LEGACY CLEANUP, TEXAS STYLE

A white paper for workers' compensation payers and TPAs

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PRIUM
The difference is physician engagement

INTRODUCTION

The first phase of Texas Closed Formulary (TCF) for workers' compensation claims with a date of injury (DOI) on or after September 1, 2011 was a success. Now the focus has switched to the cleanup of legacy workers' compensation claims with a DOI prior to September 1, 2011. The TCF rules very specifically outline the process and timeline associated with this cleanup, which are both addressed herein. Given the potentially extreme physical and psychological addiction associated with these drugs, it is time to get started towards those deadlines. **This should make it the "Year of Legacy Claim Cleanup" in Texas.**

TCF BACKGROUND

Texas House Bill 7 (HB-7), signed into law on June 1, 2005 with changes effective September 1, 2005, was the beginning point to address high workers' compensation claim costs and poor return-to-work outcomes. Strong support for utilization review was included to give payers a better opportunity to contest the medical appropriateness of treatment in cases that did not yield a reasonable outcome for the injured worker. The infrastructure for dispute was created using prospective (or preauthorization), concurrent and retrospective review methods.

The baseline for evaluation was established when the Official Disability Guidelines (ODG) were selected as the standard of care for any treatment provided on or after May 1, 2007. Over time, mandates were put into place for preauthorization of certain treatments and procedures prone to overutilization (e.g., physical and occupational therapy), unpredictable outcomes (e.g., spinal surgery) and questionable cost-benefit (durable medical equipment in excess of $500).

Pharmacy was always part of the plan, so pursuant to that and effective on September 1, 2011 the TCF was initiated for new workers' compensation claims. Preauthorization is now required for:

- Any prescription medication approved by the Food and Drug Administration that has an ODG status of "N"
- Medications that are investigational or experimental
- Compounded medications containing drug(s) with an ODG status of "N"

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Interestingly, since the inception of the TCF on September 1, 2011, there has been a significant decline in the prescribing of drugs that would qualify for TCF preauthorization for new claims. One of PRIUM's pharmacy benefit manager (PBM) partners provided an analysis of drug transactions from September 1, 2010 through December 31, 2011 that corroborates this "gut" intuition, as evidenced below:

All Dispensed Drugs

	DOI 09/01/10 thru 08/31/11	DOI 09/01/11 thru 12/22/11
# of Days:	360	111
# of Claims:	6,385	1,409
Average # new claims/day:	17.74	12.69
# of Scripts:	28,527	4,261
Average # scripts/day:	79.24	38.39
# of "N" drugs:	2,617	169
Average # "N" drugs/day:	7.27	1.52
% of "N" drugs to overall:	9.17%	3.97%

As shown on page 2, the average number of "N" drugs per day and their ratio to the overall number of scripts has decreased dramatically. Interestingly, the top five drugs used for both date ranges (Voltaren gel, Soma, Lidoderm patches, Flector patches and Zipsor) remained consistent. This indicates the types of drugs have not necessarily changed, but the frequency in which they have been prescribed has driven utilization down.

For a more precise comparison, an analysis of the drugs dispensed within the first 90 days after DOI shows a slightly less, but still compelling reduction in the use of "N" drugs:

Drugs Dispensed Within 90 Days of DOI

	DOI 09/01/10 thru 08/31/11	DOI 09/01/11 thru 12/22/11
# of Scripts:	18,359	1,825
# of "N" drugs:	1,355	64
% of "N" drugs to overall:	7.38%	3.51%

Note: Additionally, these results were later corroborated by a published report from the DWC in June of 2012[1].

A conclusion can be drawn from this data analysis that the new formulary rules have achieved the desired effect to reduce the use of these potentially addictive and often medically inappropriate drugs, although not in the way initially thought. The original expectation was that there would be a huge influx of preauthorization requests for these drugs, either directly from the treating physicians or via the pharmacy that was prevented from dispensing because of the TCF embedded within a PBM's point-of-sale system.

