INSIGHTS

Sponsor's Message on Workers' Compensation

Beyond Transactions

The Human Side of Pharmacy Benefit Management

The phone rings and Kathy, a Progressive Medical/PMSI associate, answers with a friendly voice. The caller, an injured worker, tells her that he's nearly out of his medication and isn't sure what to do. Kathy calmly reassures him – "All will be ok." She verifies his information, pulls up his file, and all is quickly resolved. The injured worker thanks Kathy for her help, the relief clearly evident in his voice.

On another line, a physician returns a call to John, one of our clinical pharmacists, who left a message to discuss one of her patients. John explains that we have detected that the injured worker has been submitting prescriptions for pain medications from several other physicians—a sign of potential misuse. The physician is appreciative for the additional insight.

Meanwhile in Washington DC, our government affairs team meets with those from other workers' compensation service providers, legislators, and payers, working to affect positive change through legislation and regulatory action. And, in cities across the country, account managers meet with clients to provide guidance and discuss trends, while IT keeps communication and data securely flowing.

Inherently Human

These human interactions happen all day, every day, at Progressive Medical/PMSI. They have for many years, contributing to a reputation for providing exceptional, reliable, and accountable service, sharing proactive intelligence to help our clients stay ahead of trends, and creating innovative solutions that drive down costs and improve both clinical and financial outcomes. For many years, we've been a consummate advocate for positive improvement to our industry. And we've been long-dedicated to empowering claims payers to do the right thing for injured parties.

So when it came time to select a name for the combined company, we sought to find one that captured more than our ability to drive down transaction costs, but also our long-standing passion for taking exceptional care of our customers; the human side of our business. After a very thoughtful branding process, **we are excited to announce that Progressive Medical and PMSI is becoming Helios**.

The Story behind Helios

We selected Helios for its strong representation of our brand, the vigor in which we operate, and our overall positive disposition.

The name Helios conveys energy, warmth, and illumination and reflects consistency, reliability, stability, safety, and optimism. Helios represents our commitment to providing our clients with insight, knowledge, and sound guidance to help make better decisions, from first fill to settlement. And it captures our long-standing passion for providing innovative pharmacy benefit management, ancillary, and settlement solutions for the workers' compensation and auto no-fault markets.

New Name, Steadfast Commitment

We are changing our name and logo to signify our unified organization, to embody our shared business philosophies, and reflect the bright future that lies ahead. And, while we are moving forward with a new name and a fresh look, our values—integrity, respect, and humility—remain intact. Our vision and strategy are unchanged. Our mission to be a best-in-class provider of cost containment services for the workers' compensation and auto no-fault industries continues.

Bright Future

These are exciting times for our company as we continue the storied legacies of Progressive Medical and PMSI as Helios.

For more information on our new brand name, visit www.HereComesSun.com

Join us at WCI Annual Conference

Visit us at Booth #503 to learn more about our Pharmacy Benefit Management, Ancillary, and Settlement Solutions

Plus, attend our Educational Track:
Managing Pharmaceuticals: A Life of Claim Experience
Wed., Aug. 20th, 9a - 12:30p

In a three-part session, we'll explore pharmaceutical management for the life of the claim. Join us for one or all three of these sessions:

- Pre-Dispense Controls – A Clinical Focus
- Claim Development and Escalation—Bringing it all together
- Moving Towards Settlement – Are you prepared?

Progressive Medical & pmsi

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www.FirstFilltoSettlement.com

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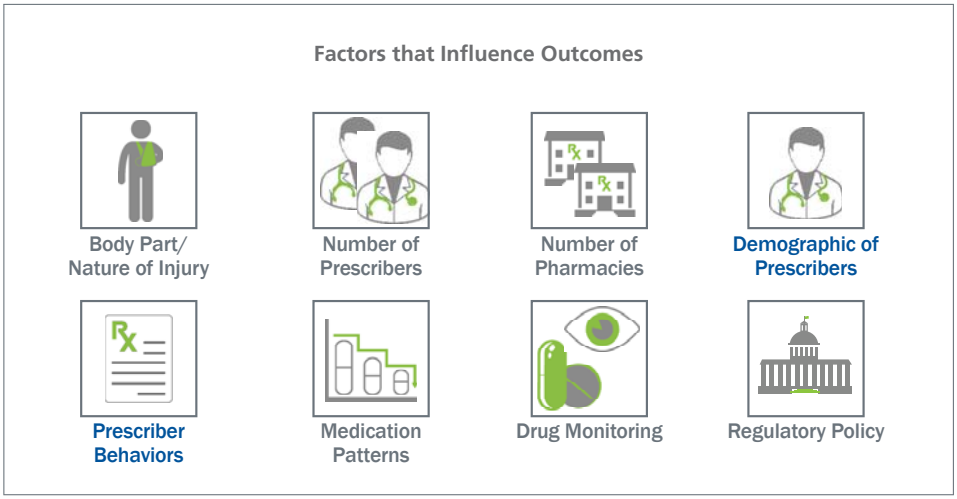
Prescriber Influence

The role of Nurse Practitioners and Physician Assistants in Workers' Compensation



The increasing demand for medical care due to the implementation of the Affordable Care Act is changing the healthcare landscape. Shortage of physicians, access to care, changes in reimbursement rules and rates, and a number of underserved patient populations have led to an expansion in the role of Nurse Practitioners (NPs) and Physician Assistants (PAs) in healthcare.

In fact, *The Milwaukee Journal Sentinel* and *MedPage Today* reported earlier this year that "non-doctors," a group which includes NPs and PAs, wrote thirty million prescriptions for narcotic painkillers nationwide in 2013. This is about one third of the 92 million prescriptions written by primary care doctors, according to data provided by IMS Health.

Nurse Practitioners

Nurse Practitioners are registered nurses who have completed graduate-level education and have trained to provide a broad range of primary care services. According to the American Association of Nurse Practitioners (AANP), there are more than 189,000 NPs practicing in the U.S., the majority of whom work in a primary care setting; however, practice authority differs among the states. Some states allow NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments, including prescribe medications. Others limit these functions by requiring a "collaborative agreement" with, or supervision by, a physician or outside health discipline in order for the NP to provide patient care.

Physician Assistants

According to the American Academy of Physician Assistants (AAPA), physician assistants on the other hand, practice medicine under the supervision of a physician, and more than two-thirds work with specialists. Unlike their NP counterparts, in most states, the supervising physician delegates the scope of practice for PAs, and all states including DC permit delegated prescribing by PAs. This means that a PA may prescribe medications – including controlled substances.

Because prescriber demographics and behavior can influence the outcome of a workers' compensation claim, particularly as relates to potential future costs, the expanding role and prescribing patterns of nurse practitioners and physician assistants warrants a closer look. What we've found is that the practice not only appears to be more pronounced in workers' compensation, but is influencing outcomes.

Workers' Compensation Impact

Looking at our data, in 2013, 15.8% of prescriptions for opioid analgesics were written by NPs and PAs, compared to just 14.2% in 2012. This increase is seemingly insignificant until you consider that in 2007, the number was just shy of 7%; which means in six years, the percentage has more than doubled. Not to mention, all else equal, we've found that claims with prescriptions written by NPs have an 8% higher long-term pharmacy cost than those written by other prescribers. They also tend to have higher morphine equivalent dose (MED) per prescription. The average MED per prescription is 83 for a NP, while PAs and other prescribers average about 70.

Older claims incur higher costs and involve more prescription medications. Therefore, the influence on cost and MED could simply stem from the fact that NPs are treating older claims. Review of our data reveals that for claims age bands three years and less, NPs are involved with 3 – 4% of injured workers. This number increases to 7% for claims older than three years. Conversely, PA involvement declines as a claim matures.

Another possible cause is the difference in legislation and oversight in each state. For example, some states, like Florida, Alabama, and Louisiana, seem to be dodging the trend entirely, with less than 2% of workers' compensation prescriptions written by non-doctors. Other states, such as Tennessee and North Carolina are driving the trend more strongly, with 21 – 23% of prescriptions written by non-doctors today, compared with about 10% in 2007. Meanwhile, New Hampshire has long had the highest rate of non-doctors prescribing in workers' compensation, at more than 30% today. Looking more deeplyinto these and other states may offer additional insight.

