Wasted Dollars, Wasted Lives—How Opioid Overprescribing and Physician Dispensing Are Harming Claimants and Employers

By Joseph Paduda • President, CompPharma, LLC

Workers compensation pharmacy costs are much higher than they should be. With $1.4 billion going to pay for narcotics that deliver little benefit to workers comp claimants, and $1.7 billion spent on highly inflated costs for drugs from physician dispensers, it is clear that hundreds of millions of dollars in employer premiums are wasted on drugs that do little to benefit claimants but greatly enrich physician dispensing companies.

Opioids in Workers Comp—Inappropriate, Expensive, and Addicting

Employers and insurers will spend $1.4 billion on narcotics this year for workers compensation claimants, with the vast majority of those dollars paying for opioids such as OxyContin®, Percocet®, and Actiq® (fentanyl)—drugs that are not indicated for the vast majority of workers comp injuries.

There's very little credible evidence that long-term opioid use is appropriate treatment for workers comp injuries. These are drugs that were primarily developed—and approved by the FDA—for treating end-stage cancer pain. But there is ample evidence that long-term opioid use leads to longer claim duration, long-term disability, higher costs, and higher medical expenses.

Along with the questions around the benefits of opioids for work-related injuries, the research indicates that few prescribing physicians—a mere 1 in 20—are complying with best practices, namely:

- Assessing the patient's initial and subsequent functionality, pain level, and risk of depression
- Requiring patients to complete and sign an Opioid Agreement
- Ordering random urine drug tests to assess compliance and potential use of street drugs and other drugs

Solutions do exist, yet far too few payers or regulators are aggressively addressing the problem.

How Did We Get Here?

Opioids are synthetic versions of opium-derived drugs originally developed for treating patients with end-stage cancer. Remarkably effective at reducing pain in many instances, many were meant to last only a few hours to deal with "breakthrough" pain. In the long term, they can provide relief from chronic pain when used appropriately within guidelines.

In the late 1990s, at least 20 states passed new laws, regulations, or policies, moving from the near prohibition of opioids to allowing usage without dosing guidance. The laws were based on weak science that, in turn, was based on experience with cancer pain.

Now, those same drugs are widely prescribed for musculoskeletal injuries, where their usefulness is, at best, highly questionable. A 2009 study (Franklin et al, *Clinical Journal of Pain,* Dec. 2009) found that less than a third of patients taking opioids for low back pain improved by at least 30% in pain function; even fewer (16%) saw improvement in functionality. At least two separate studies indicate the negative effect of narcotics on disability duration. Industry reports seem to indicate that the longer injured workers are on narcotics, the longer they are off work and the greater the

likelihood of addiction rehabilitation ("Narcotics in Workers Compensation," NCCI Research Brief, Dec. 2009).

The California Workers Compensation Institute (CWCI) reported that average claim costs of workers receiving seven or more opioid prescriptions for back problems without spinal cord involvement were three times greater than those for workers who received zero or one opioid prescription. The workers receiving multiple opioid prescriptions were 2.7 times more likely to be off work and had 4.7 times as many days off work (Swedlow et al, "CWCI Special Report," 2008).

Solutions

The inherent but often-ignored consequence of overuse of opioids is a dramatic increase in the risk of addiction and dependency. The harsh reality of addiction liability is that a very high proportion of claimants who have been on opioids for more than 90 days are at high risk for addiction. Sadly, many insurers don't want to screen for addiction because they don't want to "own" that addiction. That ignores the fact that the insurer *already* owns the addiction; it is just choosing to treat that addiction with the drug of choice rather than employ an intelligent, evidence-based approach to resolving the problem. The price tag for ongoing opioids usage runs $1,000 to $12,000 per month plus associated costs for treating side effects, extended disability duration, and settlement expense.

The question is not "Do you want to own the addiction?" but rather "*How long* do you want to own the addiction?"

Discouraging overprescribing is one step; providing guidance for primary care providers on the safe and effective use of opioids for chronic noncancer pain must be the priority going forward. Payers must take a strong stance, advocating for treatment agreements where patients are screened, randomly drug tested, and offered addiction/dependency treatment when the daily dose reaches 120 MED (morphine equivalent dose) and pain and function have not substantially improved. While there are no silver bullets, treating addiction with outpatient medically assisted detox, drug therapy, and cognitive behavioral therapy must be a priority. Inpatient programs may also be helpful.

