The Prescription Drug Challenge

**Trends, Tools & Tips to Manage this Complex and Costly Area of Workers Comp**

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Objectives

1. Current work comp environment
2. Modern challenges
3. What role does a PBM play?
4. Good claim gone bad
5. What you should be doing
Moving target:

CURRENT WORKERS' COMP ENVIRONMENT
Pharmacy Costs and Workers’ Compensation

- Pharmacy costs in workers’ compensation account for approximately 19% of the total medical expense.
- For claims 1- to 2-years-old, prescription costs make up about 3% of total medical costs, and more than 40% of total medical costs for claims more than 11 years old\(^1\)
- 9% of patients who receive medications account for 78% of the pharmacy costs\(^2\)

\(^1\) NCCI Prescription Drug Study: 2011 Update
\(^2\) Healthesystems 2009 Drug Trends Data
Opioids in Current Workers' Comp Environment

- Opioids are prescribed mostly for back injury
  - 423% increase for opioids for back pain in the past 10 years
  - Over 32% of opioid prescriptions are for back injury claims
  - Most are inappropriate
- Prevalence of opioid use early in the life of a claim is increasing
- Share of opioid prescription costs per claim increases as claim ages
The 5-Year Mark

- Claims with Opioid Drugs; 2010

**% of Cost by Age of Claim**

- 74% (72 Months +)
- 9% (60 Months)
- 6% (36 Months)
- 6% (24 Months)
- 5% (12 Months)

75% of Spend on Claims > 5 years

**Claim Count by Age of Claim**

- 40% (12 Months)
- 15% (72 Months +)
- 11% (36 Months)
- 10% (60 Months)
- 10% (24 Months)

75% of Claims < 5 years

- Early Intervention Can Be Key
The challenges we face:

HARD-HITTING ISSUES IN WORKERS’ COMP
Opioids

- Clinical trials and current guidelines question the long-term effectiveness of opioids.
- Prescribing decisions made early in the course of therapy often have profound implications.
- Without monitoring, patients are unlikely to be adherent to prescribed therapy.

“"The United States makes up only 4.6 percent of the world's population, but consumes 80 percent of its opioids -- and 99 percent of the world's hydrocodone" - INCB report, 2010
Opioids and the Workers’ Comp System

• “When opioids are presented in a claim, there is a 322% greater likelihood for litigation, a 264% greater likelihood for lost time from work and a 38% chance that the claim will remain open longer and incur additional costs.” - CWCI research on narcotic usage in California’s work comp system

• “Temporary Disability Claimants treating with opioids average 105 paid days off in contrast to the average of 30 days when narcotics are not prescribed.” - Roberto Ceniceros, Business Insurance

• “Claimants that received the highest narcotic dosage levels had 200% higher medical costs than claimants receiving lower dosages.” - CWCI research on narcotic usage in California’s work comp system
• What is MED and how do the strengths of opioids differ?

The MED scale presented represents approximations of doses compared to a standard reference, morphine. It is not intended to imply exact dose conversions. Route of administration for comparison is oral. Other routes of administration and differences in dosages could significantly change the estimation.
Risk of Chronic Opioid Use

- Opioid users with treatment > 90 days are 700% more likely to be using after 400 days.
- Injured workers with opioid use >90 days showed 11x to 14x greater odds of having chronic work loss compared to non-opioid users.
- Breakdown of opioid users (percent of overdoses):
  - 80% with MED ≤ 100mg, one prescriber (20%)
  - 10% with high doses (MED ≥ 100mg), one prescriber (40%)
  - 10% with high doses, multiple prescribers (40%)
- 76% of drug abusers receive meds from someone else.
2nd largest driver of workers’ compensation costs after opioid use

Per pill charges at several hundred percent more than identical medications from pharmacy

Minnesota has several barriers to physician dispensing
Physician dispensing

“Pros”
- Increased patient compliance
- Convenience
- Initiate treatment immediately

“Cons”
- Increased risk to patient health and safety
- Increased cost due to overcharging
- Overutilization of key medications
- Lack of visibility
Compounds

- What does “compound” mean to work comp?
  - Topical cream or ointment
  - “Custom” prepared at a pharmacy
- Why are these a problem?
  - Many of these drugs don’t work topically
  - There is no safety information on these
  - The concentrations used have no support from medical studies
  - There is no control on the preparation like there is with FDA-approved products
  - The costs are unreasonable
Compounds

