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Rx *Informer*

Topics and issues impacting workers' compensation pharmacy costs

inside:

In the workers' comp and drug therapy arenas, the challenges are constantly evolving.

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A Forward-looking Pharmacy Program Delivers Value

Managing the challenges related to prescription drugs in the workers' compensation industry is a constantly evolving area. The list of complex topics covers a wide range of pharmacy business functions including clinical, technical and legal disciplines in addition to navigating market forces, all of which require constant planning and targeted focus.

In all of these cases, information is key. Current and timely information can help a PBM and payers strategize and develop forward-looking solutions for issues on the horizon while quickly addressing immediate challenges. The information presented in this document is a compilation of timely topics impacting payers and the pharmacy management industry today or others which may have a likelihood to do so in the near future.

A highly successful workers' comp PBM program uses a variety of tools to mitigate expensive and costly issues. In many cases, the most effective solutions likely are not one-time fixes because in workers' comp the challenges are constantly evolving. This past year alone has seen a number of emerging trends, such as new and reformulated medications coming to market; repackaged and compounded drugs; shifting prescribing patterns and significant regulatory changes. The keys to managing these complex issues, while improving program efficiency and reducing cost, involve proactive engagement, innovative approaches and sophisticated technology capabilities.

Flexibility and a client-tailored, total program approach are key elements to a successful PBM program and are crucial in many situations, whether it's dealing with legislative changes or client specific needs. In many cases these changes and solutions are technology driven and can entail improving existing pharmacy program processes by making them more efficient or developing new, innovative solutions to address the evolving market.

In the end, PBMs must keep customers one step ahead, looking for ways to minimize the financial impact and complexities of industry changes. In addition they must be focused on providing greater value to customers because as industry results have clearly demonstrated, drug discount pricing alone will not equate to better overall results. It has been proven time and again that the price of the pill is not necessarily driving the cost; it's more likely to be the amount and frequency. Most importantly, a PBM should be there to manage the entire workers' compensation prescription drug continuum. As a result, payers will realize greater cost savings while maintaining solid strategies to continue succeeding in the long run.

Repackaged Medications

When Healthesystems first started reporting on this challenging trend a few years ago, some industry insiders ignored the issue because it was (and to a certain extent still remains) a relatively small percentage of overall prescription volume. Since that original report, the use of these formulations has risen to an alarming level and considering the overbilled amounts in the most egregious cases, the dollars lost are hardly insignificant. More importantly, the growth from this dispensing source has been exponential over these past five years, and isn't showing any sign of slowing down. Repackaged medications represent the latest trend in a series of exploited legislative loopholes. Repackagers take a bulk medication and re-label it in a smaller package with a new NDC (National Drug Code) and assign a new Average Wholesale Price (AWP), frequently at an inflated rate compared to the original product. Because of a loophole in many state laws, the repackaging companies are considered "labelers," which is why they are able to set their own AWP for these products, and easily controvert state fee schedules and other cost-containment measures. The result is the same drugs have an average cost per prescription far exceeding those dispensed at a traditional point of service.

Typically, repackaged medications are associated with physician dispensing. Advocates for this practice often tout patient convenience and improved compliance with therapy as chief benefits. Some states (e.g., Texas) have restrictions around the physician dispensing practice, allowing it only in select circumstances (rural areas, etc.). Repackagers, however, have implemented new methods to circumvent the spirit of this statute — for example opening pharmacy operations frequently located closely to medical arts and pain clinic areas. However, it is important to note that not all repackagers are cost-abusive (in fact, only a small fraction account disproportionately for the majority of costs).

Currently, the majority of repackaging firms operate in a handful of states — CA, TX, AZ, FL and MA. However, due to the time usually involved with closing legislative loopholes, their influence is likely to spread until preemptive action is taken to eliminate the reimbursement differentials that so heavily favor these firms.

Several years ago the state of California, where the majority of this activity started, enacted legislation which included restrictive reimbursement guidelines for repackaged drugs which quickly had a positive effect. Recently, Arizona also introduced similar guidelines to address the fast growing practice, however, there are signs certain companies in the repackaging industry have started modifying their business practices in an attempt bypass the rules in these states. This includes not using the repackaged drug number sequence usually included in the assigned NDC and thus avoiding detection during the prescription adjudication process. Addressing this type of challenge requires significant data mining and analytics expertise since it may not be easily identifiable on the surface of the prescription transaction level. In addition, many PBM's may not necessarily have the adjudication methodology in place to be able to apply the allowable jurisdictional rules in states like CA and AZ whereby repackaged drugs can be adjudicated to the lowest cost therapeutic equivalent. However, based upon the continued growth in volume, the challenges will likely continue to grow and it is crucial for the PBM to have both the technological and clinical tools in place to implement and maintain a successful long term strategy.

