 14

Page 3, line 22, replace "medications" with "substances"

Page 3, line 26, remove "reduce the prescription"

Page 3, line 27, remove "levels or" and remove "such" and after "reduction" insert "in the opioid therapy"

Page 4, line 1, replace "shall" with "to"

Page 4, line 12, remove "Within the first thirty days of treatment of an injured employee under an opioid"

Page 4, line 13, replace "maintenance analgesia therapy," with "The organization may require" and replace "shall" with "to" and remove "to"

Page 4, line 14, remove "the organization"

Page 4, line 15, replace "Time-limited goals," with "Anticipated length of opioid therapy"

Page 4, line 26, after "An" insert "organization approved"

Page 4, line 27, remove "This agreement must be renewed every six months."

Page 4, line 31, after the period insert "The agreement will restrict treatment access and limit opioid prescriptions to an identified single prescriber."

Page 5, line 1, replace "presriber" with "prescriber"

Renumber accordingly