Regardless of the reason, our data shows that a collaborative approach in conjunction with the ability to proactively predict potential high risk, high cost claims sooner positions payers to make better decisions, ultimately leading to earlier claim closure, return to work and greater cost savings.

As the role of NPs and PAs continues to expand, having insight into how these (and other) prescriber demographics and practices influence outcomes along with the clinical expertise, tools and resources to effectively control pharmacy cost and utilization will become increasingly important to a payer's overall cost containment strategy.

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Clinical Programs Show Positive Impact On Work Comp Pharmacy Cost, Utilization

The workers' compensation industry continues to face many difficult challenges—steep increases in inflation of average wholesale price (AWP), misuse and abuse of opioid analgesics, and controversial issues such as appropriate Morphine Equivalency Dose (MED), use of compounded medications, legalization of medical marijuana, and the profileration of physician dispensing. Yet despite these challenges, the combined entity of Progressive Medical and PMSI has achieved notable results from pharmacy programs in 2013.

Our **2014 Drug Trend Report**—the first that combines data from both companies—provides a comprehensive discussion of the key factors and trends that influence pharmacy cost containment and utilization management. The following presents a brief overview of some of the key performance statistics in the report.

Overall Prescription Cost per Claim

Effective cost containment relies heavily on the ability to manage the influence of out-of-network bills, compounded and specialty medications, formulary controls, and utilization at every stage of the claim. In 2013, the application of our programs, in collaboration with our clients, not only ensured injured workers received the right medication at the right time, but served to protect the financial interests of our clients in the process. Decreases in cost per days' supply as well as product and claim mix overcame a 7.8% increase in AWP and achieved 1.7% decrease in overall prescription cost per claim.

Opioid Analgesics Utilization and Cost per Claim

In 2013, our clients saw a decrease in the percentage of injured workers using opioid analgesics, from 64.2% to 62.1%. There was also a 5% reduction in the utilization of opioid analgesics; meanwhile the prescription cost per claim decreased by 6%.

Additionally, those who used opioid analgesics used lower doses than reported in the previous year. The Morphine Equivalent Dose (MED) per claim declined by 9.6%, representing a significant year-over-year reduction in MED per claim. Given the high cost and safety risks associated with opioid analgesics, this decline is encouraging.

Generic Efficiency and Utilization

Generic efficiency remained strong at 99.7% due to our effective point-of-sale and formulary controls. Generic utilization also improved 1.9 points, from 74.1% to 76.0%. One of the reasons for this increase is the application of our Generic Opportunity service, in which we reach out to the prescriber, claims professional or injured worker where allowable via written correspondence to discuss the availability of medically equivalent generic medications.

Network Penetration

Our combined company delivers the best aspects of third party billing, bill review and pharmacy benefit management into one comprehensive solution. As a result, we achieve up to 98% retail network penetration by electronically adjudicating claims in real time with every national pharmacy chain, and virtually all independent pharmacies.

Mail Order

In the past, the days' supply for a mail order prescription remained higher than its retail equivalent, at 53.5 days and 24.6 days, respectively. Similarly, the average cost per days' supply of mail order prescriptions was 17.3% less than its retail equivalent, at $4.83 for mail order versus $5.84 for retail.

Our Solutions

These successes are directly attributed to a series of deliberate, well-timed, and persistent actions by our team of experienced, passionate professionals working in partnership with our clients and other industry stakeholders to optimize medication therapy regimes.

Our clinical tools and resources empower claims professionals to make more informed decisions at every stage of the claim, while the application of global utilization management strategies emphasize prevention, patient safety, and collaboration to help ensure the injured worker receives the right medication at the right time. Working alongside our clients we continue to make workers' comp better, together.

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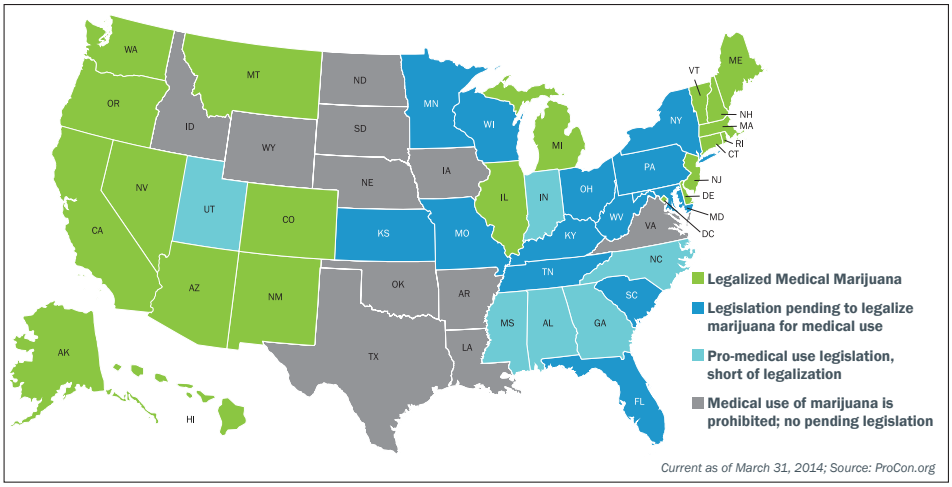
The Unique Challenge of Medical Marijuana in Workers' Compensation



Current as of March 31, 2014; Source: ProCon.org

Across the country, marijuana *(cannabis sativa)* is making headlines, as individual states pass laws to legalize its use medically and, in some cases, recreationally. Currently 20 states and Washington DC have passed laws legalizing medical marijuana, and 13 states have pending legislation. These actions have created a bit of a quandary, as marijuana is still classified as a Schedule I drug, and therefore illegal at the federal level.

In the workers' compensation industry, utilization of medical marijuana presents a unique challenge. For starters, there are significant barriers to safe prescribing and dispensing processes under the current system. As a Schedule I drug, marijuana does not have an assigned National Drug Code (NDC) and therefore cannot be electronically adjudicated. Additionally, state guidelines for the use of medicinal marijuana vary greatly, and in most cases, are vague. Futher still, quality control and grading standards of marijuana have yet to be determined and established medical guidelines, such as the Official Disability Guidelines (ODG), do not support the prescribing of medical marijuana for the treatment of chronic pain due to the serious risks involved. ODG recommends "caution in the prescribing of medical marijuana for pain, especially in instances in which learning and memory are integral."

Stakeholder Concerns

Stakeholders throughout the industry are afraid that use of medical marijuana will impede recovery or harm the injured worker. According to the National Institute on Drug Abuse (NIDA), marijuana smoke contains a toxic mixture of gases and particulates that are known to be harmful to the lungs. Because marijuana contains up to 70% more cancer-causing chemicals than tobacco smoke and deposits four times as much tar in the lungs, it has the potential to promote cancer of the lungs and respiratory tract.

There is also worry about delayed return-to-work. In addition to increased heart rate while under the influence, users also experience short-term memory loss, impaired judgment and ability to focus, and lose coordination and balance function. Marijuana use is also linked to depression, anxiety, and decreased motivation.

Employer Challenges

For the employer, a heightened level of concern may understandably exist when an injured worker returns to a safety-sensitive occupation, such as driving or construction, while subject to the potential adverse cognitive and psychological effects of marijuana. Secondly, quantification of the amount of marijuana consumed by the injured worker is not available through urine drug testing, thereby limiting the ability to determine if he or she has consumed the prescribed dose, or is in fact acutely intoxicated.

Plus, with the recent legalization for recreational use in both Colorado and Washington, employers may also need to clearly define (if not redefine) policies regarding the use of marijuana in the workplace and drug-free workplace requirements. Finally, due to the inability to control cost and utilization through electronic adjudication and clinical oversight, the potential for delayed return to work and side effects have the distinct ability to add cost to the system. Increased claims costs can negatively impact experience mods, which in turn can influence premium and collateral requirements.

Ongoing Discussion

The legalization of marijuana in multiple states across the country, for medical and recreational use, is generating conversation among all levels of stakeholders in the workers' compensation industry. The complexities of such discussions require careful review of the current knowledge and evidence from trusted sources across the healthcare spectrum, particularly with respect to the safety concerns and perceived effectiveness of marijuana when used for medical purposes. As the landscape continues to change and as the regulatory, medical and payor communities define their position on medical marijuana, a PBM can be a valuable ally in understanding the intricacies of this challenge.