Common ingredients:
- Baclofen, ketamine, diclofenac, lidocaine, prilocaine, menthol, capsaicin, cyclobenzaprine, gabapentin, tramadol

Private label compounds
- Terocin Lotion
- Medrox Ointment/Pad
- Dendracin Neurodendraxin
- Medi-Derm cream
## Ingredient Comparisons

<table>
<thead>
<tr>
<th>Private Label Products</th>
<th>Price per 1 ounce*</th>
<th>Comparable OTC Products</th>
<th>Price per 1 ounce*</th>
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<tbody>
<tr>
<td><strong>Dendracin Lotion</strong></td>
<td>$110.00</td>
<td>Ziks cream</td>
<td>$5.00</td>
</tr>
<tr>
<td>Methyl Salicylate 30%</td>
<td></td>
<td>Methyl Salicylate 12%</td>
<td></td>
</tr>
<tr>
<td>Menthol USP 10%</td>
<td></td>
<td>Menthol USP 1%</td>
<td></td>
</tr>
<tr>
<td>Capsaicin 0.0375%</td>
<td></td>
<td>Capsaicin 0.025%</td>
<td></td>
</tr>
<tr>
<td><strong>Medrox patch/pad</strong></td>
<td>$29.00</td>
<td>Salonpas pain relieving</td>
<td>$0.10 to $0.50</td>
</tr>
<tr>
<td>(Price per patch/pad)</td>
<td></td>
<td>patch</td>
<td></td>
</tr>
<tr>
<td>Methyl Salicylate 20%</td>
<td></td>
<td>Methyl Salicylate 6.3%</td>
<td></td>
</tr>
<tr>
<td>Menthol USP 5%</td>
<td></td>
<td>Menthol 5.7%</td>
<td></td>
</tr>
<tr>
<td>Capsaicin 0.0375%</td>
<td></td>
<td>Camphor 1.2%</td>
<td></td>
</tr>
</tbody>
</table>

*Price per ounce is retail or billed pricing rounded off to simplify, unless otherwise indicated. The differences in strengths are likely insignificant from a clinical perspective as these agents are considered minimally or inconsistently effective.
Polypharmacy

- 3 to 5 or more different medications taken by a patient at the same time
  - Workers’ compensation medications + medications for non-work-related conditions
- Rational polypharmacy may be appropriate
  - Disease symptoms, multiple illnesses, to augment another drug
- Inappropriate polypharmacy can result in serious harm
  - Medications used to treat side effects
  - New adverse effects
  - Drug-drug interactions
  - Drug/disease interactions

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The Cost of Polypharmacy

- If early detection and clinical intervention do not occur, instances of polypharmacy can quickly grow out of control.

- Polypharmacy costs can certainly add up:
  - delayed return to work
  - dangerous drug/drug interactions
  - incorrect dosing

- Clinical intervention can lead to:
  - Decreased drugs
  - Improved patient outcomes
  - Increased safety
  - Reduced costs
Finding solutions:

WHAT ROLE DOES A PBM PLAY?
Who are some of the key stakeholders?

- Claimant
- PBM
- Clinical Pharmacist
- Claims Professional
- Prescribing Physician(s)
- Employer

PBM Clinical Role:

- Drug plan review and analysis
- Disease management
- Prospective and retrospective drug utilization review
- Early detection and intervention
- Physician outreach and consultation
- Clinical outcomes measuring and reporting
Value of PBM Monitoring

Inappropriate Medication Therapy:

- Therapeutic duplications – two drugs from the same class used together
- Duration of therapy – exceeds maximum recommended time
- Dosing concerns – max dose exceeded, sub-therapeutic dose
- Polypharmacy – use of more medications than clinically appropriate
- Medication lacking indication – diagnosis doesn’t match drug
- Indicators of fraud, abuse, & diversion
  - Brand name preference
  - Early fill trends
  - Suspect medication combinations
- Multiple prescribers and multiple pharmacies
Outcomes of Inappropriate Medication Therapy:

- Dangerous drug-drug interactions/Risk adverse effects – excessive sedation, respiratory depression, suicidal ideation, serotonin syndrome, heart problems
- Delay in returning to work
  - Loss of self-worth, Loss of sense of purpose
- Increased Pharmacy and Medical Costs

Claims with Multiple Prescribers see:

- 5.9x higher annual cost for all prescriptions
- 6.1x higher annual opioid prescription cost
- Nearly 3x as many prescribers
- Nearly 4x as many pharmacies annually
Putting it into perspective:

