

MITIGATING COST DRIVERS IN WORKERS' COMPENSATION

Integrated Case Management Works!



Agenda

- 1 Current trends in WC – What about the PPACA?
- 2 Predictive Analytics
- 3 Co-morbidities
- 4 Obesity
- 5 Aging Workforce
- 6 Antibiotic Resistance
- 7 Controlled Prescription Drugs
- 8 Physician Dispensing
- 9 Compounded Medications



PPACA

Will there be an impact on workers' compensation?

The Patient Protection and Affordable Care Act

Only direct impact on w/c – changes to the Federal Coal Mine Black Lung Program – liberalized qualifying for benefits. PPACA is a major reorganization of the healthcare industry – no one knows impact for sure

- ✓ No specific language in the law that directly or explicitly affects w/c
- ✓ Cost Shifting – In the past if a patient did not have health insurance, costs may have shifted to w/c, and in the industry at MMI costs shifted from w/c to Medicare¹
- ✓ Reform may account for a 5% - 10% decline in WC ER bill volume²
- ✓ May lead to federalization of w/c system³
- ✓ Wellness Programs
- ✓ EBM protocols
- ✓ DME

¹ Dean Hashimoto MD, JD August 2013 WCI

² Rand Institute – "The impact of Health Care Reform on W/C Medical Care" 2012

³ According to Steve Schmutz, Founder of Claimwire.com

PPACA (cont.)

Will there be an impact on workers' compensation?

The Patient Protection and Affordable Care Act (cont.)

- ✓ Consolidation of healthcare
- ✓ Inadequate supply of primary care doctors
- ✓ Use of PAs and Nurse Practitioners.
- ✓ Quality of care
- ✓ Employers are learning the value

PPACA (cont.)

Will there be an impact on workers' compensation?

The Patient Protection and Affordable Care Act (cont.)

- ✓ A Central part of ACA is creation/expansion of Accountable Care Organizations (ACO)
- ✓ An ACO is a network of doctors and hospitals that shares financial and medical responsibility by providing patients with coordinated services
- ✓ Financial responsibility => paid more if ACO meet quality metrics at lower cost
- ✓ Cost => total cost for a group of patients (at least 5,000)
- ✓ Explicit goal of ACA: increase # of patients covered by "capitated" payment plans

Financial Incentives Facing ACOs: An Illustration

Fee for Service GH Insurance Plan

- ✓ Worker seeks care for back pain
- ✓ If not work related, provider paid fee for service by GH insurer
- ✓ If work related, provider paid fee for service – often higher prices by WC insurer (less any PPO discounting available)

Capitated GH Insurance Plan

- ✓ Worker seeks care for back pain
- ✓ If work related, provider paid fee for service by WC insurer
- ✓ If not work related, provider has already been pre-paid for care

If you have any question as to causal relationship of the claim, would you use a capitated group?



Predictive Modeling
*or fondly referred to as Prescriptive
Analytics Modeling*



Predictive Modeling

- Predictive modeling is a process used in predictive analytics
- A predictive model is made up of a number of predictors, which are variable factors that are likely to influence future behavior or results. In marketing, for example, a customer's gender, age, and purchase history might predict the likelihood of a future sale
- Predictive modeling is essentially a way to forecast or predict a higher likelihood of certain events occurring
- Industry Use: Medical, Insurance, Weather, Banking

Source: Presentation at the WCI in FL August 2012

What is Predictive Modeling in the Workers' Compensation Setting?



- Utilization of data to predict increased recovery time as it relates to age, type of work, and preexisting conditions
- Allows factual determination of projected Return to Work dates
- Allows factual projections of increased recovery time
- Allows for more accurate setting of reserves

What does Predictive Modeling take into account?



- Medical Factors
- Co-Morbidities
- Employee Attitude
- Workplace Environment
- Psychosocial Factors
- Other External Contributors

What are Co-morbidities?



- **Underlying health conditions that afflict millions of American workers every year**
 - ✓ Diabetes, heart disease, obesity, and HTN are just a few of the personal medical conditions that influence the outcome of a w/c case. (HTN most prevalent)
- **Often the claims professional may not learn of the IW's comorbidity until treatment begins**
 - ✓ Initial comorbidity diagnosis tends to occur early in the life of the claim
 - ✓ Only a small portion of visits to the doctor or hospital result in the recording of a comorbidity diagnosis
 - ✓ This data is infrequently reported on by the treating Dr. Many times the doctor will say, "Why report it? Do you plan to act on my findings?"