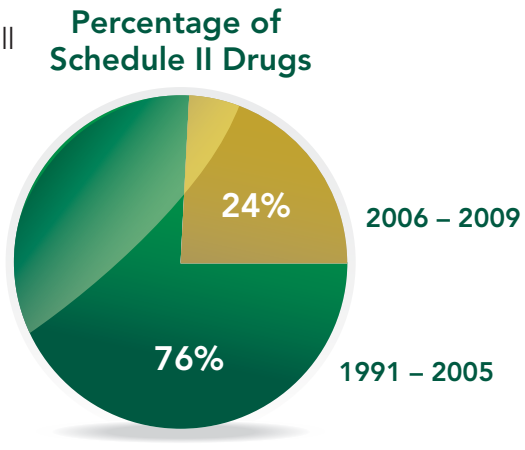
Instead, it appears that treating physicians have determined alternative methods for treating pain because of the new statutory requirements, potentially including:

- Switching to more conservative therapy
- Switching to "Y" drugs
- Switching to interventional methods (e.g., injections or nerve blocks)
- Cost shifting to the injured worker's group health policy or Medicare/Medicaid
- The injured worker paying for the drugs themselves

Also possible is the chance that the results were a statistical anomaly and will even out over time. It is still early and these apparent trends could change or the analysis may not show a complete picture, but for now it appears that Texas has forced a reevaluation of how and when these drugs should be used as a treatment option.

NOW ONTO THE LEGACY CLAIMS

Research published on October 27, 2011 by the Texas Department of Insurance Workers' Compensation Research and Evaluation Group found that pharmacy payments consistently represent 13 percent of all workers' compensation medical payments in Texas[2]. In addition, legacy claims had significantly higher average pharmacy costs (injury years 1991-2005 = $3,636) in 2010 than newer claims (injury years 2006-2009 = $266)[3]. And, overall, approximately 76 percent of the prescriptions for Schedule II drugs are for injury years 1991-2005[4]. So while gaining early control over new claims is important, the primary driver of cost and overutilization remains centered on legacy claims.



Average Pharmacy Cost Per Claim

DOIs IN 1991-2005	DOIs IN 2006-2009
$3,636	$266

Thankfully, the Texas Department of Workers' Compensation (DWC) had the foresight to address both new claims and the thousands of legacy claims that are driving workers' compensation claim expenses. Since the passage of HB-7, statutes and rules have been supportive of a retrospective review of an injured worker's drug regimen to ensure it is medically appropriate and necessary based on injury type. Realizing the administrative burden the new formulary rules would place on payers due to the high volume of legacy claims, the DWC created a two-year transition process. Thus, payers must ensure legacy claims comply with the closed formulary rule by September 1, 2013. At that time, every legacy claim with a DOI prior to September 1, 2011 will need to confirm medical necessity for each "N" drug in its regimen or be subject to the TCF preauthorization process. The DWC was very explicit in their expectations for this process[5]:

- Beginning no later than March 1, 2013 each payer shall identify legacy claims where an excluded drug was prescribed after September 1, 2012. They must provide written notification to the injured worker, prescribing physician and pharmacy of the impending formulary applicability along with a contact name and number for discussion

- At any time between September 1, 2011 and September 1, 2013 every prescribing physician must include a statement of medical necessity with the prescription for an excluded drug

- Either the payer or prescribing physician may initiate discussion about a claim's drug regimen and attempt to agree on modifications that would bring it into compliance. The payer must document all agreements and terms and share a copy with both the treating physician and injured worker

- If that agreement is in writing and changes are actually implemented, then treatment provided as a result of the agreement is not subject to retrospective review

- All "N" drugs for every claim will be subject to the TCF starting on September 1, 2013

While there is an appeals process (Medical Interlocutory Order) for circumstances where the risk of a medical emergency exists, there is no specific dispute resolution process when an agreement is not reached concerning medically appropriate changes to the drug regimen[6]. So the DWC's intent seems to be to reduce the need for the MIO process by weaning inappropriate drugs well in advance of them possibly being denied by the TCF on or after September 1, 2013.

Given the DWC's rules for evaluating legacy claim drug regimens and the length of time it could take to discontinue medically inappropriate drugs that have a higher propensity for addiction and have been used for a long duration, it would be wise for payers to start the process of legacy claim cleanup as soon as possible. Taking into account how the DWC has documented the timeline and expectations, a process that would yield optimal results could be outlined as follows:

Legacy Claim Cleanup Process

1. Payer creates a list of all claims that have at least one drug that fits the criteria dispensed on or after September 1, 2012
2. For each identified claim, the payer (or agent) notifies the prescribing physician, corresponding injured worker and dispensing pharmacy in writing of the need to address the drug regimen per the TCF
3. A peer physician engages the prescribing physician to compare the drug regimen to ODG for medical appropriateness
4. If drugs are found inconsistent with ODG, the physicians agree upon appropriate changes to the drug regimen (possibly introducing alternative treatment in lieu of the drugs) and commit to that agreement in writing
5. The discontinuance process commences, managed by the prescribing physician or possibly a specialist in functional restoration/detoxification
6. Once all changes have been implemented, a statement of medical necessity is formulated that covers the ongoing use of the modified drug regimen that would be available to all parties upon the TCF implementation on September 1, 2013

