Executive Summary

Since 1996, twenty-three states and the District of Columbia have passed laws allowing for the medical use of marijuana for certain medical conditions, including chronic pain. However, during this time marijuana has remained a Schedule I substance at the federal level, which is defined as a drug with no currently accepted medical use and a high potential for abuse. In those states where medical and/or recreational use is allowed, state laws are in conflict with federal laws causing confusion.

To address this confusion, guidelines from independent and state organizations were examined with a focus on requirements for pain treatment agreements and urine drug screens in the management of chronic pain claims. These requirements were applied to recognized prescriber behavior toward marijuana use including: failing to address the use of marijuana, zero tolerance toward marijuana use and allowing marijuana use in select patients.

Patient safety issues were identified where prescribers failed to address the use of marijuana by allowing it and/or allowing its use concurrently with other medications. The resulting analysis concludes that guidelines should require the use of pain treatment agreements and these agreements should address the appropriateness of marijuana use by a patient.

States with Legalized Medical and/or Recreational Marijuana Use

The legality of marijuana is a very fluid situation as many other states, and the Federal Government, have introduced legislation to legalize the use of medical marijuana.

As of March 2015, Colorado, Washington, Alaska, Oregon and the District of Columbia have passed measures allowing for the recreational use of marijuana.
"Chronic pain affects about 100 million American adults -- more than the total affected by heart disease, cancer and diabetes combined. Pain treatment costs the nation up to $635 billion each year in medical treatment and lost workplace productivity." ¹

Chronic Pain

The increasing prevalence of chronic pain and the subsequent use and abuse of prescription medications is an alarming national health issue. As chronic pain treatments increase, so do the concerns regarding managing costs in the workers’ compensation industry.

Numerous treatment options for chronic pain exist. These vary greatly from non-invasive therapies such as psychotherapy, cognitive behavioral therapy and relaxation to more invasive therapies such as electrical stimulation and surgery. Unfortunately, none of these interventions are proven to eliminate pain in all cases; and determining appropriate treatment protocols for chronic pain patients can become difficult after initial interventions fail to adequately relieve pain.

Several organizations have published guidelines for pain management, including those recognizable in workers’ compensation such as the Official Disability Guidelines (ODG) and the American College of Occupational and Environmental Medicine (ACOEM). In addition, states with medication treatment and/or utilization guidelines (e.g. Washington and Colorado) detail appropriate chronic pain treatments in workers’ compensation claimants.

Regardless of the referenced guidelines, medications remain a cornerstone of pain management, including chronic pain. Drug classes involved include:

- muscle relaxants
- non-steroidal
- anti-inflammatories (NSAIDs)
- anticonvulsants
- antidepressants
- opioids

Acute pain medication management typically involves the use of NSAIDs and opioids for more severe injuries. For chronic pain conditions, first-line treatment involves the use of antidepressants or anticonvulsants according to guidelines.²³ However, these therapies are sometimes insufficient and other drug classes are required, such as opioids.

Opioids

Opioids are some of the most powerful pain medications available. Opioids provide pain relief by reducing the intensity of pain signals that reach the brain; resulting in diminished effects by the painful stimulus, a euphoric feeling (or sense of well-being) and may slow the signals responsible for breathing.⁴

As a class, opioid medications are increasingly discussed in both medical and lay literature. Reports published in 2013 by the Centers for Disease Control and Prevention (CDC) state that there were 16,651 prescription painkiller deaths in 2010. Additionally, more than 12 million people were reported to be using prescription painkillers non-medically.⁵

Examples of Opioid Medications

- Hydrocodone products (Vicodin®)
- Oxycodone products (Percocet®)
- Morphine products (Kadian®)
- Hydromorphone products (Dilaudid®)

Common Side Effects

- Nausea
- Vomiting
- Constipation
- Headache
- Dizziness
Given the concerns with opioid medications, prescribers have begun investigating treatment alternatives to manage their patients' pain. This has included the use of interventional therapies such as pain injections, but also includes investigating alternative substances such as marijuana.

