MINDER
Managing Disability

Dialogue

How can the California PDMP assist in workers' compensation claims?

When an injured worker submits a claim, it is the commencement of a project consisting of processes aimed at returning the injured worker to gainful and sustainable work at the earliest possible time. In this journey, checkpoints and milestones are the best means to monitor progress. Checkpoints generally relate to visits with a medical practitioner where medical conditions are checked against expectations and if necessary, treatments are adjusted. Milestones are associated with reaching a goal and in the case of workers' compensation claims management, the ultimate goal is returning the injured person to work.

A physician could jeopardize a patient's health and safety if they're unaware the patient is taking Scheduled controlled substances, by prescribing inappropriate medications.

At the first medical appointment, the physician is required to prepare a report for the claims administrator based on a comprehensive medical examination of the injured person including a review of their medical history. At the same time, the physician can access **CURES (Controlled Substance Utilization Review and Evaluation System)** to check whether the patient has received any Scheduled controlled substances in the prior 12 months. Through this access, the physician can determine an at-risk patient and accordingly establish a treatment plan that considers both medications and adjunctive treatments. Also, if a patient is identified as an addict, they can be referred for rehabilitation and social re-integration. With subsequent medical appointments, the physician can again use CURES to check for any changes to the patient's Scheduled controlled substances usage since their last visit. Identified changes in medical conditions need to be submitted in a progress report to the claims administrator.

The importance of a physician using CURES to check a patient's use of Scheduled controlled substances cannot be overemphasized, especially in workers' compensation where a patient may not be forthcoming in sharing comorbidity information due to a lack of trust. The control which California claims administrators have over the selection of medical practitioners available to injured workers, has been a major factor contributing to this lack of trust.

CURES, under the control of the Department of Justice (DOJ) tracks each person who has received Schedule II, III or IV controlled substances along with other pertinent data such as prescriber and dispenser. In addition to the medical profession having access to CURES, it is available to DOJ Investigators and law enforcement agencies to identify persons who visit a number of physicians to obtain supplies of Scheduled controlled substances for abuse and diversion (i.e. physician shopping). Pharmacists and numerous regulatory boards from the Medical Board to the Veterinary Board also have access to CURES providing them with the opportunity to monitor the medical profession for aberrant prescribing of Scheduled controlled substances including unnecessarily increasing MME (morphine milligram equivalent) levels and dispensing multiple Scheduled controlled substances such as benzodiazepines and amphetamines.

While states like Florida implemented a PDMP (Prescription Drug Monitoring Program) as late as 2011, California has monitored Scheduled II controlled substances since 1940 and with the introduction of CURES in 1996 extended its monitoring to include Schedule III and IV controlled substances. Online access to CURES has also been available to the medical profession since 2009. Consequently, California has not experienced the abuse and diversion which Florida has had with their pill mills. A pill mill has been described as a '*rogue pain management clinic where prescription drugs were inappropriately prescribed and dispensed*'. In addition to Florida introducing a PDMP law, it concurrently introduced a pill mill law. Early studies on the impact of the PDMP, known as "E-FORCSE (Electronic - Florida Online Reporting of Controlled Substance Evaluation Program)" identified both a reduction in drug-attributed mortality rates and the diversion rates of prescription opioids. However, a study released in August 2015 by researchers from the Johns Hopkins Bloomberg School of Public Health suggested that it was the pill mill law that was primarily responsible for the decline in opioid medication abuse rather than the PDMP. Nonetheless, a PDMP is still a deterrent to the person contemplating drug abuse and diversion.

Access to CURES by claims administrators or their representatives (i.e. third party payers) will not deliver improved quality of care or reduce prescription drug fraud and abuse and add unnecessary costs through duplication of efforts already being performed by others using CURES as outlined earlier. Close monitoring of checkpoints however, by the claims administrator using technology, will provide benefits. Monitoring is accomplished through what is commonly referred to as **"encounter data"** and includes diagnoses, services performed and medications dispensed along with amounts charged and paid. Diagnoses, medical procedures and pharmaceuticals translated into coding systems such as ICD-10 (International Classification of Disease, 10th revision), HCPCS (HeathCare Common Procedure Coding System) and NDC (National Drug Code) respectively, provide excellent opportunities to automate the monitoring of encounter data.