Medical Factors/Co-morbidities



- Obesity
- Diabetes
- Hypertension
- Smoking

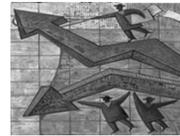
Co-morbidities
So Why Care about Cost Drivers in W/C?



The share of workers compensation claims with a comorbidity diagnosis nearly tripled from Accident Year 2000 to Accident Year 2009

- ✓ Growing from a share of 2.4% to 6.6%
- ✓ CDC
- ✓ Claims with a comorbidity diagnosis
- ✓ Workers with comorbidities

Co-morbidities
So What Can You Do?



- Be proactive
- Nurse case management
- Quickly address minor injuries
 - ✓ Use of a 24/7 Nurse Triage program can be instrumental in ensuring your IW is assessed early and appropriately
- Consider implementation of a wellness program at work

Employee Attitude/ Workplace Environment



- Pain catastrophizing, Unhelpful beliefs and expectations
- Preoccupation with health, worry, distress, fear of movement
- Uncertainty about the future, extreme symptom reporting, Passive coping

- Fear of injury, Low expectation of resuming work, high physical job demand (perceived or actual)
- Low job satisfaction, low social support, or social dysfunction in workplace
- Lack of job accommodations/modified work
- Lack of employer communication with employees

Ways Predictive Modeling Can Change Claims Strategies



- **Second Set of Eyes**
 - Your Case Manager is an invaluable resource
 - Your CM company should provide comorbidity information and its impact on benchmarking
- Keeping a tighter diary on claims that are flagged
- Arm your insured with Information
 - Can make better informed decisions
 - More emphasis on RTW
- Helps to identify Red Flags
- Helps to identify problem cases more effectively
- Predictive Modeling does not take the place of good solid claims handling, but it does help the adjuster make educated decisions, based on facts, and set more accurate reserves!

Examples of Benchmarking Using the ODG



HERNIA REPAIR

Without surgery (truss), light work: 0 days

With endoscopic surgery, clerical/modified work: 7 days

With endoscopic surgery, manual work: 14 days

With endoscopic surgery, heavy manual work: 28 days

With open surgery, clerical/modified work: 14 days

With open surgery, manual work: 21-28 days

With open surgery, heavy manual work: 42-56 days

With open surgery, bilateral, heavy manual work: 42-56 days

Additional time to re-do hernia repair: 14-28 days

Co-morbidities of obesity, smoking, and hypertension for a 50 yr old male in the state of IL can extend length of disability by 30 days.

Examples of Benchmarking Using the ODG



ROTATOR CUFF REPAIR

Arthroscopic surgical repair/acromioplasty (Grade III¹), clerical/modified work: 28-56 days

Arthroscopic surgical repair/acromioplasty, manual work, non-dominant arm: 56-90 days

Arthroscopic surgical repair/acromioplasty, manual work, dominant arm: 70-90 days

Open surgery (Grade III), clerical/modified work: 42-56 days

Open surgery, manual work, non-dominant arm: 70-90 days

Open surgery, manual work, dominant arm: 90-106 days

Open surgery, heavy manual work if cause of disability: 154 days

Co-morbidities for a woman in her 40s with a shoulder surgery? Obese, anxiety, arthritis? Increased by 83 days.

Your employees are how you find them



"You've been sick before, so getting sick is a preexisting condition."

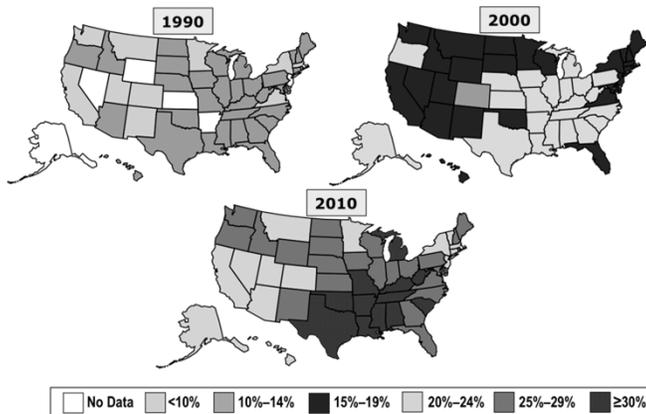
Obesity



"They revised the Food Pyramid again."