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New Rules Begin to Clarify the SMART Act

The SMART Act (*Strengthening Medicare and Repaying Taxpayers Act*) was signed into law in January 2013 as reform for several aspects of the Medicare Secondary Payer Act (MSP) and the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) for workers' compensation and liability claims. Since then, the industry has sat in wait to see how the Centers for Medicare and Medicaid Services (CMS) would take action. Recent rulemakings pertaining to required actions from the SMART Act are now taking center stage.

Section 201 Conditional Payment Final Demand, Appeals Process, and Web Portal

The Act states that a claimant may notify the Secretary of the expected date and amount of settlement, judgment, or award within 120 days of that date, and that the Secretary must provide conditional payment information through a website within 15 days after a payment is made. Additionally, if certain conditions are met, the last statement downloaded from the website can be considered the final demand amount. If there is a dispute over the conditional payment amount, the Secretary must respond to the dispute within 11 days or the proposed resolution will be deemed acceptable.

On September 20, 2013, CMS issued an interim final rule which specifies the process and timeline for expanding the current MSP web portal to comply with this section. While CMS is applauded for taking action on this item, CMS states that it will implement all systems and process changes to the web portal no later than January 1, 2016; therefore, the web portal may be a few years away.

In December 2013, CMS issued a Notice of Proposed Rule Making (NPRM) for an appeals process to be utilized by applicable plans for conditional payment disputes. It appears likely that this appeals process could be rolled out in 2014 because it only applies to conditional payments and is looking to mirror the existing appeals process for Medicare beneficiaries.

Section 202 Thresholds for Reporting and Conditional Payment Reimbursement

The SMART Act requires CMS to set a threshold amount by November 15th of each year in which a settlement would not need to be reported under MMSEA Section 111 rules, and would not require conditional payment reimbursement under MSP. On February 18, 2014, CMS issued an alert notifying the industry that liability settlements under $1,000 would not need to be reported and would not require conditional payment reimbursement.

This threshold for nominal accounts allows CMS to use their resources more wisely. Some may see the $1,000 settlement threshold amount as too low. However, it is likely to increase, as CMS is required to re-calculate and re-issue a threshold amount annually.

Section 203 Discretionary Fines for Noncompliance with Mandatory Insurer Reporting

CMS issued an Advance Notice of Proposed Rule Making (ANPRM), which would carve out circumstances where penalties could be imposed for violations of MMSEA Section 111 reporting requirements. We may see some movement and actual rules created in 2014 for the circumstances where CMS may issue penalties. However, since the process is not likely to be in place until late 2014, we may not see penalties issued until 2015 or later. Either way, Responsible Reporting Entities (RREs) will now at least have some guidelines around when CMS may issue penalties.

Looking Ahead

We are pleased that ongoing discussions and meetings with CMS have resulted in many positive changes to the settlement process. Additionally, CMS is commended for seeking not only to expand and improve processes, but for also addressing specific concerns raised by stakeholders. Keep abreast of requirements of the SMART Act and other workers' compensation and liability industry rules by subscribing to our blog at www.MedicareInsights.com.

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Physician Dispensing Solutions and the Art of Compromise

Even with several states implementing legislative and regulatory reforms, physician dispensing continues to be a challenge in the workers' compensation industry. Several industry organizations have studied the issue of physician dispensing, including Workers' Compensation Research Institute (WCRI) and California Workers' Compensation Institute (CWCI). WCRI's 2013 report on physician dispensing, which studied 23 states, shows that physician dispensing is as high as 51% of all prescriptions in these states. Plus, the percentage of total pharmacy payments for physician-dispensed medication was nearly 60%.

Meanwhile, several states (15 at last count) have taken steps to address the price of physician-dispensed drugs, including: Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Michigan, Mississippi, Oklahoma, South Carolina, and Tennessee; six others prohibit the practice, including Utah, Wyoming, Massachusetts, Montana, New York, and Texas.

One of the most hotly contested repackaged medication bills was in Florida, which finally passed in 2013 after three years of bitter debate. Senator Alan Hays was able to craft a compromise that garnered enough votes to pass the House and Senate. His bill, SB 662, restricts reimbursement for repackaged medications dispensed by a physician to 112.5% of the average wholesale price (AWP) of the drug as set by the original manufacturer of the underlying drug. While this reimbursement is still higher than that received by retail pharmacies, it is a huge step forward towards not only addressing but also clarifying reimbursement rules.

Sen. Hays asserts that all stakeholders can play a very active and important role in helping to control costs while reducing risks to injured workers. Consider the following:

- Know the state's policy related to physician dispensing and repackaged medications. It's a lot easier to participate in the legislative process before legislation is passed than it is to modify regulation afterward.
- Engage with and educate legislators. While versed on many issues, legislators benefit greatly from the knowledge and first-hand experience industry professionals share.
- Join forces with similar-minded organizations and help legislators understand the issues, what impact various courses of action would have, and offer potential solutions.
- Be prepared to invest your time and resources such as data and subject matter expertise. Legislators appreciate knowing they have experts in their corner when preparing to present to committees.

Legislative Action on the Horizon.

Pennsylvania House Bill 1846, introduced in late 2013, seeks to control physician dispensing costs by limiting prescriptions to a five-day supply and establish reimbursements at 110% of AWP of the original manufacturer's NDC. WCRI released a study in September 2013 on the impact of physician dispensing and repackaged drugs in Pennsylvania, which confirmed that physician-dispensed medication had reached over 38% of the total pharmacy spend for injured workers in Pennsylvania—an increase of 18% of total prescription costs from just three years earlier. Additionally, the study showed that these price "differences" were inconsistent, varying from physician to physician for the same drug.

Pennsylvania will not be the only state addressing this issue in 2014. Legislators will be busy in Maryland and Hawaii, both of which have reintroduced bills to address the reimbursement of repackaged medications; Louisiana, which will likely have legislation to overhaul their fee schedule, including limiting the reimbursement for repackaged medications based on AWP of the original manufacturer's drug; not to mention Arizona, Tennessee, and Wisconsin, all of whom have bills dealing with reimbursement of physician-dispensed drugs. Perhaps with a little compromise, these states too will begin to address the costs associated with it.

View the entire video for an interview with Senator Hays as he shares his experience with political leverage, thoughts on the art of compromise and the value of payors' participation in the legislative process.

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Legislative Review 2013

2013 Legislative Highlights

Throughout 2013, numerous strategies have been deployed to control drug utilization, cap the cost of physician-dispensed medications, strengthen prescribing and dispensing controls, and streamline workers' compensation billing. Some of the year's highlights are summarized below:

Physician Dispensing & Repackaged Drugs

Delaware: Effective September 11, reimbursement for repackaged drugs is based upon the Average Wholesale Price (AWP) of the underlying drug as identified by the original National Drug Code (NDC). Physician dispensers are reimbursed the same as the overall fee schedule; however, they do not receive a dispensing fee.

Florida: Effective July 1, Senate Bill 662 requires physician dispensers to bill using the original NDC as well as the dispensed NDC when dispensing a repackaged drug. Reimbursement is capped using the original NDC, and payors are no longer permitted to reduce pharmacy payments to contracted rates unless the billing provider is privy to the contract being applied.

Idaho: New regulations require that dispensing physicians be reimbursed at the AWP of the original/underlying NDC with no dispensing fee. Bills submitted without such may be rejected or held until it is provided.

Indiana: Adopted regulations require reimbursement for physician dispensers to be based on AWP of the original NDC. Without it, bills may be reimbursed based on the lowest cost generic equivalent.

Michigan: Regulations adopted require all bills for physician-dispensed products to include the original manufacturer's NDC, and all repackaged generic products to be reimbursed at the equivalent generic.

Compound Drugs

Delaware: Compound drugs must be billed listing each ingredient and its corresponding NDC, and will be reimbursed based on each NDC at the standard pharmacy fee schedule. A single $10 compounding fee per prescription is allowed for physician dispensers.

Ohio: Regulations establish reimbursement for non-sterile compounds to be limited to the lesser of the usual and customary price or AWP of the commonly stocked package size minus 9% for each ingredient. Also, maximum reimbursement for any one compound prescription is $600.

