Managing the Unintended Pain of Opioids in the Workers' Compensation Industry

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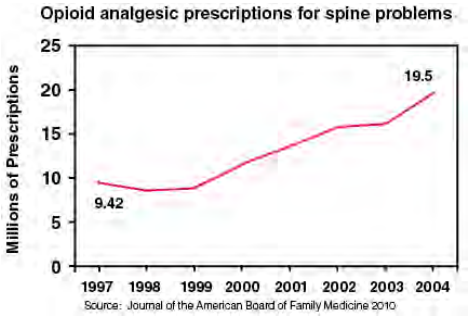
25-40% of workers' compensation prescription dollars involve the use of one class of medications: Opioids.

Executive Summary

- Dramatic increases in opioid use causes concern not only from a drug cost standpoint, but also because evidence suggests a link to longer duration of disability.
- Misuse, overuse and addiction are real risks that extend well beyond the worker's compensation industry.
- Well-established communication with the physician, backed by evidence based pain management guidelines and best practices, can improve the end results for every stakeholder: decreasing liability for the physician, improving outcomes and decreasing side effects for the patient.

Musculoskeletal pain is the most common cause of work-place disability, both short and long term, so it's a natural result that pain management drug therapy is such a large part worker's compensation claims. Further complicating this matter is the environment in which, in many cases, the patient receives care at no personal cost and, as a result, has no financial incentive to contain prescription use. With 25-40% of workers' compensation prescription dollars involving pain management via the use of opioids, the stakes are high when it comes to keeping these costs under control.



Opioid therapy represents a significant and necessary component of pain management, yet opioids and other controlled substances represent an area with significant potential for fraud and abuse. Following recent arrests and seizures in cases of Florida "pill mills" where doctors allegedly dispensed more than 660,000 dosage units of Oxycodone, a Drug Enforcement Administration (DEA) administrator stated that "Prescription drug abuse is our country's fastest growing drug problem."[1] The problem is so severe that Florida law enforcement is proposing that fingerprints be required of people filling schedule II prescriptions at pharmacies. Further compounding the situation is the fact that the treatment of pain is inherently challenging in itself, with

medical professionals left to differentiate between a drug abuse/seeker and a patient that is genuinely in pain.

Recent studies show an increase in expenditures for opioids used for back pain of 423%, without demonstrated improvement in patient outcomes or disability rates. Concurrently, the number of opioid prescriptions rose 108% from 1997 through 2004.[2] A 2008 study of the California Worker's Compensation Institute involved 166,366 injured workers with medical back conditions without spinal cord involvement. For this group, 854,244 opioid prescriptions were dispensed, with an average of 5.2 prescriptions per claim.[3]

Claimants who received high-dose opioids were disabled an average of 69 days more than those who didn't receive them.

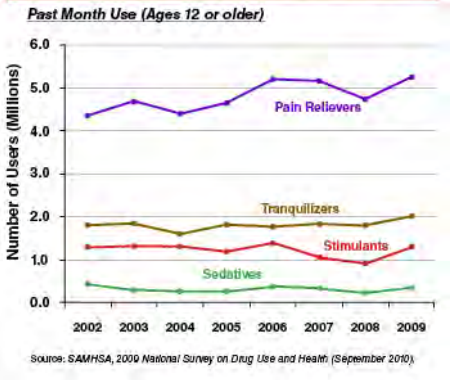
A possible risk factor for long-term disability

In addition to prescription costs, research indicates a relationship between the use of opioid drug therapy for acute occupational low back pain and longer duration of disability. A study of 8,443 claimants with low back pain showed that those who received high-dose opioids were disabled an average of 69 days more than those who received none.[4] Corroborating evidence has shown that chronic opioid use initiated early in the treatment of low back pain, particularly in the workers' compensation setting, is associated with negative outcomes, including increased time away from work, increased risk for addiction and longer duration of treatment.[5,6,7] And the longer the treatment, the higher the per month cost.