**Marijuana**

The main active chemical in marijuana is delta-9-tetrahydrocannabinol or THC. THC acts upon specific sites in the brain called cannabinoid receptors which are responsible for eliciting marijuana's effects. These effects vary by user, the amount taken and the environment in which it is used. Advocates for medical marijuana indicated that marijuana may have therapeutic potential to reduce pain, control nausea, stimulate appetite and reduce ocular pressure. However, evidence does not support the use of marijuana for these conditions.

On a federal level, THC is classified as a Schedule I substance by the Controlled Substance Act of 1970. A Schedule I designation is given based upon the high potential for abuse of a substance and no accepted medical use. Additionally, it is unclear how to properly dose medical marijuana because its ingredients are not well defined and can vary from plant to plant.

The many side effects of using marijuana further limit its use as a pain reliever. Similar to opioid medications, using marijuana for pain is associated with side effects that can be troublesome and cause patient harm. This includes memory impairment and visual disturbances which can impair a person's ability to operate machinery or perform other workplace functions. The duration of action for marijuana can be difficult to predict as it varies by user, but can last from 2 to 6 hours. According to studies, chronic users of marijuana may start to exhibit signs of energy loss, a lack of interest in tasks and difficulty learning new skills. These effects could impact workplace performance and impair return to work.

The side effects from marijuana use can be amplified when combined with other pain medications. For example, decreased functioning of the central nervous system (CNS) is a potential side effect of muscle relaxants, anticonvulsants, antidepressants and opioids. These effects can be worsened when a psychoactive substance, like marijuana, is used concurrently. Psychoactive substances are those that temporarily diminish the function or activity of the CNS. This is an identified limitation for using marijuana to treat pain.

Patients who fail to communicate to their treating physicians which medications they are taking concurrently to treat chronic pain, including prescription medications, over the counter medications and illicit substances, such as marijuana, run an increased risk of harm resulting from inadvertent amplification of the intended therapeutic effects of medications prescribed by their treating providers. Encouraging open and honest communication with patients will improve the ability of providers to make the most appropriate therapeutic decision. Nationally recognized workers' compensation medical management guidelines, such as ACOEM and ODG, recommend open and honest communication be accomplished through the use of written treatment agreements between prescriber and patient. Although these agreements go by various names, ranging from pain agreements to opioid contracts, their purpose is the same: provide a baseline for defining an effective relationship between the patient and the prescriber.
So why is there confusion regarding marijuana use in chronic pain patients?

With guidelines from independent organizations, such as ODG and ACOEM, recommending marijuana use be avoided in the treatment of chronic, non-cancer pain, there should be little confusion regarding its role in chronic pain management. However, confusion generally begins when a patient requests to use marijuana for their medical condition and/or a prescriber recommends the use of marijuana in a workers’ compensation claimant. Documented incidences of patients requesting marijuana for medical treatment include the *Creole Steele v. Ricky Stewart* and *Vialpando v. Ben’s Automotive Services* court decisions (discussed in the next section). The confusion is amplified as a result of the changing legal status of marijuana on the state level.

In addition to the twenty three states and the District of Columbia that have passed laws allowing marijuana to be used for a variety of medical conditions, Washington, Colorado, Oregon, Alaska and the District of Columbia have passed measures allowing for the recreational use of marijuana. State laws that allow for medical and/or recreational use of marijuana are in conflict with federal laws. The varied legal status of marijuana on the state and federal levels has been the primary cause for much of the confusion surrounding the penalties of marijuana use in the workers’ compensation system.