If the prescribing physician will not cooperate in peer conversation or agree to suggested changes for ODG compliance, there are several alternative actions that can be taken to ensure proper treatment for the injured worker. Informal comments within Texas indicate that complaints to the Medical Quality Review Panel and/or the Texas Medical Board would be appropriate. Written recommendations from the reviewing physician could also be sent to the prescribing physician for an objective clinical rebuttal. The negative side effects from the long-term use of the drugs could also be directly presented to the injured worker to help educate and empower them. Regardless of the initial lack of prescribing physician cooperation, numerous beneficial options exist to accomplish compliance.

TIME IS OF THE ESSENCE

There are several reasons for payers to take immediate steps to begin TCF legacy claim cleanup and ensure compliance:

- Some of the "N" drugs could take several months to discontinue
- There are thousands of claims that have a DOI before September 1, 2011 with at least one "N" drug
- It will take additional time to identify compounded medications that include an "N" drug
- Contact and engagement with treating physicians and injured workers will take significant periods of time
- Those claims that are not compliant could face a per-day fine of up to $25,000

TRANSITION TO TCF CLOSED FORMULARY WITH EASE

PRIUM has extensive experience working with Texas claims since HB-7's implementation in 2005 and has monitored the evolution of the TCF since 2009. The cleanup process defined by the DWC remarkably mirrors PRIUM's award-winning Qualified Medical Intervention (QMI) program. This innovative solution uses evidence-based medicine (EBM) and jurisdictionally-specific guidelines to determine the most clinically appropriate and causally-related care plan for current and ongoing treatment.

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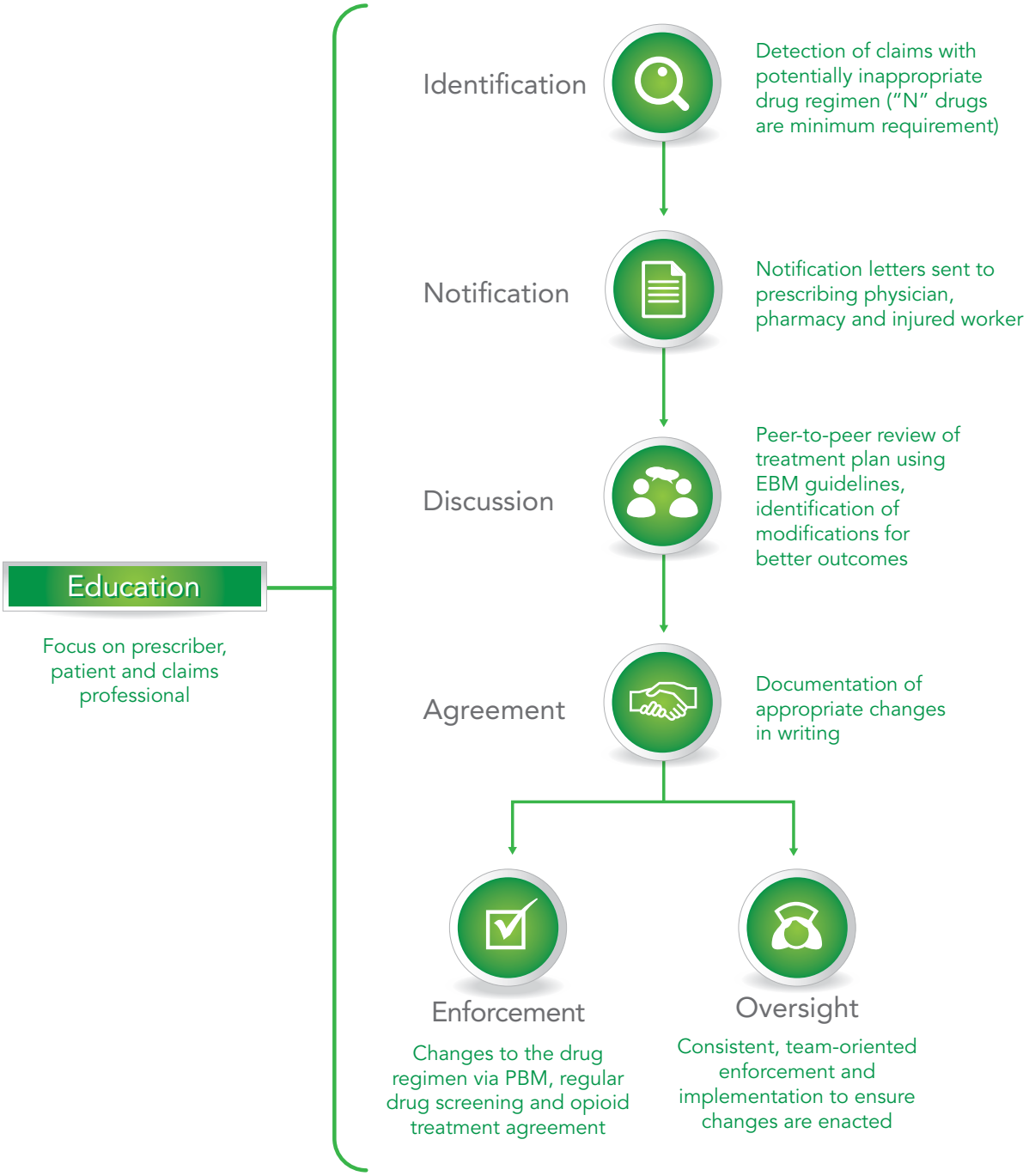
PRIUM is different from other peer review programs because it directly and most effectively engages the treating physician, resulting in a 75 percent discussion rate. QMI uses actively practicing physicians to collaborate with prescribers, typically resulting in a modified treatment plan based on a 53 percent agreement rate. Another distinctive advantage of QMI is that our oversight team consisting of nurses and highly experienced workers' compensation adjusters continually monitors and communicates with the prescribing physician during implementation of the new plan.