Costs of overuse, misuse and addiction

Although opioids are considered to be necessary, appropriate and reasonable for certain patients, usage has increased dramatically, to the point that the United States now consumes 80% of the global opioid supply, while representing only 4.6% of the world's population.[8] This has resulted in subsequent increases in misuse and diversion.[9,10]

Current Nonmedical Use of Specific Prescription-Type Drugs, 2002 - 2009

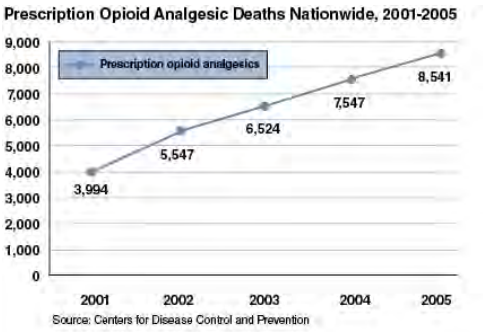


The most commonly diverted controlled prescription drugs (CPDs) are opioid pain relievers, according to data from the DEA and the National Survey on Drug Use and Health.[11] In 2009, an estimated 5.3 million Americans aged 12 and older reported non-medical use of prescription pain medications in the past month, a 20% rise over 2002 estimates. Prescription pain relievers obtained from family and friends are the main source of illegal opioids, and in 80% of those cases, the opioid was reportedly obtained from a single prescriber.[12]

Opioid abusers had significantly higher prevalence rates for a number of different health factors, compared with non-abusers. Non-opioid

poisoning, hepatitis (A, B, or C), psychiatric illnesses, and pancreatitis were 9-78 times higher. Medical and prescription drug utilization was also higher for abusers versus non-abusers:

- Hospital inpatient visits were more than 12 times higher
- Mean annual direct health care costs were more than 8 times higher
- Mean drug costs were more than 5 times higher
- Prescription drug claims for opioids were nearly 60% versus approximately 20%[13]



The increased cost can also be calculated in terms of emergency room visits and death rates. Emergency room visits associated with narcotic pain relievers have increased 163% since 1995.[14]

With the costs not only in dollars, but also in the potential for problems, many of them serious, with long-term usage, it is essential to have a clear and effective strategy in place when it comes to opioid therapy.

A Multi-Faceted Action Plan

Clearly, opioid management is a complex problem, calling for a comprehensive approach to limit its impact on the industry. Education, technology-based systems of identifying potential problems and an open line of communication with physicians are all key areas to explore in order to control opioid use.

Proper assessment of the patient and development of a treatment plan is a key first step in appropriate management. According to the Official Disability Guidelines, certain questions to explore prior to initiating therapy include:

- Have any reasonable alternatives to treatment been tried?
- Has the patient been screened for addiction risk and is there likelihood of abuse or an adverse outcome?
- Are there red flags that indicate that opioids may not be helpful in the chronic phase, such as:
  - Little or no relief with opioid therapy in the acute and subacute phases
  - A diagnosis, such as pain disorder associated with psychological factors of anxiety or depression, which falls in a category that has not been shown to have good success with opioid therapy.
  - Patient requested opioid medications when there are inconsistencies in history, presentations, behaviors and the like.[15]

Knowledge of pain management choices and associated risks, especially in the treatment of chronic pain, along with the latest strategies in appropriate usage can equip workers' compensation organizations with the information they need to most effectively manage this increasingly significant portion of the business.

A step therapy approach can improve care, deter abuse and avoid dangerous side effects.

Step therapy is a key strategy in pain management that offers benefits to the worker's compensation industry. Largely used in group health as a way to limit costs, this step-wise approach drives good clinical choices such as initiating therapy with a lower dose or short-acting opioids and only "stepping up" to agents like OxyContin if the injured patient does not experience relief from pain. This is only one example of thousands where this approach may improve care, deter abuse and avoid dangerous side effects.

Claims professionals are an essential component in recognizing a potential problem or opportunity for mitigation. It is essential not only to empower adjusters to question inappropriate therapy, but also to pinpoint fraud, waste and potential evidence of abuse. But, to be successful, they need to be empowered with the knowledge to do so.

Among the newer, more powerful and more expensive narcotic medications for treating pain, such as oral transmucosal fentanyl citrate, there is little to warrant the use of these medications outside of their approved and limited use in areas such as end-stage cancer pain. Effective technology systems are essential in identifying potential problems or misuse of opioid therapy. A system of well-defined triggers can be utilized to initiate a review of prescribing patterns that indicate when opioid use in a chronic pain case is not optimally managed. Such triggers might include:

- Appropriateness of use, such as long-acting opioids prescribed early in treatment or to an opioid naïve patient
- Use of injectable opioids for non-cancer patients
- Chronic use of name brand medications with no valid health reason
- Multiple opioids prescribed, multiple prescribers or the use of multiple pharmacies

