Workers' Comp

Morphine Equivalent Dose (MED) Continues to Decline

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3 MIN READ

In 2018 Coventry's pharmacy benefit management solution, First Script®, saw a 7.8% decrease in average MED per prescription for its retail and mail-order channels. This was the largest decrease in the last 5 years across First Script's retail and mail-order programs. In addition, there was a reduction in the percentage of opioid scripts with greater than or equal to 90 MED. To better understand why this is important let's answer a few questions. First, what is MED? With the nation's focus on the opioid epidemic being at an all-time high it is likely you have heard the term morphine equivalent dose or MED. But what exactly does that mean and why do we use it? MED is a calculated standardized value of the total opioid intake of a person over 24 hours. Since opioids have different potencies (i.e. 5mg of oxycodone does not equal 5mg of morphine in terms of pain relief) we need to equate all opioids to morphine based on their relative potencies. Doing this creates a standardized approach for looking at daily opioid intake. Essentially, you start with apples (oxycodone) and oranges (morphine), and using a calculation, convert the apples (oxycodone) to oranges (morphine) to simply add up all the oranges (morphine). So why is lowering MED so important? The greatest risk from opioids comes from their potential to cause life threatening respiratory depression. While any amount of opioid medication can cause respiratory depression, the risk increases as MED levels increase. MED levels are such an area of concern that even the Centers for Disease Control and Prevention (CDC) and Official Disability Guideline (ODG) both recommend keeping MED to the lowest effective dose, preferably less than 50 MED, and to avoid escalating above 90 MED. So, what led to First Script realizing the largest decrease in MED in 5 years? There are several factors that have likely contributed to this decrease.

- Early intervention - this is key to controlling opioid utilization and MED escalation. Clinical programs target claims with opioid utilization early on, when intervention is most impactful. By encouraging appropriate guideline driven opioid treatment through outreach and education, MED levels are kept in check.
- Awareness - the amount of attention that the opioid epidemic receives cannot be ignored. This topic is written about everywhere from peer reviewed journal articles to twitter posts and everything in between. You could say it is common knowledge that there is a problem with opioids in this country. This awareness likely has positive effects on controlling MED levels because in general, when people know more, they do better. An injured worker may be more likely to give physical therapy a try in lieu of asking for an increase in pain medication because they are more aware of the dangers.
- Jurisdictional Rules - states are continuing to do their part in controlling opioids by placing restrictions on how these medications can be prescribed. Many states have imposed rules such as quantity limits, day

supply limits, and maximum daily dose limits. Some states are even putting controls on how opioids are prescribed alongside other medications in hopes to reduce adverse events and deaths associated with dangerous drug combinations. For example, Hawaii has adopted a rule that opioids and benzodiazepines (an anxiety-reducing, sedative-hypnotic, muscle relaxant and anticonvulsant used to treat panic attacks, insomnia, muscle spasms, seizures, and alcohol withdrawal) are not to be prescribed concurrently for longer than 7 days.

Lowering MED levels is not achieved in a bubble, there are many outside factors that contribute. Taking control of the opioid epidemic is a collaborative process and with continued efforts, education and innovation we can expand upon this positive trend.



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