Top Workers' Comp Repackaged Drugs

The following are some of the most frequently repackaged drugs based upon Healthesystems' analysis:

Hydrocodone/APAP

Carisoprodol

Naproxen

Tramadol

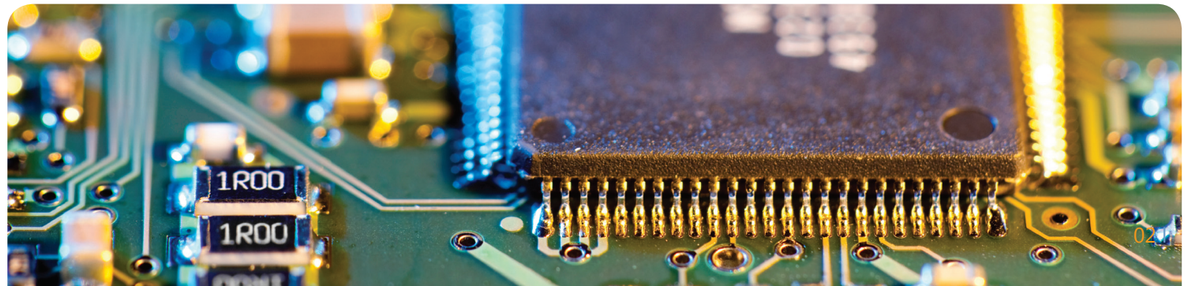
Cyclobenzaprine

Ibuprofen

Financial Impact Example

Here's an example of the potential financial impact resulting from a repackaged drug:

A repackaged prescription for a tablet of Hydrocodone/APAP is billed at an AWP rate of $1.74 per pill, while the lowest cost therapeutic equivalent of the same drug dispensed in a non-repackaged form is $0.39 per pill (over 4 times the amount).



Based on cases Healthesystems has observed, it frequently cannot be determined if medical food products are being prescribed applying any regard to total daily doses or whether there is concern for toxicity potentially caused by these substances.

Medical Foods

A new potential issue to keep in sight for workers' compensation payers is the prescribing of "medical foods" in some isolated workers' comp populations. A number of concerns exist regarding the reliance on "medical foods" to treat this patient population including safety, efficacy and cost.

According to the FDA, a medical food is distinguished by being "specially formulated … to meet the distinctive nutritional requirements of a disease or condition … for the patient who is seriously ill … who requires the product as a major [aspect of] treatment."[1] The medical food designation is typically for products that provide nutrition when a patient is unable to obtain all of the necessary calories or nutrients from a traditional diet, such as cases when a patient must be tube fed. In contrast, medical foods are also frequently dispensed by closed networks of subscribing physicians where they are marketed as novel treatments addressing underlying nutritional deficiencies caused by disease.[2]

Questions should be raised concerning therapeutic and toxic levels of these substances. What parameters are used to determine a patient-specific dose? Is this a weight-based protocol? What are the typical adverse effects caused by these substances, and what are signs/symptoms of its toxicity? What is an "unsafe" dose of an agent such as Theramine or GABAdone? Based on cases Healthesystems has observed, it frequently cannot be determined if these products are being prescribed applying any regard to total daily doses or whether there is concern for toxicity potentially caused by these substances.

For example, one medical food, Theramine, is purportedly used to "stimulate production of serotonin, GABA, norepinephrine, nitric oxide, and acetylcholine." Another agent, GABAdone, "provides amino acids that are precursors to neurotransmitters." It is unclear how these products that purport to increase the levels of these neurotransmitters similar to prescription SSRIs (e.g., Prozac, Celexa) can safely be used at an unlimited level. If, importantly, there is no toxic dose of Theramine or GABAdone, then, conversely, it should also be questioned whether there is a therapeutic dose.

It is medically recognized that some disease states result directly in nutritional deficiencies (.e.g., pancreatic or kidney insufficiency, pellagra, scurvy, etc.) — and supplementing the patient's diet with nutritional substances is often necessary in these cases. However, the language used in the law has allowed all manner of products to be marketed without oversight. Currently, medical foods do not undergo FDA review and have neither been proven safe nor effective by the FDA. There are generally no human clinical studies to review or documented drug interactions, side-effects, or hepatic, renal, and gastrointestinal effects of these combinations.