Mississippi: Regulations add to existing requirements by limiting the maximum total reimbursement for compound cream medications to $300 for 120 grams per month, and any additional quantity over that requires further documentation and prior-authorization.

Prescribing and Dispensing Controls

New York: Senate Bill 7637 (I-STOP) reclassified all products containing hydrocodone from a Controlled Substance-Schedule III (C-III) to a C-II, which restricts prescriptions to a maximum duration of 30 days and prevents refills. It also changed Tramadol from a non-controlled substance to a C-IV, limiting prescriptions to a maximum of six months, including refills.

Oklahoma: House Bill 1783 prohibits refills for drugs containing hydrocodone with another active ingredient, but fails to change the schedule or controlled substance classification. Physicians can still write prescriptions for the drug's permitted length or classification, but as of November 1, refills are prohibited. Also, Senate Bill 1062 requires adoption, by rule, of a closed formulary similar to that of Texas.

Tennessee: Senate Bill 676 changes the existing controlled substance laws to restrict the dispensing of all opioids and benzodiazepines. The bill does not change the schedule or controlled substance classification of these drugs; rather, it restricts dispensing for any quantity greater than 30 days.

Prescription Drug Monitoring Programs

In California, Senate Bill 809 established a fund to maintain and support California's financially struggling PDMP. Connecticut decreased reporting timeframes, expanded the list of entities required to report information, and granted authority to add drugs beyond Schedules II-V to their PDMP. North Carolina also decreased mandatory reporting timeframes, and now requires reporting payment methods.

In Rhode Island Schedule IV drugs must be reported, and in Oregon, patient gender, number of refills and days dispensed are also required for reporting. Tennessee updated reporting formats and timeframes and also added additional reporting categories. Georgia and Maryland have taken steps to further define required reporting data for their future PDMP programs.

View current legislative maps.

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Who Will Become a Long-Term Opioid User?

PMSI's Predictive Model Links Early Drug Usage and Claim Information to Outcomes

The workers' compensation industry has a complicated relationship with narcotics and opioids. They play a major role in managing pain for injured workers yet they are also addictive, and there is little research to support long-term opioid use for most chronic pain sufferers. Additionally, narcotics comprise more than a third of workers' compensation pharmacy spend.

In response to the negative impact that the escalating use of opioids can have on claims costs, return to work, and the occurrence of addiction and abuse, workers' compensation payors and state regulatory agencies are looking for effective methods to manage opioid use. A careful balance is needed to promote the appropriate use of opioids in order to achieve an optimal level of pain control that promotes return to work and improved quality of life. The challenge is to catch issues with opioids before they occur, to promote and escalate clinical interventions that will result in better injured worker outcomes and cost containment. This is where predictive modeling can play a vital role.

Predictive modeling is the science of using advanced statistical analysis of past experience to find hidden connectors that more accurately predict future outcomes. Rather than analyzing one case at a time based on only the current information available, predictive modeling provides added perspective by allowing a view of the claim within the context of tens of thousands of other transactions at the same point in the lifecycle of the claim.

Claims Data Can Predict Outcomes

Predictive analytics allow claims handlers to identify the riskiest claimants early, helping to ensure that medical providers take a more proactive approach to treatment. By more precisely predicting which patients will develop chronic conditions or will respond best to certain types of medications or therapies, the focus can not only be on treating existing conditions but also on preventing escalation to more costly, and oftentimes harmful therapies.

Due to the increased cost and chronic work loss when opioids are involved in an injured worker's treatment plan, PMSI has developed a predictive model to forecast who will become a long-term opioid user. We examined claims data and focused on activity patterns, treatment patterns, physician prescribing behavior, and demographics, and found unique commonalities between long-term opioid users compared to short-term users.

When equipped with this data, Pharmacy Benefit Managers (PBMs) and their clinical teams can partner with claims professionals and case managers to intervene early and provide comprehensive oversight of the injured workers, leading to better medical outcomes.

From our database of millions of transactions, PMSI's RiskIS™ analytics engine consistently feeds in data to continuously evolve the accuracy of the baseline norm values, enabling us to perform analytics and apply predictive models to accurately identify outlier behaviors. PMSI's predictive modeling capabilities feed into our suite of clinical programs, providing for cost containment and maximum medical outcomes for injured workers.

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Trimming the Fat

The Impact of Obesity on Workers' Compensation Claims

In June 2013, the American Medical Association voted to label obesity—a condition that affects an estimated 97 million Americans—as a disease. Although not a legal decision, this classification could have implications for provider reimbursement and therefore, the workers' compensation system.

Obesity is generally defined as having a body mass index of 30 or more, and morbid obesity as having a body mass index of 40 or more. According to the Centers for Disease Control and Prevention (CDC), more than one-third of U.S. adults (35.7%) are obese, costing the U.S. $147 billion (2008) annually. The American Journal of Health Promotion states that obesity's impact on the workplace is profound: $8 billion in obesity-related healthcare; 39 million lost work days; 239 million restricted-activity days; 90 million bed days; and 63 million physician visits.

Historically, in workers' compensation, a medical provider might include an obesity co-morbidity code on their medical bill if they felt the condition needed to be addressed before the injury could be treated, such as an obese injured worker needing to lose weight before surgery. Now, it's possible that obesity as a result of injury—such as when an injured worker gains weight due to lack of exercise because of an injury or as a result of a medication prescribed to them during recovery—is compensable. As such, additional treatment will be required and claim costs will increase.

In fact, the American Journal of Health Promotion found that for claims involving obese injured workers, the primary cost drivers tended to be complex surgery, physical therapy, and medication and supplies.

When an injured worker requires durable medical equipment or home healthcare, obesity can play a major role in equipment selection and cost. Bariatric equipment and other specialty devices to accommodate obese injured workers are simply more expensive. Plus, obesity rarely occurs alone—multiple co-morbidities can further complicate the treatment plan for the injured worker.

Weighing the Cost

A Duke University study (2007) found a clear relationship between Body Mass Index (BMI) and claim costs. Medical costs were ***seven times higher*** among the heaviest employees than those within the recommended BMI, according to the study. Medical claims costs per 100 workers were $7,500 for those with normal BMI (18.5 to 24.9); $13,300 for overweight (25 to 29.9); $19,000 for mildly obese (30 to 34.9); $23,300 for moderately obese (35 to 39.9); and $51,000+ for severely obese (> 40).

A follow up study (2009) by the National Council on Compensation Insurance (NCCI) showed that the cost difference between comparable claims of obese and non-obese injured workers increases as claims mature. Claims involving obese injured workers are nearly ***three times more expensive*** than claims involving non-obese injured workers at the 12-month mark, but climb to a factor of **4.5** at the three year mark, and **5.3** at the five year mark (*Laws & Schmid, 2009*).

As a result, obese injured workers progress at a much slower pace, require longer physical therapy, and are even less likely to fully recover from their injuries (NCCI, 2009).

Through PMSI's proprietary DMEComplete™ and HomeHealthCareComplete™ programs, we proactively identify obese injured workers at the onset of the claim. Height and weight are required on every order for durable medical equipment and home healthcare in order to adequately secure the appropriate equipment. We manage our network providers to ensure that appropriate bariatric programs are in place to prevent re-injury. For example, wheelchairs that are too small can put pressure on tissue and cause pressure sores and wounds, and equipment that cannot support the claimant's weight can break and cause secondary injuries.

The NCCI study also showed that mandatory utilization review and mandatory bill review significantly reduce the cost difference between obese and non-obese injured workers. Utilization control strategies are embedded within our MedAssess™ clinical program. Every order is validated for appropriateness of services, equipment, and supplies to the compensable injury and the needs of the injured worker.

> Medical costs were ***seven times higher*** among the heaviest employees than those within the recommended BMI.
>
> *- Duke University study*

While obesity is taking center-stage in the workers' compensation industry, PMSI continues to drive cost containment strategies to lessen the impact, reduce claim costs, and provide better medical outcomes for the injured worker.