As identified, the substances in marijuana are classified as a Schedule I substance on the federal level. Therefore, possession of marijuana is a federal crime and can result in federal penalties up to three years in prison and fines of $1,000. Sale and cultivation of a Schedule I substance carries maximum penalties including life in prison and $1,000,000 fines. In an August 2013 memorandum to U.S. Attorneys, the Department of Justice affirmed that marijuana remains illegal under the CSA and that federal prosecutors would continue to aggressively enforce the statute. In the same documents, however, the Department of Justice identified eight areas of enforcement priority and indicated that outside of those priorities it would generally defer to state and local authorities. In those states that have legalized marijuana use, medically or recreationally, local authorities have been given deference not to enforce federal penalties.

The impact these policy changes have on chronic pain patients is often unclear to workers’ compensation claims administrators. The following chart summarizes the new regulations in states that have legalized marijuana use. This chart is not intended as professional, medical or legal advice, and is for informational purposes only.

“Prescription drug abuse (with opioids) has become the nation’s fastest growing drug problem and has been labeled an epidemic by the CDC.”

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*Original publication date, May 2014; Revision published March 2015.*
Medication Reimbursement

One of the most important questions in the mind of a workers' compensation claims administrator is that regarding medication reimbursement, and whether they must pay for medical marijuana in a state where it has been legalized for medical use. Unfortunately, laws vary by state creating challenges for entities that span multiple jurisdictions. In the case of states that have both medical and recreational marijuana use, specifically Alaska, Oregon and Colorado, the language of the law indicates that the costs of medical marijuana are not required to be reimbursed by an insurer.\textsuperscript{15,16,17} Washington, a state that also has legalized medical and recreational marijuana use, is a notable exception as the language of the law states health insurers, “may enact coverage or non-coverage criteria...for payment or non-payment of medical cannabis in their sole discretion.”\textsuperscript{18}

<table>
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<th>State</th>
<th>Medical Marijuana Language</th>
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| Alaska\textsuperscript{15} | (c) A governmental, private or health insurance provider is not liable for any claim for reimbursement for expenses associated with medical uses of marijuana.  
(d) Nothing in this chapter requires any accommodation of any medical use of marijuana:  
(1) in any place of employment;  
(2) in any correctional facility, medical facility or facility monitored by the department or the Department of Administration;  
(3) on or within 500 feet of school grounds;  
(4) at or within 500 feet of a recreation or youth center;  
(5) or on a school bus. |
| Colorado\textsuperscript{16} | (10)(a) No governmental, private or any other health insurance provider shall be required to be liable for any claim for reimbursement for the medical use of marijuana.  
(b) Nothing in this section shall require any employer to accommodate this medical use of marijuana in any work place. |
| Oregon\textsuperscript{17} | Nothing in ORS 475.300 to 475.346 shall be construed to require:  
(1) A government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana; or  
(2) An employer to accommodate the medical use of marijuana in any workplace. [1999 c.4 §16] |
| Washington\textsuperscript{18} | (2) Nothing in this chapter establishes a right of care as a covered benefit or requires any state purchased health care as defined in RCW 41.05.011 or other health carrier or health plan as defined in Title 48 RCW to be liable for any claim for reimbursement for the medical use of cannabis. Such entities may enact coverage or non-coverage criteria or related policies for payment or non-payment of medical cannabis in their sole discretion. |
Specific to workers’ compensation, the ability of an adjuster to approve or deny medications based upon the presence of recreational marijuana is not routinely addressed. In general, ODG would recommend following the parameters of the written pain treatment agreement regarding the approval of medications when marijuana use becomes known.

In the case of potentially paying for a claim of medical marijuana to treat chronic pain, the law says insurers have to pay “for reasonable and necessary expenses that are proven to be efficacious.” Marijuana would not appear to meet this criteria as it has not been proven to be effective as demonstrated by its designation as a Schedule I medication on the federal level. ODG supports the idea of non-payment for medical marijuana stating, “for every disease and disorder for which marijuana has been recommended, there is a better, FDA approved medication.”

Nonetheless, several court decisions exist in which a payer was found to be responsible for reimbursement of medical marijuana.