Prescribers and patients may mistake these products as FDA-approved for a number of reasons. Manufacturers of these items typically assign fictitious National Drug Code (NDC) numbers to the products; this is the number all FDA-approved medications bear. Similarly, their labels tout the common drug statement required of all prescription medications: "CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION." However, the presence of these markings alone does not confer legitimacy on these products, nor does it imply FDA approval.

To further legitimize these products, medical foods like Theramine and Hypertensa are often combined with FDA-approved medications (e.g., muscle relaxants, blood pressure medications, NSAIDs, etc.) in patient-ready "convenience packs." No evidenced-based data exists to prove the safety or efficacy of the ingredients in these medical foods – which range from cocoa and gingko (Sentra PM®), grape seed and cinnamon (Theramine®), to the esoteric amino acids histidine and arginine (Hypertensa®). Nevertheless, when combined with generically available medications such as naproxen (Theraproxen®) and lisinopril (Lytensapril®), these "new" formulations are priced with a substantial markup.

Issues of patient safety must be considered when these products are used; unproven safety profiles and unfounded claims of efficacy make medical foods potentially dangerous agents. The problem is complex, but solvable. It will take the collaborative participation by healthcare providers, regulatory agencies, legislators, manufacturers, and consumers to regulate the use of these products.

Medical Foods Observed by Healthesystems

Sentra PM®	Trepoxen Pak	Lytensopril®
Sentra AM®	Sentrazolpid Pak PM	Senophylline™
Limbrel®	Gabazolamine Pak™	Strazepam™
Gabadone™	Prazolamine Pak™	Trazamine™
Theramine®	Theratramado Pak - 60	Theraproxen®
Gabitidine Pak™	Theratramado Pak - 90	
Gaboxetine Pak™	Hypertensa®	

Verticē™

A Powerful Web-based Client Portal

Since introducing the web-based Verticē claims information portal to Healthesystems clients, almost 90% of prior authorization activity occurs using this robust online tool. The result? An adjuster never has to pick up the phone unless it's absolutely necessary. And because the transactional environment occurs in real-time, the Healthesystems customer service staff is able to respond immediately (removing what used to take multiple phone calls). The Healthesystems proactive approach also provides injured workers with a more reliable, "high-touch" service experience.

Approximately 16 percent of the time when a pharmacy transaction requires a prior authorization, the injured worker is standing at the pharmacy counter. A real-time information portal, such as Verticē, removes the delay, and allows issues to be resolved immediately.

Appropriate use of abuse-deterrent opioids needs to be part of a comprehensive monitoring program on the part of the provider, one with which the patient willing and actively participates.

Abuse-deterrent Opioids

The prescription of opioids in the United States has risen dramatically over the past 15 years. Methadone prescribing rose nearly a thousand percent between 1997 and 2005[1], and is thought to be in large part due to a shift in prescribing resulting from the bad press Oxycontin received in the late 90s. In addition, according to the National Center for Health Statistics, the number of deaths from opioid overdoses over the same period rose nearly 400%, coinciding with the increased rate of prescribing while the United States continues to be the greatest consumer of prescription opioids and accounts for 99% of worldwide hydrocodone use (hydrocodone has continued to be ranked as one of the top drugs dispensed in the workers' compensation population for more than a decade, and is also considered to be widely abused). Similar to the statistics on overdoses, clinical studies have been documenting an attendant rise in the rate of opioid abuse and addiction.

Over the past two years several new "abuse-deterrent" formulations of opioids have been released to the market in an attempt to curb the misuse of these powerful drugs. The new formulations include either a physical or chemical barrier that prevents or provides an impediment to the ways the drugs are typically abused – crushing, chewing, injecting. Given the addiction potential the opioid class possesses, the place in therapy for these new agents on the surface seems intuitive, however, the question still needs to be asked, when should these new formulations be used in treating chronic pain?

One of the more notable opioid drug entrants includes the recently released reformulated Oxycontin. As one of the most prescribed and frequently problematic drugs for treating injured workers, this new brand formulation will continue to require close oversight from payers regardless of the new formulation properties. In addition, the brand designation may likely impact overall prescription costs.