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When an "Average" Claim Turns into "Agony"

Controlling High-Exposure, High-Cost Claims

While most workers' compensation cases generally follow a routine process, a few high-exposure cases can become long-term and costly. As costs compound annually, these claims can generate millions of dollars in spend across the life of the injury. Although chronic, high exposure, and catastrophic claims make up less than five percent of a payor's total inventory, the associated costs can be more than double that of an average claim, and continue for more than five times the typical duration.

Research by the Workers' Compensation Research Institute (WCRI) shows that injured workers who are disabled for longer than six months have less than a 50% chance of ever returning to their job. After a year, the chances that they will return to work drop to a mere 10%. At this point, the injured worker is likely to be deeply embedded in medication regimens, and may possibly be on high doses of narcotics. Weaning from this therapy may be challenging, and costs continue to escalate.

Prescription drugs make up a large percentage of total spend as claim costs rise. The National Council of Compensation Insurance (NCCI) reports that prescription costs per claim have increased steadily since 2007, reaching $265 billion in 2011 (Annual Issues Symposium, NCCI, 2013). But, NCCI's research shows that utilization—not the price of the drug itself—is a major driver of total prescription cost per claim.

Ensuring appropriate care while minimizing cost is paramount to managing any claim. Strong clinical controls need to be emphasized at the initial point of injury, and therapy reviewed regularly for appropriateness of care, intervening as necessary. A strong pharmacy benefit manager (PBM) will provide programs that could proactively identify and control potentially extreme cases.

Proactive utilization controls are a key function that PBM's use to prevent high exposure claims. However, not all PBMs have robust predictive or clinical programs in place to identify and intervene upon high-risk injured workers. If a claim has escaped clinical oversight because of the lack of such programs and has continued past the duration of an average claim, the result can be a high-cost, troublesome claim—difficult to manage and even more difficult to settle.

With expertise in both predictive modeling and clinical programs, PMSI offers a program that allows a payor to select claims that require intensive clinical intervention to either prevent or lower the risk of costs continuing to spiral out of control. PMSI's ClaimSelect program allows payors to identify an individual or a select group of high-risk claimants who would benefit from our pharmacy management services and clinical programs.

A flexible PBM program, ClaimSelect allows payors, third-party administrators (TPAs), and excess carriers to enroll individual claims in a customized PBM program that will best meet the goals of the claim. As a result, an average 25-30% savings in pharmacy costs can be achieved, which results in significant savings in long-term claims and can greatly assist in reaching settlement.

ClaimSelect's flexible platform also provides a PBM program that the injured worker can elect to enroll in after settlement. These injured workers would then have access to medication through PMSI's network of nearly 65,000 retail pharmacies and nationwide mail order program—at reduced prices—in order to stretch settlement dollars.

> ***Utilization***—not the price of the drug itself—is a ***major driver*** of total prescription cost per claim.
>
> *- NCCI*

High-cost claims can have a huge impact on a payor's workers' compensation spend. Left unresolved, costs will continue to soar. PMSI's ClaimSelect program allows payors, excess carriers, and TPAs to enroll specific claimants in a program that will control costs and deliver optimum medical outcomes for their injured workers.

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Texas Closed Formulary: Two Year Review

In January 2011, the Texas Division of Workers' Compensation (TDWC) adopted pharmacy closed formulary rules as a means of containing rising pharmacy costs in workers' compensation. The first phase of this rule took effect on September 1, 2011 for injured workers with date of injury (DOI) on or after this date, which were defined by TDWC as "new" claims. The other key group, "legacy" claimants, at time of rule adoption, was exempted from the closed formulary—until now.

On September 1, 2013, all injured workers in Texas (with the exception of federal claims and those with DOI before 1/1/1991) must now adhere to the rules and regulations of the closed formulary. TDWC mandated specific regulatory processes in order to prepare legacy claimants for application of the closed formulary. These processes called for continued communication between the carrier and the treating physician regarding the legacy claimant's pharmacy treatments after the September 1, 2013 application of the closed formulary.

PMSI has been working with our carrier, TPA and self-insured employer clients to communicate with all impacted claimants, prescribing doctors, and dispensing pharmacies regarding the closed formulary rule application to ensure injured worker access to appropriate medications. The success of this early outreach has helped ease the transition for our clients' legacy claimants well in advance of the 2013 implementation date. In one such outreach program, 33% of treating physicians agreed to switch to formulary medications; 30% request Utilization Reviews (UR); 16% wean the patient off the non-formulary drug; and 14% discontinue the non-formulary drug from the injured worker's therapy.

As a result, PMSI saw a continuous decline in unique "N" or non-formulary drug transactions per month for legacy claimants in a very short time frame—and all in advance of the September 1 implementation date.

Impact on Total Drug Spend

To determine the initial impact of the Texas closed formulary on total drug spend for newly injured claimants, PMSI performed a comparison study of pre- and post-implementation of the closed formulary. The pre-implementation group was defined as claimants with DOI between September 1, 2010 and February 1, 2011. The post-implementation group was defined as new claimants with injuries between September 1, 2011 and February 1, 2012. Both groups received prescriptions within the first 30 days after injury.

The claimant groups were followed for 360 days after injury to determine the total prescription spend for those injured workers with ongoing prescription medication use. For each time period, the total prescription spend was significantly less for the new claimant population affected by the newly implemented closed formulary rules compared to the pre-implementation group.

Implementation of the closed formulary had a large impact on average spend per claim for prescription medications, with the largest impact occurring during the 91-180 and 181-170 day periods after injury. Consistent with historical utilization trends for chronic injuries, claimants who continued to receive prescription medications after the ninth month following initial injury (around 8% of the population) were likely to have high, ongoing medication spend. This represents an escalation point in the life of the claim that should trigger engagement of additional clinical and medical resources to manage ongoing prescription use.

Average Prescription Spend Per Claimant

Days Post Injury	Pre-Formulary	Post-Formulary	% Difference
0 - 90	$163.53	$152.15	-7%
91 - 180	$354.79	$234.97	-34%
181 - 270	$408.96	$317.60	-22%
271 - 360	$456.89	$420.68	-8%

Studies produced by PMSI and the Texas Department of Insurance seem to point to reductions in drug spend and drug utilization as well as changes in practitioner prescribing patterns as a result of the Texas closed formulary. These positive, initial results have the rest of the country watching as legacy claimants are transitioned onto the closed formulary, to analyze possible adoption of this medication management strategy in their state.

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Minimizing the Impact of Medicare Part D Exposure on Medicare Set-Aside Allocations

In 2006, Medicare began providing prescription drug coverage for Medicare beneficiaries, known as Part D, as a result of the Medicare Modernization Act of 2003. Therefore, workers' compensation settlements also had to include an allocation for future prescription drug treatment in Medicare Set-Aside allocations (MSAs). However, several issues have complicated this, causing unreasonably high settlement amounts, often leading to claims remaining open longer or not settling at all.

Rising Pharmacy Costs

According to the Centers for Medicare and Medicaid Services (CMS), prescription drug spending is estimated to have grown to 3.9 percent in 2011 (up from 1.2 percent in 2010) and to have reached $269.2 billion. In 2014, prescription drug spending growth is expected to increase sharply, to 8.8 percent due to the Affordable Care Act.

Calculation Issues

CMS calculates the prescription allocation based on the current treatment regimen. Most drugs are included in the allocation for the entire life expectancy of the injured worker, regardless of whether or not it is likely the injured worker will continue taking that drug. For example, some drugs are not approved for long term use, or may not be recommended for use after a certain age (i.e. in elderly patients), yet CMS' calculation will more than likely not take these factors into consideration.

Additionally, CMS does not take into account any state fee schedules or formularies and all Part D pricing is based on Redbook Average Wholesale Price (AWP). Also, if the current treatment includes a brand drug, CMS will use the brand price in the calculation, even if the patent will expire at some point in the claimant's life expectancy, which would provide for a less costly generic equivalent.

Solutions

Attempting to mitigate the value of an MSA at the time settlement negotiations are already underway is often too late. The best approach to reduce an MSA's value is a proactive approach early in the process and prior to settlement.

Identify High-Risk Claims

Criteria for identifying claims with high allocation potential may be based on claimant age, or longevity of the claim, wherein the injured worker has been disabled long enough to be eligible for Medicare benefits. Additional criteria may involve claims that have incurred a certain medical spend threshold or meet particular medication dispensing triggers.