- In Creole Steele v. Ricky Stewart, 86 So. 3d 757, 760 (La.App. 3 Cir. 2012), the Louisiana Third Circuit Court of Appeal upheld a ruling by a workers’ compensation judge that an employee’s prescription of a drug containing THC was a “necessary medical expense” under Louisiana law and ordered the employer to pay for the prescription. Note, however, that even though the case was decided against the employer for its failure to authorize the purchase of a prescription form of marijuana, the appeals court affirmed the lower court’s refusal to award penalties and attorney fees to the claimant. In other words, the court required the employer to reimburse the claimant for the prescription form of marijuana, but did not assess any penalties against the employer or require the employer to pay for the claimant’s attorney fees.

- In Vialpando v. Ben’s Automotive Services, 2014-NMCA-084, 1 (N.M. Ct.App. 2014), the New Mexico Court of Appeals affirmed a decision by a workers’ compensation judge that an employer must pay for an injured employee’s medical marijuana treatment pursuant to the Lynn and Erin Compassionate Use Act (Compassionate Use Act), finding that such treatment was reasonable and necessary medical care. The court side-stepped the issue of a potential conflict with federal law by pointing out that the employer did not cite to any federal statute that the employer would be forced to violate in reimbursing the claimant for a substance that is illegal under federal law, and thus, relying on the legal argument that it is the responsibility of the pleading party to state its case, not the court.

Why do pain treatment agreements become more critical for managing patient care in states with legalized marijuana?

As pain agreements minimally define the appropriate behavior between both patient and prescriber, they serve as an excellent guide for claims administrators to supervise the medical benefits of their injured workers. By referencing the treatment parameters laid out in these documents, claims administrators shall have insight into the appropriate response to identified marijuana use. Examples of how this can be accomplished will be explored by examining regulations in both Colorado and Washington. In these states, pain treatment agreements are recognized as requirements in the workers’ compensation medical guidelines.
Minimum Required Content for Pain Treatment Agreements (per ODG)

- Goals of therapy
- Defined outcome measures
- Defined non-pharmacologic treatments
- Only one prescriber gives prescriptions and one pharmacy dispenses prescriptions
- Limits on number of medications and doses with limited refills that will only occur at appointments
- Medications are not to be altered without prescriber’s permission
- Heavy machinery/automobile operating is not to occur until drug-induced sedation/drowsiness has cleared
- Treatment compliance must occur for all other modalities enlisted
- Urine drug screens may be required
- Patient’s acknowledgment of potential adverse effects of the use of opioids including addiction
- Information about opioid management can be shared with family members and other prescribers as necessary
- If opioid use is not effective, the option of discontinuing this therapy may occur
- Outlined consequence of non-adherence to the treatment agreement

Data retrieved from the Official Disability Treatment Guidelines (ODG), 2014

**Colorado**

Colorado’s Rule 17, Exhibit 9 requires the use of pain treatment agreements for all chronic pain patients. These same guidelines discuss marijuana stating, “At the time of this guidelines writing, marijuana use is illegal under federal law and cannot be recommended for use in this guideline. The Colorado statute also states that insurers are not required to pay for marijuana.”

Minimum Required Content for Pain Treatment Agreements (per Colorado)

- Side effects anticipated from the medication
- Requirement to continue active therapy
- Need to achieve functional goals including return to work for most cases
- Reasons for termination of opioid management, referral to addiction treatment or for tapering opioids (tapering is usually over 30 days)
- Discussion regarding how screens positive for marijuana or alcohol will be handled
- Contracts should be written at a 6th grade reading level to accommodate the majority of patients

Data retrieved from the State of Colorado, Department of Labor and Employment, Division of Workers’ Compensation Rule 17, Exhibit 9: Chronic Pain Disorder Medical Treatment Guidelines, 2007.