Obesity

Costs & Implications

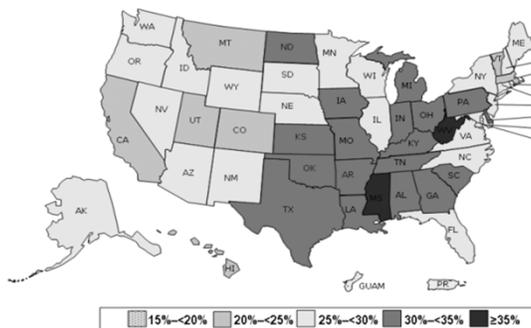


Obesity

Costs & Implications



Prevalence* of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2013



Source: Behavioral Risk Factor Surveillance Systems, CDC.

Obesity

Costs & Implications



- The AMA reclassified obesity as a disease in 2013
- In a recent Duke University Study of WC claims they found the medical costs for obese employees are nearly 7 times more expensive than employees of recommended weight!
- It is anticipated by 2030 there will be a 33% increase in the incidence of obesity!
- A NCCI study of matched pairs (exact claim types – except one is obese and one is recommended weight) reveals in the aggregate obese claims are 2.8 times more expensive than non-obese claims. Per Finkelstein obesity accounts for 10% of all medical spending and could amount to \$147 billion in 2008. This is about twice the amount in 1998.
- In regards to W/C - obese employees filed twice as many claims, had 13 times as many lost workdays and their medical and indemnity costs were 7 and 11 times as high, respectively.

Obesity

Costs & Implications – (cont.)



- In an NCCI study – they researched the effect of obesity on reserving a claim
- Variables within this study were gender, length of time the claim is open, age of the employee and legal climate of a state (i.e., do they have bill/utilization review)
- Findings
 - ✓ Effect of obesity on the medical cost/claim is substantial
 - ✓ The entirety of the effect reveals itself over time as claims mature
 - ✓ The study quantified the effect of the legislative environment on the effect of obesity on claim costs

Obesity

Which diagnoses are most impacted?



- Examples of diagnoses with higher costs for obese employees
 - ✓ Orthopedic injuries especially those affecting ambulation
 - ✓ Lumbar disc displacement with myelopathy - the obese claim had complex surgeries and hospital charges
 - ✓ Tear medial meniscus of knee
 - ✓ Sprain of shoulder, cervicalgia
 - ✓ Obesity increases the healing time for fractures, strains and sprains
 - ✓ Sprain Lumbar Region
 - ✓ Obesity complicates surgery

Obesity

How to mitigate cost driver?



- Employing Bill Review and Utilization Review
- CM should always obtain information about BMI
- Utilizing Case Management on morbidly obese claims may show a positive ROI
- Your CM should utilize a co-morbidity calculator that will assist with determining expected increases in lost time due to obesity, gender, location, etc.
- It will be important for the Case Manager to be aware of
- Primary cost drivers on these types of claims are physical therapy, complex surgery, drugs and supplies

The Aging Workforce



Why the increase in older workers?

- ✓ Longer Life expectancies
- ✓ Enjoy working and being productive
- ✓ Stock market plunge
- ✓ Decline in home prices
- ✓ Life savings severely depleted – the idea of a “normal retirement” is now more wishful thinking than achievable reality
- ✓ In one sense, all workers are aging workers
- ✓ The number of older workers continuing to work full time is on the increase (now 77%)

Aging Workforce

What are the challenges and opportunities?



- It is anticipated the costs will continue to increase as numbers of older workers increase. Between 1977 and 2007 employment of workers over 65
- The increase in numbers do present both challenges and opportunities
- Challenges include
- Opportunities involve taking steps to reduce the risks in the workplace for older workers

Aging Workforce

What are the challenges and opportunities?



- Older employees are more adversely affected by the secondary effects of their injuries
- Some fractures, such as a hip fracture might result in forced immobilization and surgery
- Medical co-morbidities such as diabetes, osteoporosis, and obesity are also more common in older employees, increasing a person's risk for injury or illness
- All of these factors contribute to longer times away from work and the potential for slower recovery for older employees

Aging Workforce

Costs and Implications



- Claims - Falls, slips and trips are by far the greatest cause of injury among older workers (47%) , Strains (23%)
- Indemnity and medical payments – Workers 55 and older experience a median of 12 lost work days for an injury, twice the amount for a worker aged 20 – 24
- Compensability following an injury may also be harder to determine

Aging Workforce

Resources Available



Total Worker Health – The TWH approach advocates for a holistic understanding of the factors that contribute to worker well-being

- Keeping workers safe is the foundation upon which a TWH approach is built
- In June 2011, NIOSH launched the TWH program

What is Productive Aging?