Estimate Exposure

An estimate of the proposed exposure will allow the adjuster to determine if clinical interventions are necessary or if the Part D projection is in line with expectations to settle the claim. If not, a comprehensive review by an independent clinical pharmacist and nurse can help identify possible interventions to reduce the lifetime cost and MSA implications.

Activate Clinical Controls

After reviewing the proposed clinical action plan, a peer physician can contact the treating physician(s) to discuss the treatment plan, the potential consequences of the plan, and any modifications that might be reasonable for the safety of the injured worker and the lifetime exposure to the payer

Monitor and Reassess

Clinical monitoring is best handled by an independent nurse whose sole focus is assuring that treatment modifications are followed, and the adjuster updates the prescription formulary with their Pharmacy Benefit Manager (PBM). The potential MSA value should be adjusted once written documentation of the treatment changes has been obtained.

The PBM Advantage

As the only provider that offers in-house PBM and MSA programs, PMSI utilizes comprehensive transactional claims data to implement pharmacy utilization controls that can minimize settlement issues and costs. Through SettlementComplete℠, payers plan for settlement early in the claim lifecycle to minimize the impact of Part D on MSAs.

Take a proactive approach to reducing high MSA allocations through early intervention programs that identify key allocation cost drivers and execute a clear action plan that drives down costs.

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Effective Mail Order Recruitment

According to PMSI's 2013 *Annual Drug Trends Report*, the average mail order cost per day of supply in 2012 was approximately 21% less than the average retail cost per day of supply. As a result, every 1% shift in days of supply from retail to mail order during the year resulted in a 0.14% reduction in spend. A successful mail order program that is fully integrated into the overall pharmacy benefit management (PBM) network penetration strategy can yield significant savings, especially for long-term and high-cost claims.

While the argument for mail order is strong and has benefits for the injured worker, employer and payor, it can still be difficult to convert injured workers to use mail order. The real challenge is not only identifying the candidates who qualify for mail order, but also the characteristics of those who will use the service.

Most PBMs look at their data and say 'females tend to respond more than males' or 'older claims are better targets for mail order,' but their analytics only look at variables in isolation. PMSI's Informatics team mined three years of mail order recruitment data to develop a robust statistical model using a *combination of variables*. With this model, the greatest efforts can be spent on claimants with the greatest propensity to respond positively.

Study Results

After looking at hundreds of combinations of variables from over three years of data, PMSI's Informatics department found that injured workers over the age of 40 are 47% more likely to respond than their younger counterparts.

When looking at state of jurisdiction, response rates varied considerably, possibly because of legislative and regulatory differences. In general, the New England states showed an average response rate of 20%, and many of the Midwestern states had higher than average response rates. States in the Southeastern US showed lower than average response rates.

PMSI's mail order recruitment model also showed that the greater the age of the claim, the less likely the claimant will respond to mail order recruitment and that gender of the claimant had little influence on the rate of response. Spanish-speaking claimants are twice as likely to respond to mail order recruitment efforts, but 14% less likely to actually use or remain on mail order than English-speaking injured workers.

In addition to the demographic results, PMSI's Informatics team also noted differences in response rates based on type of medication and days of supply. For example, those utilizing medication with high days of supply and those with high narcotics usage are less likely to respond to mail order recruitment efforts but injured workers utilizing cardiovascular drugs are more likely to respond.

PMSI Mail Order Pharmacy Program

PMSI ships more than 300,000 prescriptions through its Mail Order Pharmacy program every year, embedding it as an integrated part of managing the pharmacy claims process. As a result of this integration of mail order into a robust retail and specialty network program, significant savings and maximum clinical outcomes can be obtained. PMSI's program adheres to rigorous standards to guarantee accuracy and clinical safety for all medications, including Schedule II narcotics.

Our Mail Order Pharmacy program is managed by in-house pharmacists who specialize in workers' compensation injuries and drug therapy. These professionals provide oversight on claims and act as a second level of drug utilization review to identify and correct duplicate therapies, implement additional generic conversion opportunities, or discover potential drug interactions—reducing risk and further reducing costs.

PMSI's extensive insight into the claimant-specific factors that influence the transition to mail order allows for customized, targeted campaigns. Through this segmented marketing approach, PMSI can proactively and quickly work to shift injured workers from the more expensive retail channel to the less costly mail order delivery channel, maximizing client savings.

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Controlling Compounded Medications in Workers' Compensation

From PMSI's 2013 Annual Drug Trends Report, available at www.pmsionline.com/Drug-Trends

The cost and utilization of compounded medications in workers' compensation has come under close scrutiny, as use by injured workers represents a greater portion of spend and has increased in many states. Compounded medications do not fall under the jurisdiction of the U.S. Food and Drug Administration (FDA) so each state is free to establish its own regulations to control the production, distribution and pricing of compounded drugs—leading to disparity among states.

Research by the California Workers' Compensation Institute (CWCI) examined changes in compounded drug utilization and payments before and after implementation of Assembly Bill 378 (AB 378) in California. AB 378 strengthened the pharmacy fee schedule in California by requiring that any compounded drug used to treat an injured worker must be billed at the ingredient level by the compounding pharmacy or dispensing physician, with each ingredient identified using the applicable NDC of the ingredient and the corresponding quantity. Reimbursement paid to physicians who dispense compounded medications is restricted to no more than 300% of the physician-documented paid cost for the ingredients of the compound, and cannot exceed $20 above the documented cost.

Among the key findings of the CWCI study:

- Compounded drug prescriptions dispensed to injured workers experienced a relative 35% decline but reimbursements increased. The percentage of workers' compensation prescription dollars used to pay for these drugs continued to grow, climbing from 11.6% of all prescription payments prior to reform to 12.6% after AB 378 took effect—a relative increase of 9%.
- Average amount paid per compounded drug increased 68.2% from pre- to post-reform, while the average amount paid for non-compounded prescriptions decreased 4.6% for the same period.
- The number of NDC ingredients in compounded prescriptions dispensed to injured workers increased 13.1%, while the average price paid per NDC ingredient increased 48.7%.
- There was a 25.5% increase in the quantity per NDC ingredient but virtually no change in average days' supply, suggesting more potent compound drugs are being dispensed.
- Certain ingredients that were reimbursed at higher levels were often prescribed despite lack of adequate documented benefits. For example, dextromethorphan powder is often added to compounds yet lacks conclusive support for its use in transdermal pain management formulations. Therefore, its use is likely unwarranted and the cost should not be incurred.

While AB 378 was well intentioned, it clearly demonstrates the ability of entities associated with compounding to change their business models to continue to achieve high-profit margins in the dispensing of compounded medications.

SOLUTIONS

PMSI strongly supports regulatory and legislative efforts to control costs of compounds provided to injured workers without prohibiting the practice and access to appropriate, safe, efficacious, and cost-effective compounded medications when needed as legitimate therapy. PMSI also supports enhancements to existing billing regulations/requirements such as adoption and utilization of the IAIABC standards (NCPDP billing standards for paper and electronic pharmacy bills) that allow for a more precise billing and reimbursement of compounds without the requirement to change any current pharmacy state fee schedules.

In situations where an injured worker cannot receive appropriate compounded medications from a network pharmacy, PMSI is proactive in its efforts to manage compounding at the point of sale. Our Specialty Networks include many compounding pharmacies. Therefore, we are able to reduce the cost and evaluate the therapeutic appropriateness of compounds through clinical reviews, formularies and utilization controls. This allows PMSI to oversee the use of compounded medications, negotiate rates with the compounding pharmacies, and ensure appropriate treatment for injured workers.

Read more industry insights in our 2013 Annual Drug Trends Report, available now!

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Tightening the Belt around Fraud, Waste and Abuse

PMSI's 2012 *Annual Drug Trends Report* shows that 75% of total pharmacy spend is related to medications used for the treatment of pain. Narcotic analgesics (or Schedule II opioids) comprise almost 34% of this total drug spend. The lack of co-pays and out-of-pocket costs for workers' compensation claims make it easy for injured workers to fill every prescription, whether or not the prescription is needed. The broad use of pain medication makes the industry ripe for instances of fraud, waste and abuse.