Urine drug screening is recommended by Colorado’s Rule 17, Exhibit 9 prior to initiating opioid substances due to the public health concerns of opioid diversion. The guidelines specifically state, “discussion regarding how screens positive for marijuana or alcohol will be handled should be included in the opioid contract.” It should be noted that the guidelines do not require urine drug screening to test for marijuana.

When marijuana use becomes known in a workers’ compensation claims case in the State of Colorado, the claims administrator is recommended to follow stipulations in the required treatment agreement. The consequences for known marijuana use are required by Colorado law to be addressed in that agreement.
Washington Administrative Code (WAC) 246-853-666 refers to the prescribing osteopathic physician while WAC 246-919-856 refers to prescribing physicians in general. Both state prescribers are to use written pain treatment agreements outlining patient’s responsibilities and shall include an agreement by the patient to not abuse alcohol or other medically unauthorized substances. Therefore, claims administrators in Washington are recommended to follow the stipulations of the pain treatment agreement when marijuana use is discovered in their patients.

<table>
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<tr>
<th>Minimum Required Content for Pain Treatment Agreements (per Washington)</th>
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<tr>
<td>• Reasons for which drug therapy may be discontinued</td>
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<td>• Patient’s agreement to not abuse alcohol or use other medically unauthorized substances</td>
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<td>• Patient’s agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills</td>
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<tr>
<td>• Patient’s agreement to provide biological samples for urine/serum medical level screening when requested</td>
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<td>• Requirement of all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system</td>
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<tr>
<td>• A written authorization for physician to release agreement for treatment to local emergency departments, urgent care facilities and pharmacies and written authorization for other practitioners to report violations of the agreement</td>
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<tr>
<td>• Written authorization permitting physician to notify proper authorities if he/she has reason to believe patient has engaged in illegal activity</td>
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<tr>
<td>• Acknowledgment of patient’s responsibility to safeguard all medications and keep them in a secure location</td>
</tr>
<tr>
<td>• Acknowledgment that if patient violates the terms of the agreement, the violation and the prescriber’s response to the violation will be documented with the rationale for changes in the treatment plan</td>
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Data retrieved from WAC 246-853-666 and WAC 246-919-856

The Impact of Prescriber Practices

Given the practices established by both Colorado and Washington, prescriber behavior concerning marijuana use in most states with legalized medical use of marijuana can be summarized very generally into one of three recognized trends:

Don’t Ask, Don’t Test

In the instances of prescribers who utilize ‘don’t ask, don’t test’, prescribers do not ask their patients about marijuana use, nor do they test for it in their urine drug screening (or if it is tested, it is not reported to them). By doing so, these prescribers address the issue through avoidance. Most still ask about and test for other illicit substances (e.g. heroin).

There are several concerns related to this type of prescriber practice as marijuana’s effects can impact other therapies. Using marijuana in conjunction with pain medications can result in additive or duplicative side effects that may lead to patient harm. This approach to marijuana use is likely the least appropriate action by a prescriber as the potential for patient harm is the greatest.
Non-Tolerance

These prescribers advise their patients not to use marijuana while receiving prescription medications. If marijuana use is learned or discovered (through methods such as urine drug screening), prescriber actions generally include having the patient choose between continuing with medication therapy or utilizing marijuana. Some prescribers practicing the non-tolerance approach do allow for one ‘slip-up’ (or instance where marijuana use occurs).

Medically Necessary

A prescriber may decide the use of marijuana is acceptable for their patient if the patient has a condition in which the use of marijuana has a favorable risk-benefit ratio. In these instances, a prescriber will monitor marijuana’s effects on their patients, including monitoring for interactions with other current therapies. Generally, a prescriber will allow this practice if the marijuana use is reported to them ahead of time, rather than being discovered through urine drug screening or other means.

This approach does not eliminate liability concerns for prescribers, as on a federal level, marijuana does not have any recognized medical use. Documentation by the prescriber is of critical importance in these instances to protect both the patient and the prescriber. Knowing prescriber behavior toward medical marijuana use can be beneficial to claims administrators, as it can impact other aspects of the claim, create stronger prescriber relationships and improve patient care.

