

Legacy Cleanup, Texas Style

Introduction

With the successful implementation of the Texas Closed Formulary (TCF) on prescription drugs for Workers' Compensation (WC) claims with a Date of Injury (DOI) on/after 9/1/11¹, the focus now should switch to the cleanup of "legacy claims" (all WC claims with a DOI prior to 9/1/11). The Texas Pharmacy Formulary rules very specifically outline the process and timeline associated with this cleanup², both addressed later in this document. Given the potentially extreme physical and psychological addiction associated with these drugs, it is time to get started towards those deadlines. **This should make 2012 the "Year of Legacy Claim Cleanup" in Texas.**

TCF Background

Texas House Bill 7, signed into law on June 1, 2005 with changes effective September 1, 2005³, was the beginning point to address high medical costs and poor return-to-work outcomes. Strong support for Utilization Review (UR) was included to give Payers a better opportunity to contest the medical appropriateness of treatment that did not yield a reasonable return to work or function. The infrastructure for dispute was created with prospective (before the treatment is rendered, aka preauthorization) and concurrent (while treating is ongoing) and retrospective (after the treatment is rendered) review methods. The baseline for evaluation was established when the Official Disability Guidelines (ODG) were selected

¹ 28 TEX. ADMIN. CODE. §§§134.500, 134.506, 134.510, 134.520, 134.530, 134.540, and 124.550 were amended to be effective January 17, 2011. The amendments were published in the December 17, 2010 issue of the Texas Register (35 Tex. Reg. 11344).

² 28 TEX. ADMIN. CODE. §134.510.

³ Texas House Bill 7 was enacted by the 79th Legislature, Regular Session and effective September 1, 2005. The bill made significant changes to the State's workers' compensation system.

as the standard of care⁴ for treatment provided on/after May 1, 2007⁵. Over time, mandates were put into place for preauthorization of certain treatments and procedures prone to over-utilization (e.g., physical and occupational therapy), unpredictable outcomes (e.g., spinal surgery), or questionable cost-benefit (e.g., DME in excess of \$500). Pharmacy was always part of the plan⁶, so pursuant to that and effective 9/1/11 the TCF was initiated for new WC claims. This requires preauthorization of any FDA approved drug that has an ODG status of “N”⁷, is investigational or experimental⁸, or is a compound that contains drug(s) with an ODG status of “N”⁹. Interestingly, since the inception of the TCF on 9/1/11, there appears to have 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 for analysis the drug transactions since 09/01/10 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%

⁴28 TEX. ADMIN. CODE. §137.100(a).

⁵28 TEX. ADMIN. CODE. §137.100(h).

⁶HB-7 included §408.028 about a Pharmaceutical Services closed formulary.

⁷28 TEX. ADMIN. CODE. §134.530(b)(1)(A).

⁸28 TEX. ADMIN. CODE. §134.530(b)(1)(C).

⁹28 TEX. ADMIN. CODE. §134.530(b)(1)(B).

As shown above, the average number of “N” drugs per day and their ratio to the overall number of scripts has decreased dramatically. Interestingly, the top 5 drugs used for both date ranges (Voltaren gel, Carisoprodol, Lidoderm patches, Flector patches and Zipsor) have 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 (since there has been limited time from the TCF inception on 9/1/11), 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%

A conclusion can be drawn from this data analysis that the TCF has had the desired effect in reducing the use of these highly 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 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 (POS). Instead, it appears that the treating physicians have determined alternative methods for treating pain because of the new statutory requirements. It is still early and these apparent trends could change or maybe even be

incomplete, 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 10/27/11 by the Texas Department of Insurance Workers’ Compensation Research and Evaluation Group¹⁰ found that pharmacy payments consistently represent 13% of all medical payments in Texas¹¹. In addition, “legacy claims” had significantly higher average pharmacy costs (injury years 1991-2005 = **\$3,636**) in 2010¹² than newer claims (injury years 2006-2009 = **\$266**)¹³. And, overall, approximately 76% of the prescriptions for Schedule II drugs are for injury years 1991-2005¹⁴. So while gaining early control over new claims is important, the primary driver to cost and over-utilization remains centered on “legacy claims.”

The Texas Department of Workers’ Compensation (DWC) had the foresight to not just address new claims / injuries as part of the TCF but also the thousands of “legacy claims” (those with a DOI before 9/1/11). While the statutes and rules have been supportive since the passage of HB-7 of a retrospective review of the drug regimen for medical appropriateness and relatedness to the WC claim, the DWC is forcing the issue to address these older claims via a transition to the TCF over two years. Bottom line, **by 9/1/13 every “legacy claim” will need to have medical necessity confirmed for each “N” drug in its regimen or be subject to the TCF preauthorization process.** This is the cleanup process that has been needed for a long time but for a variety of reasons has only been sporadically successful to-date. The DWC was very explicit in their expectations for this process:

¹⁰ http://www.tdi.texas.gov/reports/wcreg/documents/Accessible_Pharm.pdf

¹¹ Id. at 3.