Another of the newly released opioids Embeda, is comprised of naltrexone combined with morphine and has also been formulated as an abuse deterrent drug. An additional drug Exalgo, which is likely the most potent of the three drugs, is not an abuse deterrent formulation and is an extended release drug. As is the case with the introduction of any new powerful pain treatment drugs, understanding the clinical implications at a patient level is most crucial to ensure positive outcomes.

In terms of the patients that may benefit from the newer, abuse-deterrent formulations – who are they? Those with a history of drug abuse (prescription or illicit), or those that might be in an environment where diversion is likely may benefit from prescription of these formulations. But it is important to remember that these formulations are not a silver bullet against abuse. Appropriate use of abuse-deterrent opioids needs to be part of a comprehensive monitoring program on the part of the provider, one with which the patient willingly and actively participates. Importantly, while abuse-deterrent opioids can discourage abuse by typical means, they do not decrease potential for overdose.

New Medications

While it can occasionally be challenging to control physician prescribing patterns and the costs associated with some of the top dispensed medications in the workers' comp population (e.g., Oxycontin, Lyrica, Cymbalta, Celebrex, Lidoderm), proactive identification of medications emerging in the marketplace offers the opportunity to create programs aimed at managing utilization and targeting inappropriate use of medications. Many medications recently brought to the market have the potential to pass on excessive and possibly unwarranted costs to payers.

For example, instead of prescribing certain new brand products, an orally available, immediate-release generic formulation of the active ingredient may be considered a better agent for a patient's initial prescription. Some older products that still fall into this category are Amrix (cyclobenzaprine extended-release capsules) and Ambien CR (zolpidem extended-release). Regarding the new "abuse-deterrent" opioid products (e.g., Embeda, Exalgo), sufficient patient history should be necessary to warrant the use of this type of formulation, as opposed to a more traditional agent like morphine ER or Oxycodone ER.

Healthesystems clinical services monitors and manages access to certain drugs, while providing an educational resource for prescribers and case managers as a means to promote proper use of new medications in workers' compensation.

	1997	2005	% Change
Methadone	518,737	5,362,815	933%
Oxycodone	4,449,562	30,628,973	588%
Fentanyl base	74,086	387,928	423%
Hydromorphone	241,078	781,287	244%
Hydrocodone	8,669,311	25,803,544	198%
Morphine	5,922,872	15,054,846	154%
Meperidine	5,765,954	4,272,520	-26%
Codeine	25,071,410	18,960,038	-24%

The prescription of opioids in the United States has risen dramatically in the past 15 years. Methadone prescribing rose nearly a thousand percent between 1997 and 2005, and is thought to be in large part due to a shift in prescribing resulting from the bad press Oxycontin received in the late 90s. As the dramatic increases this table demonstrates, abuse-deterrent formulations of opioids will likely maintain a role in therapy.

Some new medications/indications include:

New Product	Manufacturer	Approved by FDA	Therapeutic Class	FDA-Approved Indications	Market Availability
Sprix™	Roxro Pharma, Inc.	May 14, 2010	NSAID	Short term (up to 5 days) management of moderate to moderately severe pain	Unknown
Vimovo™ (naproxen and esomeprazole)	Pozen, Inc., and AstraZeneca, Plc	April 30, 2010	NSAID/Proton Pump Inhibitor Combo	Relief of signs and symptoms of osteoarthritis, rheumatoid arthritis and ankylosing spondylitis and to decrease risk of developing gastric ulcers. This product is not recommended for initial treatment of acute pain. Studies do not extend past 6 months	Available Now
Rybix®	Victory Pharma, Inc.	June 1, 2010	Short-acting opioid analgesic	Management of moderate to moderately-severe pain in adults (16 years of age or older)	Available Now
Exalgo™	Mallinckrodt Inc.	March 3, 2010	Opioid Analgesic	Management of moderate to severe pain in opioid tolerant patients requiring continuous, around-the-clock opioid analgesia for an extended period of time	Available Now
Butrans™ (buprenorphine) transdermal patch	Purdue Pharma, L.P.	June 30, 2010	Opioid Analgesic	For the management of moderate to severe chronic pain in patients requiring a continuous, around-the-clock analgesic for an extended period of time	Anticipated first quarter 2011
Vivitrol® (NEW INDICATION)	Alkermes, Inc.	October 12, 2010	Opioid Antagonist	Prevention of relapse to opioid dependence, following opioid detoxification	Available Now
Suboxone® sublingual film	Reckitt Benckiser Pharmaceuticals, Inc.	August 30, 2010	Addiction therapy	Maintenance treatment of opioid dependence	Anticipated October 2010
Neudexta	Avanir Pharmaceuticals, Inc.	October 29, 2010	Antitussive/Antiarrhythmic	For the treatment of pseudobulbar affect (PBA)	Anticipated first quarter 2011
Latuda®	Sunovion Pharmaceuticals Inc.	October 28, 2010	Atypical Antipsychotic	For the treatment of schizophrenia	Anticipated first quarter 2011