Urine Drug Screening

In addition to pain contracts, urine drug screening is another important aspect of chronic pain claims management; particularly in states that allow for marijuana use either medically or recreationally. This is due to the public health concerns with drug diversion as well as the potential patient harm that can occur if pain medications are taken with illicit substances. Often the requirements for these screenings are stated in pain treatment agreements.

Both state and independent medical guidelines recommend the use of at least an annual urine drug screening for all chronic pain patients to monitor patient compliance to drug therapy. If non-compliance with drug therapy is discovered through the presence of marijuana, prescriber attitudes toward marijuana use can affect the management of the claim going forward.

In examining toxicology reports from 2005-2009 in Iowa, 22% of fatally injured workers were found to have positive tests for alcohol or other drugs.27
Conclusion

As claimants begin to receive treatment for chronic pain, concerns regarding managing costs in the workers’ compensation industry increase. With prescribers looking at alternative therapies for managing chronic pain, the pain treatment agreement becomes the critical assessment tool for consensus between all parties -- claims adjuster, employer, employee and prescriber.

Healthcare Solutions’ clinical team of pharmacists and nurses utilize Opioid Agreements as part of the Opioid Defense Manager® (ODM®) program. Launched in November 2012, ODM® is the first proactive, customized managed care program designed to protect the employee, prescriber and the employer by reducing inappropriate drug use while maintaining the necessary balance to provide pain relief for the patient.

Opioid Defense Manager’s patient-centered approach focuses on prevention by recognizing patient’s who are at-risk for prolonged disability, opioid dependence and risk of harm from opioid therapy. The clinical team of pharmacists and nurses then collaborate with prescribers to ensure appropriate opioid therapy including: monitoring of pain, function, adverse drug effects and risk management strategies. Claims examiners and nurse case managers work with Healthcare Solutions to access real-time alerting of potentially harmful drug use patterns to more effectively manage the patient’s drug coverage. Patients need to be involved with their care by understanding the expectations of treatment while working toward treatment goals. This is accomplished through patient education and the opioid agreements.

“For every disease and disorder for which marijuana has been recommended, there is a better, FDA-approved medication.”

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About the Author

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About Healthcare Solutions

Healthcare Solutions, Inc. is the parent company of Cypress Care, Procura, ScripNet and Modern Medical. Through its subsidiary companies, Healthcare Solutions delivers integrated medical cost management solutions to over 800 customers in workers’ compensation and auto/PIP markets. The company’s clinical - and technology -based services include pharmacy benefit management, specialty healthcare services, PPO networks, medical bill review, case management and Medicare Set-Aside services. With over 22% compounded annual growth rates, Healthcare Solutions has twice been recognized as one of the Fastest Growing companies in Georgia by Georgia Trends magazine and has received recognition by the Technology Association of Georgia for technology innovation. Utilizing market-leading technology, Healthcare Solutions delivers demonstrated benefits and savings complemented by deep industry expertise.

Healthcare Solutions’ clinical services include:

- Compound Medication Review
- Drug Indication Report
- Basic Medication Review
- Independent Pharmaceutical Evaluation
- Peer Review
- IPE and Peer Review Combination
- Urine Drug Testing

To request information about Healthcare Solutions or Modern Medical, contact Marketing at marketing@healthcaresolutions.com or visit us on the web at healthcaresolutions.com.
References


7. 21 U.S.C. § 812(c)


12. 21 U.S.C § 844(a)

13. 21 U.S.C. § 841


15. AS17.37.040


17. 0-4-278-Article XVIII (10a)

18. RCW 69.51A.060 (2)

19. RCW 69.51A


22. Creole Steele v. Ricky Stewart, 86 So. 3d 757, 760 (La.App. 3 Cir. 2012)


25. WAC 246-853-666

26. WAC 246-919-856