GOOD CLAIM GONE BAD
Sample Case Study

- Claimant case overview:

  **Patient Profile**
  - **Age:**
    - 32 years old
  - **Sex:**
    - Male
  - **Occupation:**
    - Construction worker

  **Accident Overview**
  - **Accident Year:**
    - 2007
  - **Accident Description:**
    - Injured his back falling off scaffolding from a height of 5 feet.
Drug Treatment Timeline

- **2007**
  - Acute
    - Oxycontin
    - Opana
    - Prevacid
    - Gabapentin
    - Ambien
    - Amitriptyline
    - Soma
    - Sentra AM & PM
    - Theracodophen

- **2008**
  - 1 to 3 Months
    - Hydrocodone/APAP (Vicodin eq.)
    - Ibuprofen (NSAID)
    - Prevacid (PPI)
  - 24 Months
    - Oxycodone IR
    - Hydrocodone/APAP
    - Ibuprofen/Prevacid
    - Fioricet (for headaches)
    - Flexeril (muscle relaxant)

- **2009**
  - Chronic
    - 36 Months
      - Oxycontin
      - Opana
      - Prevacid
      - Gabapentin
      - Ambien
      - Amitriptyline
      - Soma
      - Sentra AM & PM
      - Theracodophen

- **2010**

- **2011**

- **2012**

- **60 Months**
  - Exalgo
  - Opana
  - Cymbalta
  - Amitriptyline
  - Trazodone
  - Imitrex
  - Xanax
  - Soma
  - Ambien

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What indicators were missed?

1 to 3 Months
- Hydrocodone/APAP (Vicodin eq.)
- Ibuprofen (NSAID)
- Prevacid (PPI)

Duplicate therapy by different prescribers

24 Months
- Oxycodone IR
- Hydrocodone/APAP
- Ibuprofen/Prevacid
- Fioricet (for headaches)
- Flexeril (muscle relaxant)

MED > 400mg (Morphine Equivalent Dose)

36 Months
- Oxycontin
- Opana
- Prevacid
- Gabapentin
- Amitriptyline
- Soma
- Imitrex
- Xanax

60 Months
- Exalgo
- Opana
- Cymbalta
- Amitriptyline
- Trazodone
- Imitrex
- Xanax
- Soma
- Ambien

190mg MED (Morphine Equivalent Dose)
PPI continued w/o indication

Interacting Medications

Medical Foods

Masking symptoms of serotonin syndrome?

Multiple Brand Drugs
What you should be doing:

TOOLS FOR MANAGING DRUGS & SPEND
Physician dispensing and compound medications

- Ensure injured worker is provided with information on pharmacy network
- Be vigilant in monitoring trends
  - Which drugs are driving the cost?
  - Who is prescribing and dispensing the medication?
- Stay informed on state laws & regulations

Opioid utilization and appropriate use

- Are the following in place?
  - Narcotics contract - single practitioner, single pharmacy and documented compliance
  - Patient screening - addiction profile and/or psychological profile
  - **OBJECTIVE** documentation – pain level, improvement in function, side effects
  - Urine drug screen, office pill counts
  - Prescription Drug Monitoring Program
Red Flags of Opioid Use

- Lack of objective findings
- Physician treating solely on subjective complaints
- Rapid increase in the amount of medication needed
- Early refills
- Treating with multiple physicians
- Utilizing multiple pharmacies
- Inconsistent Prescription Drug Monitoring Report
- Aberrant UDS results
  - No indication of drugs prescribed
  - Drugs prescribed plus additional drugs
  - Drugs not being prescribed
What YOU can do: questions to ask

**PBM**
- Are patients receiving evidence-based treatment?
- How often are generic or lower-cost drugs being used as a first-line therapy?
- What about physicians who unnecessarily prescribe new or expensive drugs?
- Are medications being used off-label or inappropriately?
- What are the limits on physician office dispensing?
- What are areas of prescriber education, intervention, and outreach?

**Claims Administration**
- What processes are in place to help early detection of inappropriate drug utilization?
- What processes are in place to detect indications of fraud or abuse?

**Utilization Review**
- How are evidence based guidelines incorporated into drug regimen reviews?
Resources

- Federation Model Guidelines
- American College of Occupational and Environmental Medicine
  www.acoem.org/Guidelines.Opioids
- Washington State Guidelines
  www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/Opioids.pdf
- Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain
  http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf
- Opioid Dose Calculator
  www.agencymeddirectors.wa.gov/guidelines.asp
Thank You