It is expected that these issues, as well as issues not yet identified, may have unintended consequences and impact the success of the program in yet unknown ways.

TX to Adopt Closed Formulary Based on ODG

The Texas Division of Insurance (TDI) has been engaged in the process of adopting a closed formulary based on the Work Loss Data Institute's Official Disability Guidelines (ODG). While implementing a formulary based on evidence-based therapeutic guidelines such as the ODG has many benefits, the proposed process also leaves several important questions unanswered. It is expected that these issues, as well as issues not yet identified, may have unintended consequences and impact the success of the program in yet unknown ways.

The opportunities that can be realized through the use of a closed formulary are largely intuitive. Evidence-based treatment guidelines like the ODG can minimize reimbursement uncertainty among providers, and standardize the effective treatment of acute and chronic conditions. When treatments adhere to the guidelines, injured workers should benefit by receiving early access to appropriate therapies, which can potentially shorten the length of disability. And ultimately as employees return to work, the drain on employers and insurers should be lessened/contained.

The TX proposed formulary divides prescription drugs into two distinct groups (with a third, less well-defined group). One, a set of medications deemed appropriate for first-line use are designated as "Y" drugs. A second set of medications, designated "N," are considered to be inappropriate as first-line therapy; these agents would require a pre-authorization, defined as a "Statement of Medical Necessity" (SOMN) prior to reimbursement.

The new policy, as structured, will not eliminate the need to maintain continuous oversight of therapy and may present several challenges for payers and providers. The exact process for managing "N" medications, and their necessary pre-authorization SOMN forms, is still relatively unknown. Therefore there could be delayed access to "N" drugs during the onset of the new guidelines, while the physician-provided SOMN is approved. Doctors may also face challenges in providing the "written statement and supporting evidence-based documentation" required with each SOMN (§ 134.500, ODG) and questions still remain regarding the standardization of this requirement.

The lack of a quantitative restriction on "Y" drugs in the ODG adds further questions. That is, while an "N" drug would be subject to pre-authorization irrespective of its intended use, a "Y" drug has no defined utilization limits: a clinically inappropriate dose (either sub- or super-therapeutic doses) of a "Y" medication can be prescribed, without sanction.

By its nature, the ODG is only a tool. It does not obviate the need for the clinical, therapeutic input that must go along with every approval or disapproval decision at the payer level. It has been noted that "Y" doesn't equal "compensable" and "N" doesn't equal "inappropriate" — each request must be evaluated in the context of its place in therapy for a given injury.

While the net effect of the closed formulary is expected to be positive for all stakeholders, there are "unknown, unknowns" associated with its implementation — that is, there are effects that cannot be currently predicted. Overall, the ODG and the closed formulary proposed by the TDI is a step in the right direction. Until the above issues are adequately addressed, however, many unknowns still exist. Healthesystems continues to be actively engaged in the TX situation and will proactively address the new closed formulary with its clients.

Healthesystems Newsletters Offer Insight into Emerging Clinical and Compliance Issues

Healthesystems offers its clients a valuable tool for staying up-to-date on current and emerging issues facing the workers' compensation industry. Electronic newsletters featuring information on compliance and legislative issues, as well as clinical and pharmacy issues are delivered directly to subscribers inboxes.

The newsletters offered include the *Compliance Quarterly*, featuring government and compliance related content and the *Rx Postscript,* a digest of new and current pharmacy and drug therapy information.

Individuals can sign up to receive either of these valuable newsletters by visiting www.healthesystems.com/newsletters.