- An approach that emphasizes the positive aspects of growing older
- In the context of work – providing a safe and healthy environment for everyone that allow workers to function optimally at all ages

Aging Workforce

A Life-Span Perspective



The aging process involves both losses and gains

- As workers age, some dimensions of functioning decline, while others improve

The aging process is characterized by plasticity

- The potential to change is relational to one's experiences. A growing body of evidence indicates the rate of change (e.g. physical functioning) can be affected by specific activities (e.g. regular exercise)

Aging Workforce

A Life-Span Perspective



The aging process is multidimensional

- Three basic dimensions of the aging process are biological, cognitive and socio-emotional

The aging process is contextual

- The changes that occur as workers age do not take place in a vacuum

Aging Workforce

A Life-Span Perspective



- A life-span perspective assumes the aging process is complex and that two workers of the same chronological age may differ greatly when it comes to functional capacity, health, job performance and work motivation
- The changes that occur with aging are often manageable, particularly if intervention efforts begin early in the working life

Aging Workforce

How to mitigate cost driver? Total Worker Health



Working Conditions – Ergonomics, Industrial Hygiene & Safety

- Consider use of Job Analysis with Video to assist with RTW
- Consider use of Ergonomic Analysis in areas that have many older workers to assist with injury prevention. These interventions are beneficial for all employees.
 - ✓ Enhance lighting (50% greater than for younger workers)
 - ✓ Install slip-resistant flooring, repair uneven surfaces
 - ✓ Handrails, Increased contrast for stair edges and curbs
 - ✓ Reduce clutter
 - ✓ Noise dampening materials (e.g. on the factory floor)
 - ✓ Use mechanical assist devices, such as hoists or jacks to reduce awkward lifts
 - ✓ Organize work to minimize lifting and carrying
 - ✓ Relocating items from floor to waist level
 - ✓ Remove barriers that prevent access to needed materials and tools
 - ✓ Training to keep the load close to the body when lifting or carrying
 - ✓ Intersperse periods of lifting with periods of rest
 - ✓ Training to avoid awkward postures

Aging Workforce

How to mitigate cost driver? Total Worker Health



Employee Health – Healthy Lifestyles, functional capacity

- ✓ Wellness and exercise programs, Reduce physical stresses on the body – Consider a personal coaching type intervention
- ✓ Information and support for common health problems that may affect older workers
- ✓ These type of interventions can be suggested to be implemented outside of the normal costs for an individual claim – to be borne by the individual employers and can lower overall costs

Aging Workforce

Strength – The new vital sign



- Research has shown that loss of muscle mass, muscle strength and loss of muscle with weight gain all increase with age
- PT
- Ensure ongoing attendance at all scheduled PT visits, maintain close contact with the physicians regarding treatment plan and any prescribed medications
- Goal should be to RTW as quickly as medically appropriate and to prevent re-injury
- Seek out high-performing doctors, identify specialists needed early on and follow evidence based guidelines for treatment
- Maintain proper body weight, being overweight strains back muscles

Aging Workforce

How to mitigate cost driver? Total Worker Health



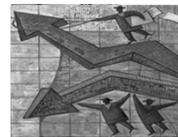
Professional Skills – Job-Related Knowledge and Competence

- ✓ Ongoing training – as older workers are most distant from their initial professional and job training.

Psychosocial Factors – Work Arrangements and Flexibility, Social Support and Culture

- ✓ Creating a supportive culture that involves better understanding of the generational composition of your workforce
- ✓ Developing a set of programs and policies that are broad enough to address the needs of all workers throughout the working life (e.g. family leave policies that appeal to both younger and older workers) and encourage positive interactions between different age cohorts (e.g. mentoring programs).
- ✓ EAP as a resource to assist in employee needs related to aging, elder care support, plan for retirement or outplacement, and address substance abuse and emotional distress

Antibiotic Resistance



- ✓ In 2012 there were about 450,000 new cases of multi-drug resistant TB
- ✓ High proportions of antibiotic resistance in bacteria that cause common infections (UTI, pneumonia, bloodstream infections)
- ✓ Treatment failures due to resistance to treatments of last resort for gonorrhea have now been reported in 10 countries. Gonorrhea may soon become untreatable as no vaccines or new drugs are in development
- ✓ Patients with infections caused by drug-resistant bacteria are generally at increased risk of worse clinical outcomes and death, and consume more healthcare resources than patients infected with the same bacteria that are not resistant

Antibiotic Resistant Infections

How to mitigate cost driver?