How QMI Works for TCF Legacy Claim Cleanup



PRIUM has customized its QMI offering to ease the administrative burden involved with legacy claim cleanup:

- Payer provides an electronic file of drug history to PRIUM
  - This file should contain all drug transactions for all Texas claims for the past 12 months
  - The data should include NDC, drug name, dosage, quantity, days' supply, dispense date, prescribing physician, dispensing pharmacy and cost

- PRIUM sends written notification to each prescribing physician, patient and pharmacy of the intent to address the medical necessity of the "N" drugs (standard document customized to the payer but consistent with the DWC template)

- PRIUM's reviewing physician contacts each prescribing physician to initiate discussion about the regimen and if inappropriate seek consensual agreement (oral and written) for change

- PRIUM coordinates with the payer's PBM to implement a customized formulary that matches the agreement

- PRIUM's Nurse Oversight remains engaged with each prescribing process until all changes are implemented

- The physicians who refuse to cooperate during this voluntary process will be re-engaged by PRIUM upon the first prescriptions after 9/1/12 with a more assertive approach

While the process is well defined by the DWC and not overly complex, the logistics for managing the process and the scope of claims that need to be addressed can be overwhelming for a payer. PRIUM is uniquely qualified to make it happen. For more information on how you can take advantage of PRIUM's experience and success in complying with the TCF, please email sales@prium.net or call 888.588.4964 today.

ABOUT THE AUTHOR

Mark Pew, Senior Vice President of Business Development, has 30 years of expertise in the property and casualty and healthcare industries, strategic planning and technology. He has worked with PRIUM in a variety of roles since 1989, including IT and operations, product and service development, and executive management. He led the development of PRIUM's eCase application in 2001 that remains the foundation for internal operations and customer interaction and is responsible for creating the Physician Pharmaceutical Review (PPR) product in 2003. Current responsibilities at PRIUM include sales, marketing, account management, strategic alliance development and new product/service development.

ABOUT PRIUM

PRIUM is a URAC-accredited utilization review and medical cost management company that serves the workers' compensation and general liability insurance industries. Services include prospective, concurrent and retrospective reviews that facilitate the management of clinical resources. Reviews are typically subject to strict statutory processes and timelines determined by the jurisdiction where the work injury occurred and/or care is delivered. PRIUM provides objective, unbiased and defensible reviews of medical necessity and causality. Medical records, discussions with treating providers, evidence-based medicine and our physician reviewers' personal education and practice experience determine the recommendations. Reviews cover healthcare and pharmaceutical services. PRIUM stands behind its clinical opinions and is willing to speak on behalf of its clients in front of any industry or statutory mediator.

SOURCES

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3. ibid.
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5. Texas Administrative Code. §134.510.
6. Texas Administrative Code. §134.500 – 134.550.