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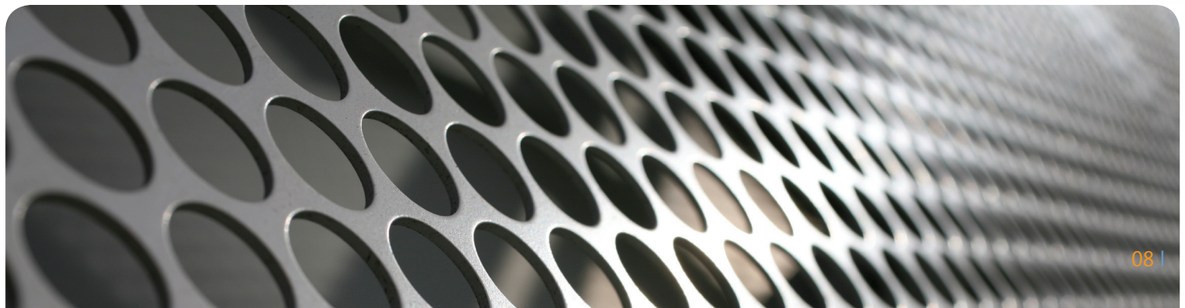

Compliance Updates

Alaska's Department of Labor recently issued regulations, effective July 31, 2010, requiring generic medications to be dispensed for injured workers. Generics should be utilized in most cases, except where the provider has indicated brand dispensing is medically necessary. Patients requesting brand medications over generic will be responsible for the difference between the brand and generic drug costs if a generic is available and there is no medical rationale to dispense a brand name drug.

Arizona The Arizona Industrial Commission recently published its 2010 Fee Schedule effective October 1, 2010. The 2010 fee schedule now directs payers to reimburse medicines at the fee schedule rates, absent a contractual agreement between the pharmacy and payer. The ICA also clarified, "network discounts may not be applied in the absence of a contractual agreement with the pharmacy authorizing such discounts." The Industrial Commission also added new language providing guidance on the direction of injured workers into a provider network.

California's Department of Industrial Relations has adopted new rules on posting notices and notification requirements for employers participating in Medical Provider Networks. The new regulations became effective October 8, 2010.

Louisiana Office of Workers' Compensation will require e-billing by 2012. Louisiana Governor Bobby Jindal signed Senate Bill 255 into law on June 4, 2010, paving the way for the Louisiana Workers' Compensation Commission to adopt rules on electronic billing.

Florida Physician Dispensing of Repackaged Drugs and Emerging Billing Trends

Physician dispensing of repackaged medication continues to be a heavily debated subject, particularly in Florida. Physician proponents cite in-office dispensing of repackaged medications helps to reinforce patient compliance with treatment plans. However, opponents are quick to point out that repackaged medications dispensed in a physician setting are marked up in price by as much as five times more than the allowable fee schedule, and this significant increase in cost far outweighs the convenience benefit.

In 2010, a bill to limit the reimbursement of repackaged medications passed in the Florida Legislature but was later vetoed by Florida Governor Charlie Crist. Despite the veto, a Florida school district has recently taken a firm position on eliminating physician dispensing and the district estimates a savings of over $700K per year by reducing the price to the Pharmacy Benefit Manager (PBM) contract rate.[1]

Recently quoted in an article in Risk & Insurance Magazine, Daryl Corr, president of Healthesystems said, "Drug re-packagers — companies that break down the original packaging of a drug into different quantities and repackage it — are proliferating in Florida. When repackaging occurs, the original National Drug Code of the drug that is repackaged is modified to a new number, while also assigning a new average wholesale price. In most cases the re-packager sets the new average wholesale price to an inflated rate. The Florida fee schedule uses the average wholesale price as the pricing benchmark; therefore the end result is an inflated cost to the payer/employer. Companies like Healthesystems, though, have the ability to identify these transactions and re-price them back to a comparable rate of the original drug."[2]

Healthesystems has recently identified an emerging trend in repackaged drug billing wherein re-packagers bypass the original National Drug Code (NDC) number used to determine reimbursement by using NDC codes that do not utilize the "repack indicator field" in most national recognized pharmacy databases, such as Medi-Span. Healthesystems is proactively addressing this issue with its clients and has implemented solutions to address this challenge.

"Companies like Healthesystems, though, have the ability to identify these transactions and re-price them back to a comparable rate of the original drug." - *Daryl Corr, President*

Florida Board of Medicine Proposes New Rules for Pain Management Clinics

Florida lawmakers recently took steps toward preventing drug diversion and abuse in the state by passing SB2272. The bill will place additional controls on many of the non-institutional pain management clinics which have cropped up across the state in recent years. The measures are intended to reduce drug diversion, prevent doctor shopping and curb the growing number of out-of-state patients who come to Florida for prescription drugs. The bill will also directly impact Florida injured workers receiving treatment at pain management clinics. The bill, which was signed into law in June 2010, became effective on October 1, 2010.