- In severe or multi-trauma injuries with open wounds
- Key is prevention and aggressive treatment
- Wound management is imperative
- Watch for documentation of MRSA
- Case Manager to provide teaching on completing full course of antibiotics, even if they feel better
- Case Management can coordinate IME or UR

Controlled Prescription Drugs



© 2009 by Randy Glasbergen.
www.glasbergen.com



**“This program is brought to you by pills! Red pills, blue pills,
green pills, purple pills, pink pills! Pills, pills, and more pills!
Ask your doctor if pills are right for you!”**

Statement and Introduction to the Opioid Crisis



- **Controlled Prescription Drugs**
 - The threat from CPD abuse is persistent
 - Annual economic cost of nonmedical use estimated at more than \$53 Billion in 2011
 - Lost productivity and crime account for most of these costs
 - 21.5% of national law enforcement agencies responding to the 2014 National Drug Threat Survey reported CPDs as the greatest drug threat (up from 9.8% in 2009)
 - Opioid analgesics are the most common type of CPD abused
 - Nearly 1.2 million dosage units of oxycodone were seized by law enforcement in 2013, up 535% from 2012

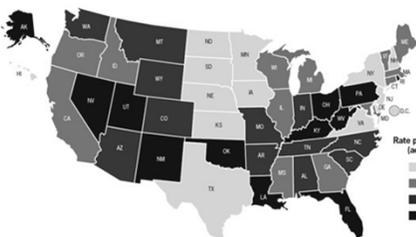
Statement and Introduction to the Opioid Crisis



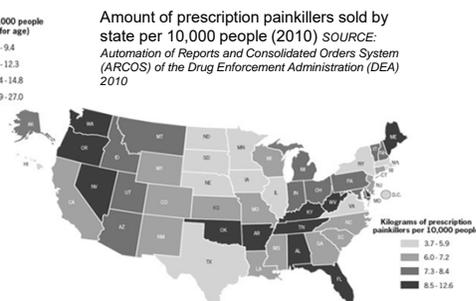
- **Controlled Prescription Drugs**
 - According to the National Survey on Drug Use and Health, while the number of people reporting non-medical use of CPDs has increased, the statistical rate has remained relatively steady
 - 6.8 million people aged 12 or older were current nonmedical users of psychotherapeutic drugs – 11.5% higher than reported in 2011
 - This included 4.9 million users of pain relievers and 2.1 million users of tranquilizers
 - CPDs are increasingly the first drug abused by initiates of illicit drug abuse
 - In 2012, an estimated 2.9 million persons aged 12 or older used an illicit drug for the first time
 - More than 1 in 4 initiated with nonmedical use of prescription drugs, second only to marijuana

Prescription Drug Use

Drug OD death rates compared to prescription painkillers



Drug overdose death rates by state per 100,000 people (2008) SOURCE: National Vital Statistics 2008



Prescription Drug Use

Common Opioids



	Trade Names
Codeine	Tylenol #3, Tylenol #4, Fiorinal #3
Hydrocodone	Vicodin, Vicoprofen, Lortab, Lorcet, Norco
Hydromorphone	Dilaudid
Morphine	MS Contin, Roxinal, Avinza
Oxycodone	Percocet, Roxicet, Endocet, Percodan, Oxycontin
Propoxyphene	Darvocet, Darvon
Methadone	Dolophine, Methadose
Fentanyl	Alfenta, Sufenta, Ultiva, Actiq

Prescription Drug Use

How did this issue develop?



Since the mid 1990s the standards for pain treatment have changed significantly, moving from historically undertreating pain to the perception of “no ceiling dose” in pain management.