Legislative and regulatory changes have started to address opioid prescriptions in workers compensation claims. Colorado is currently paying physicians to manage chronic pain based on a code-based reimbursement for review of drug screens and the implementation and monitoring of opioid agreements. Washington State has passed legislation requiring that prescribing physicians comply with best practices including drug testing and completion of Opioid Agreements.

Texas now requires physicians to seek preauthorization before prescribing narcotics such as Soma, Oxycontin®, Lidoderm®, and fentanyl to claimants. Anecdotal reports indicate that prescriptions for these drugs have fallen off considerably since this closed formulary went into effect in September 2011. It will be interesting to see the results after a year or so. While the adoption of Official Disability Guidelines (ODG) is welcome indeed, payers and employers still have to address the population of claimants currently addicted to narcotics.

The American Insurance Association has developed a comprehensive approach that includes these practices as well as implementation of prescription drug monitoring programs that communicate across state lines. Some pharmacy benefit managers have developed data mining tools that identify at-risk claimants and physicians who appear to be overprescribing opioids.

These initiatives are very, very welcome. To quote Gary Franklin, MD, medical director of Washington State's workers compensation program and the driving force behind the state's opioid legislation, "This is a 'hair on fire' issue." If your hair is not yet on fire, you're either bald or not paying attention.

Physician-Dispensed Drugs—A $1.7 Billion Problem

Using industry research as a baseline, physician-dispensed drugs likely account for at least $1.7 billion—over a quarter of all workers comp pharmacy expenses. That percentage—and the cost—is growing dramatically every year. The problem is simple: the cost for drugs dispensed in physicians' offices is typically three times the retail pharmacy price for the same drug. This equates to 2% of total workers comp medical expense or about 1% of workers comp premiums.

Advocates for physician dispensing claim that their business increases "compliance," the chance that the patient will actually take the medication. However, there's no empirical research to back up those claims. More telling, physicians dispense drugs only to workers comp and auto patients, where reimbursement is much higher; group health and Medicare/Medicaid plans won't pay the inflated costs for physician-dispensed repackaged drugs.

And it's not just price that's a problem. What physician dispensing advocates don't discuss is the increased risk for their patients. If workers compensation claimants receive

care for their occupational injury from physicians they don't normally see, there may be an increased risk of dangerous drug-to-drug interaction. Patients usually can't recall with complete accuracy the drugs they are taking or the dosages of those drugs, so the physician can't be sure that what they are prescribing is entirely safe.

When the injured worker fills a prescription at a pharmacy, the pharmacist can access its comprehensive electronic database of medications and dosages the patient has previously filled, providing an additional level of safety. This doesn't happen when the prescriber is also the dispenser. Pharmacies also have tools to avoid patient safety issues, including contraindications and early refills.

On the cost side, the evidence is incontrovertible—physician dispensing dramatically increases employers' costs. A report by the Workers Compensation Research Institute (WCRI) found that the average payment per claim for prescription drugs in the Massachusetts workers compensation system was $289, or 30% lower than the median of the 16 study states. One of the main reasons for the lower prescription costs in Massachusetts is a ban on physicians dispensing medications directly to their patients.

In contrast, WCRI also found that the average payment per workers comp claim for prescription drugs in Florida was $565, or 38% higher than the median. The primary reason for Florida's higher prescription costs? Over half of all workers comp prescription dollars are spent on repackaged drugs, with prices typically *three times* the cost of the same drug in a retail pharmacy.

How It Works

Drugs dispensed by physicians are almost always provided by drug repackagers, a niche industry that buys pills in bulk and repackages those pills into their own bottles. A quirk in the FDA's regulations enables companies that repackage pills to be classified as "manufacturers," and that allows them to determine their own price for those pills. Repackagers assign an NDC, or National Drug Code, to their repackaged drugs. In turn, they determine the Average Wholesale Price (AWP) for each NDC.

Almost all state workers comp pharmacy fee schedules are based on AWP; this allows repackagers to set their own prices and requires employers and insurers to base their payments to the physicians who dispense drugs on that (usually hugely inflated) AWP.

Solutions

Today, Texas, Massachusetts, and New York essentially ban physician dispensing by greatly limiting physicians' ability to dispense drugs. Other states allow physician dispensing but require repackagers to base their price on the "underlying NDC"; that is, the price set by the original drug's manufacturer. Georgia, Mississippi, and California have dramatically lowered costs with this solution. ■

Joseph Paduda is president of CompPharma, LLC, a consortium of workers compensation pharmacy benefit management (PBM) firms. He can be reached at jpaduda@healthstrategyassoc.com.