Prospective drug utilization review (DUR), conducted during or immediately before dispensing has long been a powerful tool to avoid dangerous drug interactions, duplication of therapy, improper dosing and other potential problems evident to the dispensing pharmacist. Combined with a retrospective Drug Regimen Review (DRR),

Customizable ARMs focus on concerns unique to injury state management.

which utilizes research conducted by clinical pharmacists, evidence-based pain management strategies and guidelines such as ODG, a comprehensive assessment may be developed to evaluate the appropriateness of drug therapy, identify adverse consequences for patients and flag potentially rising health care costs. The ultimate goal of a DRR is to engage the physician and patient in educational dialog that improves prescribing and drug use in a way that encourages long-term success. This can be a prohibitively expensive process when companies rely on peer-to-peer physician interventions. In the proper setting, an alternative pharmacist-physician consultation can be just as effective at a much lower cost.

A Look Inside an Enhanced Drug Therapy Management Program

As opioids have the potential to fall under the FDA's Risk Evaluation and Mitigation Strategies (REMS) program, education on safe use and avenues to communicate this information become more readily available, helping to ensure that benefits of opioids outweigh the risks. However, as recently as 2010, an FDA panel reportedly supports restricting the use of opioids, yet rejected the call for REMS because the plan did not require training for the physicians who prescribe these drugs. To partially fill this gap, myMatrixx focuses on drug therapy management that utilizes a comprehensive approach to pain management.

Solution-based programs for education, technology aimed at changing therapy from the onset and a system of continual communication with physicians are components of the Opioid Management Program embedded within the company's Drug Therapy Management capabilities. Our company has found success initiating educational sessions with our client's adjusters. Targeted presentations focus on the benefits and risks associated with opioid drug therapy as well as covering the latest pain management techniques for creating positive outcomes. The goal is to empower these claims professionals to most effectively manage their cases and, ultimately, reduce costs.

Our goal is always to control opioid usage from the onset of treatment claim.

At the center of Drug Therapy Management at myMatrixx is an Alert, Review and Manage (ARM) program. Part of a comprehensive communication platform, ARM starts with real-time data delivered right to the claims professional's desktop and progresses to letters and phone consultations to partner with the physician.

The program's automated system of clinical oversight is highly flexible and customizable. ARMs may be comprised of clinical concerns,

financial concerns and Fraud Waste and Abuse (FWA) concerns, or any combination of these areas. And, unlike clinical programs developed for disease management, ARM focuses on concerns unique to injury state management, including:

- Relatedness
- Appropriateness
- Fiscal Responsibility
- Excessive dose or duration of therapy
- Targeted Interventions
- Measurable Outcomes

Each ARM is tied to one or more measurable actions, initiated after review by our pharmacist and presented in a Targeted Intervention Letter to the physician. If indicated, a referral to Case Management can be generated. The ARM program is designed to track and measure the impact of these targeted interventions, measuring changes in prescribing and/or spending. Clients can work directly with our clinical team to modify existing ARMs and to develop customized alerts that target specific areas of concern to their cases.

Because of the significant potential for fraud and abuse, Opioid Management involves a special subset of ARMs that trigger a review of prescribing patterns. This could include inappropriate use of powerful pain medications such as Actiq® or Fentora®, reliance on expensive name-brand medications or excessive use or duration of use of typically accepted skeletal muscle relaxants. Utilizing advanced technology and our predictive modeling database, the company alerts everyone in the process as soon as these medications are dispensed, beginning a system of reviewing an injured patient for any issues. Our goal is always to control opioid usage from the onset of treatment.

After seeing the effect of physician consults, one client requested a review of a number of open claims, convinced they would see similar results.

The myMatrixx ARM program provides the clinical information that enables our pharmacists to take a leading role in communicating with physicians. Building this pharmacy-physician link enables myMatrixx to partner with physicians in education and implementation of strategies such as step therapy. Equally important to the step-therapy approach is complete avoidance of inappropriate drugs sometimes seen utilized in injured patients. Oral transmucosal fentanyl citrate (Actiq®) is an example of how a directed approach can virtually eliminate the use of a medication. myMatrixx has driven the use of all forms of this medication completely out of our listing of top 100 most prescribed medications.