At one point in the 80’s and 90’s, physicians were told by the drug companies that their patients could not get addicted to narcotic analgesics

Also physicians were told that patients who develop physical dependence on opioids can easily be tapered off

Prescription Drug Use

Costs and Implications in Workers' Compensation



- The average cost of claims without opioids is \$13,000, with a short acting opioid (e.g., Percocet) is \$39,000 and with a long-acting opioid is \$117,000 (900% of average)
- 19% of w/c medical costs are related to prescriptions
- Physicians are also prescribing more expensive drugs
- Narcotics account for nearly 30% of all WC Rx costs¹
- With all of the increased use of narcotics for pain relief, there has been no decrease in the amount of disability!
- The claims cost while enormous seems small in comparison to the human costs!

¹ *Express Scripts 2014 W/C Drug Trend Report*

Prescription Drug Use

Costs and Implications in Workers' Compensation



- Few members of the medical community would dispute use of narcotics to treat severe, chronic, cancer-related pain
- Currently the FDA and many states are in the process of establishing a federal and state-level programs to ensure the safe, appropriate use of narcotics.
- High cost narcotics are a greater portion of the mix of medications prescribed as claims age
 - ✓ They are a relatively small portion (9%) of narcotics prescriptions in the first service year and increase to 45% of all narcotic prescriptions in the 12th year.
 - ✓ Though fentanyl is <3% of all narcotics prescribed, it accounts for >11% of the costs

Prescription Drug Use

Costs and Implications in Workers' Compensation



- Most health care professionals don't know the difference between chemical dependence, tolerance and addiction
- Most don't know how to assess opioid abuse or appropriateness
- Most are uneducated regarding non-surgical pain-coping techniques and when they might be utilized instead of drug therapy
- Claims with heavy narcotics use are more likely to require drug abuse treatments
- In 1990 there were 1,000 pain specialists in US. In 2011 there were 10,000 pain specialists
- The potential need to complete a MSA for narcotics needs to be taken into account

Prescription Drug Use

ACOEM Guidelines



- The American College of Occupational and Environmental Medicine (ACOEM) guidelines sanction opioid therapy:
 - ✓ For acute pain only when
 - ✓ For short-term use in chronic pain
 - ✓ For continued use only in rare situations

SO ASK YOURSELF – ON YOUR CLAIMS CURRENTLY ON LONG-TERM NARCOTICS, IS THE IW TOLERATING PT AND WORKING TO GET BACK TO WORK?
IF NOT, THERE IS NO BENEFIT TO THEIR NARCOTIC RX.
REBOUND PAIN CAN ALSO BE AN ISSUE.

Prescription Drug Use

How to mitigate this cost driver?



- Working Collaboratively with all stakeholders
- Developing an Integrated Opioid Protocol

WE ALL HAVE TO WORK TOGETHER TO
ACHIEVE THE GOAL OF REDUCED OR
ELIMINATED NARCOTIC PRESCRIPTIONS.

Designing an Integrated Opioid Protocol



- Research best practices
- As a result of this research, set up protocols
- The Case Manager should work collaboratively with the prescriber
- The goal for these protocols

The question the RN should ask: "If the opioid is not facilitating decreased pain and increased function, then why is the injured worker receiving an opioid?"

Designing an Integrated Opioid Protocol



- Medication Reconciliation Assessment
- Graded Chronic Pain Scale
- Morphine dosage calculator
- Standardized Assessment Tool
- Advancement through the opioid protocols are based on these calculations and assessments
- Information regarding safe handling, usage and storage of the opioid is provided to the injured worker
- Accessing the state specific Prescription Drug Monitoring Program – Only 16% of the states mandate usage of the PDMP

Assessment Tools Used

Morphine Equivalency Calculator



The RN can upload the MED calculator to their I-phone and computer. The link to this calculator: <http://agencymeddirectors.wa.gov/mobile.html>. This calculator will allow you to quickly calculate the morphine dosages of opiates.