Have claims administrators been able to implement technology solutions to automate the monitoring of encounter data and achieve outstanding results? Over the past two decades, many claims administrators have opted to hand the management and control (i.e. outsource) of critically important functions such as utilization review, medical bill review, pharmacy monitoring including generic medication pricing analysis and the selection and monitoring of medical practitioners for their MPNs, over to other organizations. Each of these organizations however, is only concerned with that part of the encounter data which directly applies to their function for decision making, for example, pharmacy benefit managers being concerned with NDCs and medical utilization and bill review companies with HCPCS. Alternatively, utilizing all the encounter data can create and promote a vibrant synergy very capable of achieving outstanding outcomes and results for the injured worker.

Losing control of encounter data eliminates the claims administrator's ability to establish and monitor adherence to best evidence-based practices which could certainly prevent and reduce the injured worker's suffering. Furthermore, when physicians have not adhered to their proposed treatment plans, opportunities to trigger yellow and red flags for investigation are also lost by claims administrators, which in turn could prolong the entire return-to-work process. Interestingly, by selectively storing only encounter data deemed relevant to the outsourcing company in their databases (i.e. silos), have claims administrators breached the Sarbanes-Oxley Act of 2002, which

requires a company to identify the processes by which they have arrived at their financial results? The technology definition of a silo is "*a separate database or set of data files that are not part of an organization's enterprise-wide data administration*".

Although claims administrators are primarily concerned with quality medical care and decision-making for the injured worker, they must not overlook the risk factors and safety of the injured worker's family members and people around them. In August 2015, Maryland published their interim report titled, "Heroin & Opioid Emergency Task Force" which was aimed at reducing the abuse of illicit and licit drugs in their state. Claims administrators who have automated the monitoring of their encounter data can assist states like Maryland in reducing abuse and diversion by monitoring the quantities of medications being dispensed in a progressive or step therapy pain management plan for example, and encourage unused supplies to be returned to the physician at their next appointment. This can be achieved at no additional cost to the claims administrator and provides a benefit to the residents of the state by reducing the quantities of unused or unneeded prescription medications in circulation, which has been the focus of the DEA's (U.S. Drug Enforcement Agency) "take back" initiatives. To date, the DEA has collected in excess of 1,400 tons of unused medications which could otherwise have found their way into the illicit drug market.

For as long as the U.S. remains the biggest licit and illicit drug market in the world, claims administrators will remain challenged to deliver on their workers' compensation claims handling obligations. Persons addicted to drugs and those trafficking drugs, whether licit or illicit will choose the path of least resistance for their source. For the best part of the last decade, opioid analgesics along with other Scheduled controlled substances have generally been the drug-of-choice, until recent initiatives have curtailed their demand. These initiatives include states implementing a PDMP; pharmaceutical companies reformulating opioid analgesics making it more difficult for intravenous and intranasal abuse; the DEA reclassifying hydrocodone the most highly dispensed opioid analgesic from a Schedule III to a Schedule II, no longer allowing it to be prescribed with a repeat prescription and tramadol, an opioid analgesic, now being classified as a Schedule IV controlled substance where up until August 2014 it was not. Today, the drug-of-choice is either heroin or cocaine along with marijuana, which was recently legalized in a number of states. Increased use of marijuana introduces new challenges as doctors in Britain have noticed with a significant rise in patients experiencing cannabinoid hyperemesis syndrome (CHS) which makes heavy cannabis users severely ill. Colorado has also found increased suspected cases of CHS since marijuana was legalized in their state. The latest nationwide study into student use of drugs titled "Monitoring the Future" identified that one in every 17 college students smoked marijuana on a daily or near-daily basis and the same increase has been seen among high school seniors - our future workforce.

With a changing workforce, claims administrators will need to move more and more towards a biopsychosocial approach to managing medical conditions, which in-turn applies further pressure on them to embrace a **two-pronged claims management approach** of providing quality care at the lowest possible cost, which can only be achieved through the fine analytics of their consolidated encounter data. Claims costs directly influence workers' compensation premiums which can impact on employment opportunities as highlighted by Illinois Governor Bruce Rauner with a news release in August 2015 citing an Illinois employer moving its operations and 500 jobs 15 miles to a location in Indiana in order to save $1 million in workers' compensation premium.

Capturing encounter data through the claims administrator's processes and fine analytics will consistently yield the best claims outcomes from earlier return to work to lower costs associated with medical treatment through to automated overseeing of a claim including provider performance monitoring and evaluation - **all of which are the essence of superior workers' compensation claims management.**

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