Payors should watch for injured workers refilling prescriptions too soon, long-term use of targeted medications, and multiple prescribers and pharmacies. Physicians should watch for patients who claim to be allergic to everything except one specific drug, those who seem to have all the right answers to pain threshold questions while taking large quantities of pain medication, and patients who live more than 50 miles away. The issue, however, doesn't rest solely with the behaviors of the injured worker.

PMSI's Fraud, Waste and Abuse program uses the capabilities of the MedAssess Risk Intelligence System™ (Risk IS) to analyze transactions through a multi-dimensional model that monitors transactions between injured workers, physicians and pharmacies to identify high-risk behaviors. Key indicators trigger alerts, drive interventions, and continuously monitor and report in real-time.

Using analytics to attack inappropriate medication use, therapeutic duplication and potential abuse, our clinical programs are integrated into a comprehensive Fraud, Waste and Abuse specialty program and include:

High-Risk Profiling – flags outlier behavior involving narcotic prescribing and utilization.

Medication Reviews / Peer Outreach – evaluates appropriateness of prescribed therapy for the injury, which may require a peer-to-peer review.

Drug Testing and Monitoring – assesses the proper use of prescribed medication as well as detection of illegal drugs.

Generic Conversion – identifies when brand-to-generic conversion is not utilized.

Multiple Prescriber Outreach – converts multiple prescribers to one lead prescriber.

Clinical Escalation Alerts – triggers alerts when transactions meet pre-defined clinical criteria specific to narcotics.

Fraud, waste and abuse of prescription medications is a major issue throughout the entire healthcare system. Integrating proven clinical and transactional oversight with educational programs and outreach to all stakeholders can mitigate and prevent incidents of prescription drug fraud, waste and abuse in workers' compensation claims, promote cost savings and improve patient outcomes.

Pain Management Resource Center

Online access to simple tools that help ensure safe, appropriate opioid use, such as:

- Pain management basics, including signs and symptoms, medication and non-medication techniques
- How to talk to your doctor about pain, including pain assessment logs and common questions to ask
- Answers to questions on addictions, stopping medications, generics versus brand drugs and FDA drug updates

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A Calculated Approach to Managing Claims

From the time an injured worker files a claim, a series of decisions are made that influence the direction that the claim will eventually take. These decisions can have a major impact on the injured worker's ability to return to work as well as the payor's cost. There are so many factors that can complicate a seemingly average claim and turn it into a complex case, costing thousands of dollars, and possibly making settlement more difficult. If not appropriately managed through every stage, a claim may enter the system as a "minor" injury and end up a catastrophic claim.

The most effective way to advance an average claim from injury to settlement is by leveraging data intelligence to manage the claim throughout the entire claim lifecycle, proactively identifying and addressing the triggers that can send a claim spiraling out of control.

Pre-Dispense Controls

At the point of injury, the first line of defense against an average claim going awry is to implement Pre-Dispense Controls such as a drug formulary. Formularies ensure the appropriateness of a prescription for the workers' compensation injury and can be customized by injury type, duration or other factors particular to your injured worker population. PMSI research shows that 14.5% of prescriptions do not meet formulary guidelines.

Other triggers that can ultimately cause an average claim to incur high medical costs include the use of high-risk drug therapy, high-cost therapy, brand-name medications, second- or third-line medications, and refilling prescriptions too soon. Requiring pre-authorization approval to dispense prescriptions that don't pass Pre-Dispense Controls can reduce these practices, and provide savings.

Claims Escalation

In the period between three and six months, injured workers may be re-evaluated by their treating physicians, or they might also seek out a new or additional physician. Watching for multiple prescribers of narcotics or opioids is paramount at this point. PMSI research shows a 91% success rate in converting to a single opioid prescriber and a 20% average reduction in medication spend when intervening with a claim that has multiple prescribers of opioids. The use of high-cost, brand name medications, excessive dose or duration of therapy, and duplication of therapy can also be indicators of an out-of-control claim.

Clinical Escalation Alerts use treatment guidelines and evidence-based medicine to signify a high-risk change in therapy or utilization, assisting claims professionals in keeping the claim on-track. Additionally, with High-Risk Profiling instituted at this stage, high-risk claims can be identified and interventions can address concerns before they escalate out of control. PMSI research shows a 28% reduction in total drug spend for high-risk injured workers with this strategy.

Intensive Intervention

The period from six months to one year is a significant turning point for many claims. Predictive modeling can help identify high-risk and/or high-cost cases. Medication Reviews, which provide an in-depth evaluation of an injured worker's medication and medical record, can prove beneficial to reveal continued use of high-risk therapy despite prior outreach programs, breach of clinical guidelines, heavy opioid use or suspicions of inappropriate drug use, dependence or addiction. In fact, PMSI research shows that 64% of cases intervened upon at this point resulted in therapeutic changes. Subsequent Peer-to-Peer Outreach, where collaboration between the prescriber and the clinical reviewer discuss issues and recommendations for resolution, has shown an average savings of 18% - 23% in total drug spend realized after 180 days.

If a claim manages to slip past all of the other check points until now, the once-average claim becomes difficult to close out.

PMSI's Solution: MedAssess™

MedAssess is PMSI's enterprise-wide clinical suite of programs that address all stages of the claims lifecycle. This program, driven by 36+ years of experience, delivers proven results in managing cost, utilization, and appropriateness of therapy throughout the life of the claim. The MedAssess program results in validated and appropriate utilization control measures that improve outcomes at both the population and injured worker levels providing maximum savings for clients and best medical outcomes for injured workers. In short, MedAssess sets the foundation for successful outcomes for injured workers and payors.

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Get Smart about the SMART Act

New Legislation will Change the Settlement Process

In early January this year, the SMART Act was signed into law, reforming several aspects of the Medicare Secondary Payer Act (MSP) and the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) for workers' compensation and liability claims—a welcome relief to the industry. However, how the Centers for Medicare & Medicaid Services (CMS) implements these reforms over the next several months will determine how much relief is actually in sight.

Conditional Payments

A conditional payment is any amount that Medicare has paid for medical or prescription drug bills for a Medicare beneficiary that is due to a workers' compensation or liability injury. As part of the settlement, the responsible payer must re-pay Medicare for these injury-related bills. However, prior to the SMART Act, there have been no rules enforcing a timeline for CMS to provide the total amount due or collect repayment, and no way for payers to dispute the amount. This has delayed settlements considerably.

Beginning in October 2013, CMS will be required to provide a final amount to be repaid within 65 days of receiving notice of settlement date and amount. Plus, if the payer disagrees with this amount, a dispute can be filed which includes a proposed settlement amount. CMS must respond to this dispute within 11 days or the revised amount is considered accepted. Additionally, a statute of limitations of three years will be enforced, limiting CMS' ability to seek repayment after this time period.

Also, for the first time in workers' compensation, CMS will be required to publish a threshold amount by November 15th of each year, setting an amount below which conditional payments do not have to be repaid. This ensures that the government will not spend more money pursuing a MSP claim than it could recover from that claim. Important to note however, this does not apply to Medicare's interests in regard to future medicals or Medicare Set-Asides (MSAs).

Fines for Mandatory Insurer Reporting

MMSEA law originally stated that non-compliance with Mandatory Insurer Reporting (MIR) shall result in fines of $1,000 per day per claim. While payers held their breath, there wasn't any process for discretion in place. Within the next two months, CMS must solicit comments from the industry regarding which practices should be considered an event subject to sanctions. After considering the public comments, CMS will establish rules regarding the enforcement of fines.

This has two major implications for payers: (1) Be mindful of CMS' request for opinions on assessing fines and let your voice be heard, and (2) Prepare for fines now by analyzing your MIR processes for submission acceptance rates. CMS has noted that data scrubbing can significantly lower the error rate of submissions:

- Data must be accurate prior to submission. This means verifying that every reportable claim has valid and accurate data in all 250+ CMS-defined fields.
- Data from multiple source systems has to be compiled, validated and monitored to accommodate CMS' specific and often-changing requirements.
- Reporting unnecessary claims increases the error rate and CMS can reject the entire report if it reaches 20%, leaving you in non-compliance.

Using automated systems with built-in CMS rules and real-time reporting, such as PMSI's Medicare ConnectSM, payers can have a clear idea of their level of compliance. Proof of this is in PMSI's own book of business, which shows a 99.9% submission acceptance rate by CMS.

