# Opioid Treatment:
# Liability Risks in the Office/Clinic Setting

## Data Insight

2024

MedPro Group

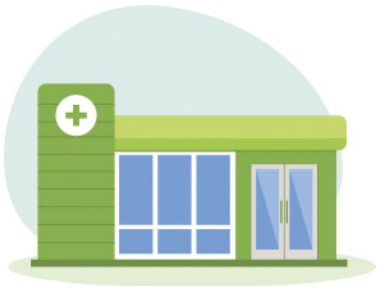
MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

# A Focus on Office-Based Medication Cases Involving Opioids



It is nearly impossible to read or watch the news without mention of the opioid crisis. From patient addiction to death from overdosing, opioid abuse can have tragic outcomes. Further, when these unfortunate events are related to medical care, they can result in malpractice allegations against healthcare providers and organizations.

Across all medical malpractice cases, clinically severe patient outcomes (i.e., outcomes involving permanent injury/disability or death) are noted in 52 percent of cases.* However, in medication-specific cases involving opioids, clinically severe outcomes occur in 67 percent of cases — of these cases, 8 in 10 result in death.** Thus, opioid-related cases rank among the malpractice allegations with the highest injury severity.***



The largest portion, 45 percent, of opioid-related malpractice allegations arise from care provided at physician/surgeon offices/clinics.

*MedPro Group + MLMIC cases opened 2013-2023 (N=>26K); **opioid-related cases (N=452); ***Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

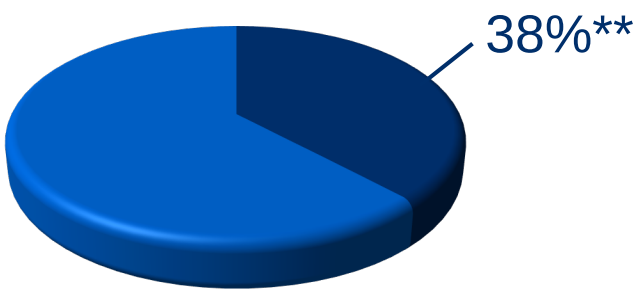
# Key Issues and Responsible Services



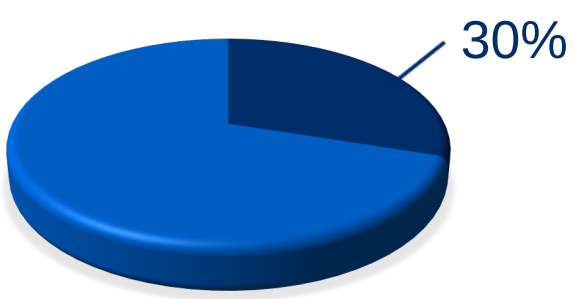
Analysis of office-based opioid cases reveals that improper management of patients' pain medication regimens accounts for the majority of allegations (82 percent) and total dollars paid* (92 percent).

**Who is most commonly responsible?**

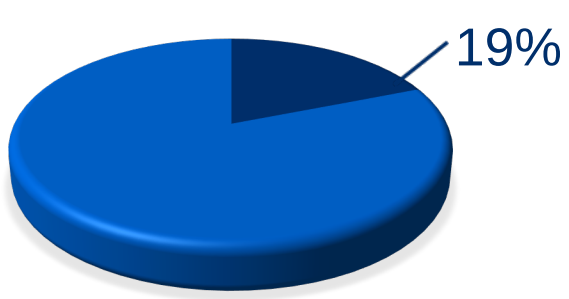
Pain management




Family medicine




Internal medicine




MedPro Group + MLMIC opioid-related office-based cases opened 2013-2023 (N=203); *Total dollars paid = expense + indemnity; **% of case volume

# Two Most Common Contributing Risk Factors



Opioid-related malpractice cases reflect multi-layered issues or failures in the process of care, also known as contributing risk factors.

Notable failures in office-based patient cases include inadequate patient assessments prior to prescribing, which then impact the decisions of which opioid therapy would be most appropriate.

Following the prescribing of opioids, inadequate monitoring occurred in 50 percent of cases. Routine patient monitoring is an essential component of opioid therapy and should be done to assess the need to continue therapy, patient compliance with treatment, and the efficacy of the medication.

| | |
|---|---|
| Selection/management of most appropriate medication regimen | 55%* |
| Inadequate patient monitoring | 50% |

MedPro Group + MLMIC opioid-related office-based cases opened 2013-2023 (N=203); *% of case volume

# Additional Contributing Risk Factors



Patient non-adherence to medication regimens is often associated with suboptimal education provided to patients/families about the importance of adhering to medication regimens as prescribed.

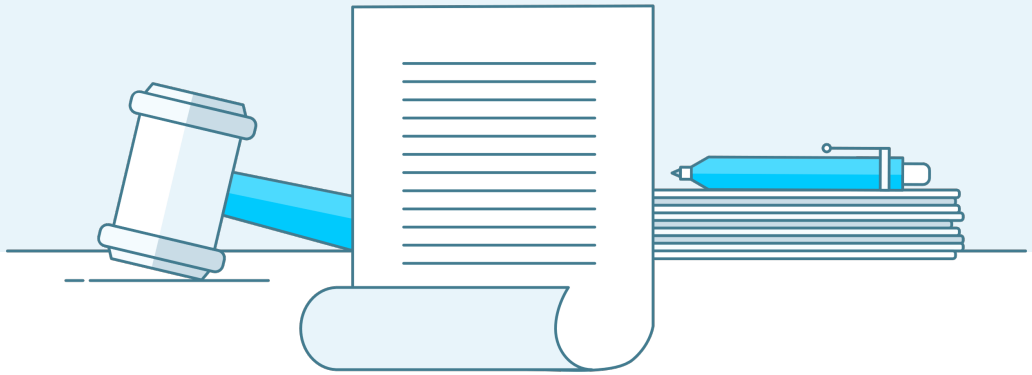
Insufficient documentation is also a critical risk factor. For patients who are receiving opioid treatment, providers should diligently document all patient assessments (including clinical rationale that supports treatment choice), any communication with the patient, verbal and written patient education, monitoring efforts, and patient compliance with the treatment regimen. Robust documentation practices can aid in the defense of malpractice actions.