¹² Id. at 5.

¹³ Id. at 8.

¹⁴ Id. at 20.

- Beginning no later than 3/1/13 each Payer shall identify “legacy claims” where an excluded drug has been prescribed after 9/1/12¹⁵ and provide a written notification to the injured worker, prescribing physician and pharmacy¹⁶ of the impending formulary applicability¹⁷ and a contact name and number for discussion¹⁸
- At any time between 9/1/11 and 9/1/13 each prescribing physician should include a statement of medical necessity with the prescription for an excluded drug¹⁹
- Either the Payer or prescribing physician may initiate discussion about a claim’s drug regimen²⁰ and attempt to agree on modifications that would bring it into compliance with ODG and TCF, and if that agreement is in writing and changes actually implemented then health care provided as a result of the agreement is not subject to retrospective review²¹
- Every “N” drug for every claim will be subject to the TCF starting on 9/1/13²²

While there is an appeals process (MIO or Medical Interlocutory Order) for circumstances where the risk of a medical emergency exists²³, there is no specific dispute resolution process in the case where an agreement is not reached on medically appropriate changes to the drug regimen as it will be addressed by the TCF starting on 9/1/13²⁴. 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 and creating a medical emergency on/after 9/1/13.

Given the DWC’s rules for evaluating “legacy claim” drug regimens, the length of time it could take to discontinue medically inappropriate drugs that are highly addictive and have been used for a long

¹⁵ 28 TEX. ADMIN. CODE. §134.510(b)(2)(A).

¹⁶ 28 TEX. ADMIN. CODE. §134.510(b)(2)(B).

¹⁷ 28 TEX. ADMIN. CODE. §134.510(b)(2)(B)(i).

¹⁸ 28 TEX. ADMIN. CODE. §134.510(b)(1)(C).

¹⁹ 28 TEX. ADMIN. CODE. § 134.510(b)(1)(A).

²⁰ 28 TEX. ADMIN. CODE. §134.510(b)(1)(B).

²¹ 28 TEX. ADMIN. CODE. §134.510(d)(2).

²² 28 TEX. ADMIN. CODE. §134.510(a).

²³ 28 TEX. ADMIN. CODE. §134.550(a).

²⁴ 28 TEX. ADMIN. CODE. § 134.510(d)(4).

duration, and momentum created by the apparent success to-date of the TCF for new claims, it would be in everyone's best interests to start the process of "legacy claims" cleanup in 2012. Taking into account how the DWC has documented the timeline and expectations, a process that would yield optimal results could be outlined as follows:

1. The Payer creates a list of all claims that have at least one drug that fits the criteria
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 9/1/13

A Turnkey Solution

Time is of the essence. Because some of the ODG "N" drugs could take several months to wean, and there are thousands of claims that have a DOI before 9/1/11 and at least one "N" drug, it is incumbent upon each Payer to initiate this process as soon as possible to allow enough time for the full process to run its course well before 9/1/13.

PRIUM has been very involved with Texas claims since HB-7's implementation in 2005 and has monitored the evolution of the TCF since 2009. The cleanup process as defined by the DWC remarkably mirrors **PRIUM**'s Qualified Medical Intervention (QMI) Program that has had astounding success on thousands of claims nationally (including significant experience in Texas) by using Evidence Based Medicine (EBM) tools like ODG to define appropriate uses of drugs and then facilitating agreement through peer discussion and actual discontinuance of drugs. To summarize the QMI Program:

- **Identification** of claims with a potentially inappropriate drug regimen via clinical and pharmacological triggers (in this case, the use of ODG "N" drugs would be a minimum requirement)
- **Discussion** between **PRIUM**'s reviewing physician and each prescribing physician, using EBM guidelines as a baseline comparison to the current treatment plan and identify areas where different treatment could yield better outcomes
- **Consensus** on appropriate changes should be documented in writing
- **Enforcement** of changes to the drug regimen via prior authorizations or exclusions in the PBM, regular drug screening and an opioid treatment agreement
- **Oversight** through direct and consistent interaction between **PRIUM**'s Nurse and the prescribing physician's office to ensure the agreed-upon changes are enacted

PRIUM has a turnkey solution to the "legacy claims" cleanup that Payers can use to manage this process. The solution works as follows:

- The 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)
- **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 VP of Business Development, brings 30 years of expertise in the property and casualty and healthcare industries, strategic planning and technology to his articles. He has worked with **PRIUM** in a variety of roles since 1989, including IT and operations and 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 PPR (Physician Pharmaceutical Review) product in 2003 and incorporating PPR into the QMI (Qualified Medical Intervention) Program in 2009. Current responsibilities at PRIUM include sales, marketing, account management, strategic alliance development, and new product/service development.

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 health care 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.