Opioid Dose Calculator		
Patient's Name:		<input type="text"/>
Today's Date:		April 2, 2014
<small>Use as an app: This calculator can be used as an app on mobile devices. Please refer to your device's instructions (or refer here: Android or iPhone/iPad) on how to add this calculator to your home screen for quick and easy access.</small>		
<small>Instructions: Fill in the mg per day* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.</small>		
Opioid (oral or transdermal):	mg per day: *	Morphine equivalents:
Codeine	<input type="text"/>	0
Fentanyl transdermal (in mcg/hr)	<input type="text"/>	0
Hydrocodone	<input type="text"/>	0
Hydromorphone	<input type="text"/>	0
Methodone	<input type="text"/>	0
Morphine	<input type="text"/>	0
Oxycodone	<input type="text"/>	0
Oxymorphone	<input type="text"/>	0
Tapentadol	<input type="text"/>	0
Tramadol	<input type="text"/>	0
TOTAL daily morphine equivalent dose (MED) = 0		
<small>*NOTE: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour</small>		
<input type="button" value="Calculate"/>	<input type="button" value="Print"/>	<input type="button" value="Reset"/>

Designing an Integrated Opioid Protocol



- Patient Education
- Pill Counts
- Pain Rehabilitation
 - Is the program based on best practices?
 - Success Rate?
 - Integrate functional restoration?
 - Plan for weaning?
 - Is the facility interdisciplinary?
 - Non-pharmacologic coping techniques taught?

Prescription Drug Use

Approaches to Pain



- PAIN REHABILITATION**
- IW is active
 - Focus on Function
 - Therapy is taught – not administered (no modalities)
 - Must change dysfunctional approach to pain
 - Internal locus of control

- PAIN MANAGEMENT**
- IW is passive
 - Focus on Symptoms
 - Physician as healer
 - Physician keeps trying to cure pain
 - External locus of control

Physician Dispensing



Physician dispensing occurs when a doctor prescribes as well as dispenses prescription drugs directly to the patient.

Drugs dispensed by the physician have been moved from their original bulk quantity into smaller quantity packages

Issues With Physician Dispensing



- Time out from work
- Medical costs
- Indemnity costs
- Lost-Time days
- Even more striking differences were noted with physician dispensed opioids
- The effect was nearly doubled and revealed 78% higher medical costs, 57% higher indemnity costs and 85% higher frequency of lost-time days associated with physician dispensed opioids

Issues With Physician Dispensing



- Physician dispensing is increased in almost every state
- Prescription repackaging is the second largest cost driver of w/c prescription drugs after the use of opioids
- The cost per unit
- This is a revenue enhancer for the physician
- Where physician dispensing of strong opioids has been eliminated there was no material increase in pharmacy-dispensed strong opioids
 - There was a 12% reduction in workers receiving stronger opioids in the first 12 months after injury
 - Physician dispensing may lead to unnecessary

Source: The impact of Physician Dispensing on Opioid Use WCRI 2014

Issues with Physician Dispensing



- **Most recent ploy for physician dispensing**
 - For example, after a 7.5 mg cyclobenzaprine was introduced in 2012, it was dispensed at \$3.79 per pill in IL. Average price for 5 mg and 10 mg ranged from 99 cents to \$1.74 per pill
 - The frequency of dispensing the new strength increased from zero% to 47% in about 14 months in California and zero% to 21% in about 4 months in IL
- **The question to ask by the CM**

Arguments For Physician Dispensing



- Patients enjoy the convenience of having their Rx filled at the physician's office
- Maximizes the benefit of prompt treatment
- Statistically, Patients pay the price for non-adherence to their prescriptions in terms of worse health and increased healthcare costs
 - Costs for inpatient care – 32% higher
 - Costs for outpatient care – 44% higher
- Initially, 12% of patients fail to fill their Rx
- Next, an additional 12% of those who fill the Rx, do not take the Rx!
- Finally, 29% of the patients stop taking their Rx before supplies run out, or before they have completed a course of therapy

Debunking Arguments for Physician Dispensing



- In the w/c realm, the majority of Rx are for pain meds, not maintenance meds (i.e., cholesterol or HTN) – so time and adherence are not an issue
- What about drug interactions?

IS THE COST FOR SUCH CONVENIENCE TO THE PATIENT WITHIN THE REALM OF REASONABLENESS FOR THE W/C PAYERS?

So what can you do?



- Educate providers
- Utilize quality providers and pharmacy benefit networks - consider use of a URAC accredited pharmacy benefit management provider
- Does your CM use ACOEM, ODG or MDA guidelines when reviewing prescribing patterns of physicians – this information is shared with the physician as needed
- Coordination of UR/peer review when needed
- Get involved Join your local state Chamber of Commerce
- For example, The IL Chamber is active in the process of education and presenting to the IWCC “the other side” to this argument (and many other issues in w/c)

Compounded Medications – Pros?