Evidence-based pain management guidelines, such as ODG, are used to develop patient-specific recommendations and treatment plans. As a follow-up to any Targeted Intervention Letter, our pharmacist makes personal contact with the physician in an effort to clarify and reach consensus on recommendations. A Drug Regimen Review (DRR) enables our clinical staff to provide physicians with detailed information for making improvements in opioid therapy, such as conversion dosages for alternative opioids with better therapeutic profiles and weaning guides, when required.

myMatrixx clients have seen positive results from our comprehensive approach to opioid management. One client in the Southeast reported on a claimant's case in which the prescribing physician has gradually implemented a number of the recommendations presented via the myMatrixx prescription review. As a result, the client reports that the claimant has "slashed over $700 off the monthly cost of her prescriptions, and so far the changes in medication are working on her pain management, which is key."

At myMatrixx, opioid use is down 16.2% vs. industry benchmarks.

For another client, myMatrixx performed a Targeted Intervention, DRR and physician conference, in which the doctor in the case "agreed and concurred to discontinue half of the patient's medications." The client, in turn, requested a review of all its open claims with $800 or greater potential, convinced that they would see significant savings and increased productivity of claimants due to decreased usage of inappropriate prescriptions.

A true measure of the success of the myMatrixx Drug Therapy management program lies in our filling relatively fewer opioid prescriptions than other Pharmacy Benefit Managers (PBM). With the percentage of opioid use at myMatrixx down 16.2% versus industry benchmarks, we believe that taking a proactive management approach is the key to yielding profitable results for our clients.

1 U.S. Drug Enforcement Administration (DEA) News Release 2011 Feb 24. http://www.justice.gov/dea/pubs/states/newsrel/2011/mia022411.html
2 Deyo, R; Mirza, S; Turner, J; Martin, B; Journal of the American Board of Family Medicine Jan;22(1):62-68
3 Report to the Industry, 2008; Pain Management and the Use of Opioids in the Treatment of Back Conditions in the California Workers Compensation System. California Workers' Comensation System. 2008, June. http://www.cwci.org/press_release.html?id=76
4 Webster, B; Verma, S; and Gatchel, R; Acute Occupational Low Back Pain and Disability Duration, Medical Costs, Subsequent Surgery and Late Opioid Use. Spine 2007:32:2127-2132
5 Martell BA, O'Connor PG, Kerns RD, Becker WC, Morales KH, Kosten TR, Fiellin DA. Systematic review: opioid treatment for chronic back pain: prevalence, efficacy, and association with addiction. Annals of Internal Medicine 2007 Jan 16:146(2):116-27.
6 Franklin, G; Rahman, E; Turner, J; et al. Opioid Use for Chronic Low Back Pain. Clinical Journal of Pain 2009:25:743-751
7 Webster, B; Verma, S; and Gatchel, R; Acute Occupational Low Back Pain and Disability Duration, Medical Costs, Subsequent Surgery and Late Opioid Use. Spine 2007:32:2127-2132
8 Manchikanti, L; Fellows, B; Ailinani, H; and Pampati, V; Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective. Pain Physician 2010:13:401-435.
9 Kuehn BM. Alarming nonfatal overdose rates found for opioids, sedatives, and tranquilizers. JAMA 2010;303:2020-1
10 Fingerhut LA. Increases in poisoning and methadone-related deaths: United States, 1999-2005. NCHS Health E-stats. http://www.cdc.gov/nchs/data/hestat/poisoning/poisoning.pdf
11 National Drug Intelligence Center, The National Prescription Drug Threat Assessment 2009 (NPDTA 09) http://www.justice.gov/ndic/pubs33/33775/background.htm#CPD
12 Substance Abuse and Mental Health Services Administration (SAMHSA). Results from the 2009 National Survey on Drug Use andHealth (NSDUH), released Sept 16, 2010 http://oas.samhsa.gov/nsduhLatest.htm
13 White AG, Birnbaum HG, Mareva MN, Daher M, Vallow S, Schein J, Katz N; Direct costs of opioid abuse in an insured population in the United States. J Manag Care Pharm. 2005 Jul-Aug;11(6):469-79. http://www.amcp.org/amcp.ark?c=jmcp&sc=articles&year=2005&volume=11&issue=6
14 Developing and Enhancing Prescription Drug Monitoring Programs. Accessed August 15, 2006 http://www.ojp.usdoj.gov/BJA/grant/05PrescripDrugSol.pdf
15 Work Loss Data Institute, Official Disability Guidelines, 2009. http://www.disabilitydurations.com/