The Florida Board of Medicine is in the process of drafting rules to support the intent of the bill. Per the proposed rules, injured workers being treated at pain clinics regulated by this new law will be required to submit to mandatory drug testing. Testing will be required prior to the initial fill of any controlled substance, and on a random basis at least twice a year. Physicians will be required to test injured workers to verify they are taking medications as prescribed without a special request from the adjuster or the medical case manager.

In order to comply with the adopted rules there is a tremendous amount of work to be completed by the Board of Medicine. The Division of Workers' Compensation may also need to consider the addition of new codes, or specific reimbursement rules for mandatory drug testing in its Health Care Provider Reimbursement Manual. If the Division of Workers' Compensation adds specific guidance to the reimbursement manual, they will be setting clear guidelines for providers that not only is testing required for workers in a pain management setting, but reimbursement will be made based on a specific code.

The new rules are expected to be adopted prior to January 2011, upon completion of the official rulemaking process.

Medical Treatment Guidelines

Over the past several years a number of workers' compensation state agencies adopted or explored the use of medical treatment guidelines as the standard of care for injured workers. Both Minnesota and New York adopted guidelines this summer and Louisiana and Montana regulators are working towards adopting guidelines by year end. At least four other states are considering treatment guidelines in their 2011 agendas. In recent years, treatment guidelines have become a common platform for providers and payers to ensure timely and appropriate delivery of healthcare to injured workers.

Regulators from across the nation gathered last month in Los Angeles at the Annual Conference of the International Association of Industrial Accident Boards and Commissions (IAIABC). A special session, Answers to Your Questions About Adopting Medical Treatment Guidelines, took place September 22nd and highlighted the growing trend towards adopting treatment guidelines and a panel shared excellent insight into the process of evaluating and implementing the guidelines.

Elizabeth Miller, Special Assistant to the Chair, New York State Workers' Compensation Board (NYSWCB) is in the process of rolling out treatment guidelines in NY. As a panel member at the forum Ms. Miller remarked, "The key to a successful implementation is outreach and education, for medical providers, their staff, claims people and even our Administrative Law Judges and attorneys. These pieces all need to work together to ensure injured workers are getting quality care more timely. With better treatment, you get better outcomes." New York's Medical Treatment Guidelines become effective December 1, 2010.

Given the positive impact the medical treatment guidelines have had, it is not surprising that workers' compensation agencies are embracing the benefits of the guidelines within their rules and regulations. Washington's Department of Labor and Industry (DLI) was the first to look at adoption of treatment guidelines, publishing its diagnosis specific guidance in 1988, which addressed inpatient admission criteria for non-surgical back pain. Within a year of this published guidance, the DLI reported a 60% decrease in these admissions, a considerable impact in a relatively short timeframe.[1]

In 1992, Colorado's Division of Workers' Compensation adopted their own version of treatment guidelines. Panelist Dr. Kathryn Mueller, Medical Director for the Colorado Workers' Compensation Division said, "These treatment guidelines are more than a tool for utilization review; they are best practices for better medical outcomes." Colorado updated their guidelines on Thoracic Outlet Syndrome in 2010 and are working on more updates which will be posted on their website in the future.

As advances in medicine and technology evolve, so should the treatment guidelines which are used as the standard of care. It is important that regulators consider the implications of adopting guidelines and respond quickly where technological, legal or other trends impact the process.

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About Healthesystems

Healthesystems is a specialty provider of innovative medical cost management solutions for the workers' compensation industry. Our comprehensive products include a leading Pharmacy Benefit Management Program, expert Clinical Review Services and a revolutionary Ancillary Benefit Management solution for prospectively managing ancillary medical services.

Our Verticē Claims Information Portal delivers real-time pharmacy and ancillary benefit management program information, reports and tools. This intuitive web portal allows claims professionals to access tools for quickly and efficiently processing provider transactions, running reports, retrieving relevant clinical information and many other functions.

By leveraging powerful technology, clinical expertise and enhanced workflow automation tools, we provide clients with flexible programs that reduce the total cost of medical care and manage drug utilization including the overuse of narcotics and other problematic drugs, all while increasing the quality of care for injured workers.

About Our Data

Data referenced in this document was produced using Healthesystems' proprietary pharmacy database information.

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