| | |
|---|---|
| Patient non-adherence to prescribed medication regimen | 34%* |
| Insufficient patient/family education about medication regimen | 30% |
| Insufficient documentation | 21% |

MedPro Group + MLMIC opioid-related office-based cases opened 2013-2023 (N=203); *% of case volume

# Case Examples





## The following stories are reflective of the allegations and contributing risk factors which drive opioid-related office-based cases.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

# Case Examples



**SETTLED**

**$995K**

**RESPONSIBLE SERVICE**

Family medicine

**KEY CONTRIBUTING FACTORS**

Patient non-adherence to treatment regimen

Inadequate monitoring of opioid regimen

Failure to provide referral to pain medicine specialist

Failure to read patient's medical record

Insufficient documentation of plan of care

IMPROPER MANAGEMENT OF OPIOID REGIMEN RESULTING IN OVERDOSE AND DEATH

A female patient in her mid-30's presented for treatment at an internal medicine practice, reporting increasing migraine episodes, anxiety, and knee pain. Along with migraine medications, the physician prescribed hydrocodone to help her manage the knee pain until an MRI could be performed.

A follow-up visit was scheduled for six weeks, but the patient did not return for five months. At that time, she had the MRI performed, was referred for an orthopedic consult, and was prescribed oxycodone and prednisone to manage the knee symptoms (hydrocodone was discontinued).

Over the next several weeks, suspicious of drug-seeking behavior, the internal medicine physician began ordering toxicology screens as a condition of filling opioid prescriptions. The patient's results were sometimes negative for opioids, but always positive for alcohol. After two failed tests, the physician refused to prescribe any additional opioids.

The patient then sought care from a family medicine physician (from the same health network) who resumed the opioid prescriptions, despite multiple failed toxicology screens in that office.

Within three weeks after the last prescription was provided, the patient was found dead at home, with the cause of death listed as multiple drug intoxication.

During defense of the subsequent malpractice case, many conflicting details were found in the family medicine physician's chart documentation. It was also discovered that the patient was receiving opioids from numerous emergency department visits, and from her gynecologist. In the family medicine chart, there was often no pain level documented, or any notes related to examination of her knee. There was no documentation of drug counseling, no referral to a pain medicine specialist, and no explanation of why the opioid prescriptions were renewed (the family medicine physician claimed that he never saw the "no more opioid prescription" note from the internal medicine physician in the electronic chart).

# Case Examples



**SETTLED**

**$350K**

**RESPONSIBLE SERVICE**

Physical/Rehabilitation medicine

Internal medicine & Neurosurgery as secondarily responsible

**KEY CONTRIBUTING FACTORS**

Patient non-adherence to treatment regimen

Inadequate monitoring of opioid regimen

Failure to provide referral to pain medicine specialist

Suboptimal communication among providers on the patient's care team

Insufficient supervision of non-physician staff

IMPROPER MANAGEMENT OF OPIOID REGIMEN RESULTING IN OVERDOSE AND DEATH

A male patient in his late 50's, with a history of chronic back pain, had been under the care of a physical medicine office practice, primarily with a physician assistant, for years. As time went on, epidural injections were no longer effective, and several opioids were added to his pain management regimen.

The patient ultimately underwent back surgery at L5-S1 which improved his pain. He then wanted to wean off of the opioid medications, but went into withdrawal symptoms, and began drinking alcohol as a coping mechanism.

He was admitted to the hospital for management of withdrawal symptoms, and then discharged with opioid prescriptions and a medication for anxiety to hold him over until his next office appointment three days later. During that appointment, the physician assistant discussed the plan for weaning off of the opioids with the patient and his wife. The patient agreed to let his wife schedule and dispense his medications and to follow-up in two weeks after seeing the spinal surgeon. Opioid prescriptions were renewed.

One week later, the patient was found dead at home. Autopsy results indicated the cause of death to be poly-drug intoxication. After the patient's death, it was discovered that he had also been diagnosed with obstructive sleep apnea, and had also been receiving opioid prescriptions from both his primary care provider (internal medicine) and his neurosurgeon.

Expert reviews were critical of the failures of all providers to ensure the signing of pain medicine 'contracts' with the patient, to perform toxicology screens, and to access available state prescription drug records.

# Risk Mitigation Resources



These pain management-related resources were curated from MedPro's publications.

- Checklist for evaluating risks in pain management approaches
- Strategies and considerations for opioid prescribing
- Patient agreements in clinical practice
- The Opioid Epidemic: continuing education webinar
- Industry resources related to opioid prescribing and pain management

Find additional helpful resources online at www.medpro.com/dynamic-risk-tools, and follow us on LinkedIn and X/Twitter (@MedProProtector).

# MedPro Group & MLMIC Data

**MedPro and MLMIC are partnered with Candello,** a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

**Derived from the essence of the word candela**, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

**Using Candello's sophisticated coding taxonomy to code claims data**, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

**Leveraging our extensive claims data**, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.