- Quality
- “Pros” according to the compounders
- CompPharma - a group of w/c PBMs sought answers to these assertions above and how to assess their efficacy and appropriateness and how to determine appropriate reimbursement

Compounded Medications – Pushing the Envelope



- Allergy
- Patients who need a medication that is not commercially available
- Marketing new uses for existing medications

Compounded Medications – Prescriber Considerations



- The most common compound in w/c
- Before prescribing or approving compounded drugs the prescriber should:
 - Vet credentials of the compounding pharmacy
 - The prescriber should know exactly what is in the compounds
 - Critically review the data related to the safety and efficacy of the drugs they contain
 - Many of the compounds contain four or more drugs
 - Keep in mind if these compounds were so effective, why aren't they being prepared commercially already?
 - The compounding pharmacist should be able to provide clinical evidence of safety and efficacy for the topical use of the individual drugs and the chemical and physical stability of the cocktail of the drugs mixed together

Compounded Medications – Prescriber Considerations



- Due diligence is the responsibility of the prescriber. Prescribers have a responsibility to question the availability of supporting documentation related to quality control and safety of compounds. This data should include:
 - Well-designed randomized, double-blind, placebo-controlled clinical trials in humans who require treatment for the condition of interest
 - Physical and chemical stability data for the compound formulation
 - Animal and human studies for safety
 - References from recognized sources of evidence-based clinical information (ODG, Cochrane Database, Work Loss Data Institute, AHRQ, and UpToDate)
- There is no FDA requirement for reporting adverse events related to the use of compounds
- Duplication of Therapy

FDA Stipulations “Investigational?”



- Medical Necessity – The FDA stipulates a compounded product must be “necessary for the identified patient.” The FDA notes appropriate medical necessity to include: a need for medication but the patient has an allergy to a certain dye in the commercially prepared product or inability to swallow a marketed dosage form and a liquid is not otherwise available
 - Since custom compounds are created without specific clinical testing they should be considered investigational. If the medication is “investigational” the patient should be required to sign an informed consent document

Compounded Medications – Are they Safe?



- A prescriber has the authority to prescribe medications for off-label use
- The prescriber may not be protected by malpractice insurance in the case of injury or death of a patient who received contaminated products
 - The prescriber is urged to consider and document their responses to the following:
 - Is there an FDA approved product that can be used? If not, why not?
 - Does the compound contain active and inactive ingredients contained in marketed products? (Any active ingredient in the compound has to be an ingredient present in an FDA-approved product.)
 - How can you ensure the compound is safe and chemically and physically stable?
 - What documentation supports the clinical safety and efficacy of the compound and all the active ingredients?

Efficacy of Compounded Medications



- Efficacy – the skin is meant to prevent systemic exposure to toxic substances
 - Various studies have been performed on NSAIDs and the results were unable to demonstrate any of the studied compounded drugs in a variety of topical vehicles were effective. The only topical NSAID that has been approved is diclofenac as a 1% gel for osteoarthritis of the knee, hand and other “amenable joints” and as 1.5% and 2% solutions for osteoarthritis of the knee, and a 1.3% topical patch for acute treatment of strains, sprains and contusions
 - Search results on other drug ingredients typically found in the drug compounds prescribed in w/c found little to no clinically appropriate information for topical use of many of the ingredients

CompPharma Resource



- A policy requiring the injured worker to sign an informed consent may be a way to ensure the patient is aware that the compounded product is not FDA approved and carries direct and indirect risks.
- While the majority of compounds are topical, sterile products are occasionally prescribed for injured workers. Please see the full CompPharma report detailed in the reference below for full information on precautions for sterile products.
- CompPharma Report: "Compounding is Confounding Workers' Compensation 2014"

Compounded Medications – What can you do to mitigate this cost?



- Approval should be limited to those situations with a unique patient-specific requirement, e.g., documented allergy or inability to swallow.
- Obtain a letter of medical necessity to obtain proof that conventional therapy has been tried and failed
- Request evidence of effectiveness and safety for topical compounds, such as an article published in a peer-reviewed medical journal with a randomized controlled trial that demonstrates effectiveness
- Avoid approval of topical compounds that contain multiple active ingredients
- In the absence of FDA approval or satisfactory evidence of effectiveness and safety, and if a decision is made to authorize the compounded medication, require a signed informed consent by the patient

Questions?

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