The bottom line

The SMART Act is putting the wheels in motion to improve the processes for protecting the Medicare Trust Fund. As a result, the settlement process can be refined, allowing for more timely and accurate settlements. Keep up-to-date on the SMART Act and other changes that affect MMSEA Section 111 and MIR by following our blog, www.MedicareInsights.com.

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Physician Dispensing

What needs to be done to control costs and utilization

Rapidly accelerating pharmacy costs and risk to patient safety due to physician-dispensed medications is one of the key issues facing the workers' compensation industry today. It now accounts for over one-third of pharmacy costs, according to the National Council on Compensation Insurance (NCCI). The issue is widely acknowledged in the industry, but there is little consensus on the best way to address it.

A major problem with physician dispensing is that pharmacy transactions occur outside the normal Pharmacy Benefit Manager (PBM) channel. Because of this, the role that the PBM typically plays can be adversely affected. The PBM is often more knowledgeable of the therapies for workers' compensation-specific injuries and thus, can provide valuable insight into appropriateness and utilization of medication.

Additionally, physicians may not have access to the injured worker's entire profile of medications dispensed and utilized outside their office. This can cause safety concerns, specifically regarding narcotic usage. PBM insight helps eliminate multiple prescribers, over-utilization of same or similar medications, and reduce risk of drug-to-drug and drug-to-disease interactions.

The PBM is also a known entity for cost containment. PBMs typically have negotiated rates with pharmacies to enable much lower unit cost pricing. A PBM can examine the utilization of a drug, seek generic substitutions, employ formularies and provide peer-to-peer intervention to help promote use of appropriate medications and services while still providing access to the medications an injured worker needs for recovery.

At a time when workers' compensation pharmacy costs are much higher than they should be, payors need to pay very close attention to where their workers' compensation dollars are going. The PBM can play a very active and important role in helping to control highly inflated costs for drugs from physician dispensers, while reducing risks for injured workers. Some areas where a PBM can help payors manage and impact the practice of physician dispensing include:

Advocate for legislative and regulatory control

The PBM must help drive legislative changes that protect legitimate pharmacy therapy access while limiting the inflationary cost of medication. PMSI's Government Affairs department is very active in monitoring and participating in legislative and regulatory action, evaluating the impact these changes make in the industry, and promoting positive public policies on behalf of our clients and their injured workers.

Control costs at the point of care

The PBM has the unique ability to utilize pharmacy data to predict and identify high-risk claims. The PBM should monitor pharmacy data, including physician-dispensed medications when they become known, and evaluate for clinical appropriateness. It should then intervene where necessary with clinical programs. The PBM can monitor and address multiple prescribers and dispensers, reducing the risk of fraud, waste and abuse as well as improving care for the injured worker. It can also leverage formularies and clinical guidelines to help at the time of dispensing to ensure that medications dispensed are medically appropriate for the injury.

Capture out-of-network spend, especially physician dispensers

PMSI, for example, has specialty networks which include select physician dispensers. These contractual arrangements with non-traditional pharmacy providers allow us to negotiate network pricing, provide better clinical oversight, and open the door for communication with the physician.

Ensure billing is correct and that state edits on physician dispensing have been applied

Medication and associated office visits are often on the same bill, making it difficult for bill review companies and payors to separate the two distinct services and associated costs. In addition, physician-dispensed medications are often repackaged and assigned a new National Drug Code (NDC) number with a significantly higher Average Wholesale Price (AWP). When appropriate, the PBM should ensure that reimbursement has been properly applied utilizing the product's original NDC and lower AWP pricing.

As states work to enact legislation to control physician dispensing, it is the responsibility of the payor to ensure that there is a balance between medically appropriate care and cost containment. If your PBM isn't taking a proactive approach to addressing physician dispensing, you could be wasting hundreds of thousands of dollars and possibly putting your injured workers at risk.

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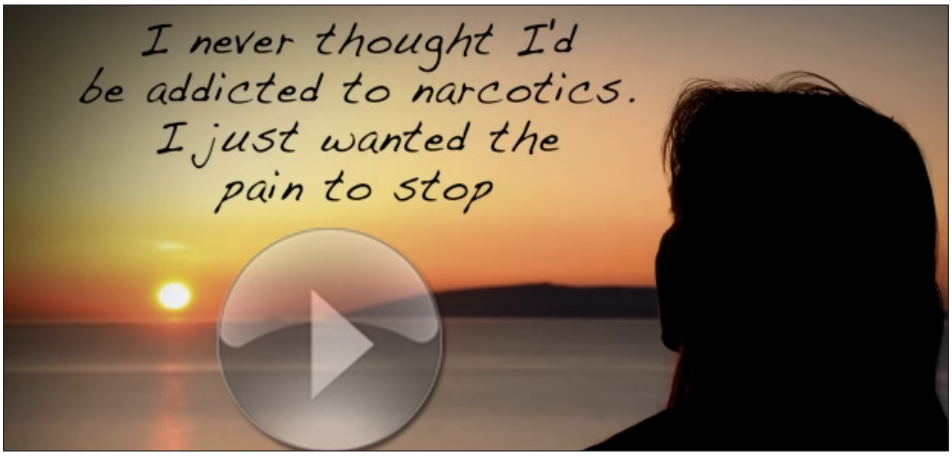
My Battle with Opioids

An Injured Worker Tells Her Story



"I never thought I'd be addicted to narcotics. I just wanted to the pain to stop.

I had a happy childhood, a lot of friends, and a loving family. I was class president, and part of homecoming court. I graduated college with honors. I had my share of struggles but never thought of coping by using alcohol or pain meds. I never even liked that feeling.

Three years ago, I was injured at work. The emergency room doctor prescribed Percocet® for the pain. I can't say that I liked the feeling then but it did seem to help. Unfortunately, the pain didn't go away and it wasn't long before I wasn't getting any relief from the medication. I went to see a specialist who prescribed a stronger dose.

When that too, seemed to have little effect, a friend of mine told me about a pain clinic. As long as I told the doctor that my pain was an 8 or higher, he would continue writing prescriptions for the meds. No one ordered a drug test or warned me about the effects of long term use. The pharmacy never denied filling a prescription.

But the pain never seemed to go away. I started going to different doctors and filling prescriptions at different pharmacies and taking several pills a day. I found that I was always thinking about when I was going to have my next pill and where it was going to come from.

About a year and a half after my injury, my legs started to hurt. I remember waking up and feeling like someone was squeezing my calves in a vice grip. I spent months going to doctors with no relief except through more pain medication. I didn't feel like I was doing anything wrong by asking for more and stronger pain medication because I WAS in pain. I begged friends for their prescriptions, and even bought them on the street. I figured everybody has a vice; some people drink, gamble, shop. I justified it. So what if a pill makes me feel better?

I started to isolate. I didn't answer my phone. I stopped paying bills and showering. I just wanted to be left alone. I was in such fear that I was going to run out of pills that I had panic attacks. Finally, I found out what was causing the pain in my legs: opioid withdrawal. I could not get enough narcotics into my system. Throughout my entire ordeal, not one doctor suggested to me that this pain in my legs could be opioid withdrawal. I believed that the pain medication should erase my pain. In the end, it intensified it.

My whole world was about my "medical problems." I never imagined that my real "problem" was drugs. I realized that the pain meds were just numbing my symptoms, not solving my problems.

I never thought I would be a drug addict. For the rest of my life, I will struggle against this addiction. I was lucky to get help."

An Injured Worker is Not a Statistic

When we talk about the opioid problem in workers' compensation, we spout statistic after statistic of how widespread the problem is and how much it's costing us. It can be easy to forget that these are real people's lives, not just numbers. Prescription drug abuse can happen to anyone. It's not just their problem—it touches the lives of many and involves many stakeholders, including the prescribing physicians, dispensing pharmacies, injured workers and their families.

A Pharmacy Benefit Manager (PBM) can provide a bird's eye view of the injured worker's progress by keeping a dutiful watch throughout the duration of care. A PBM can take the lead on clinical programs like drug testing and monitoring and conversion to a single prescriber. Although some states have Prescription Drug Monitoring Programs (PDMPs) as a means of helping control opioid misuse and abuse, the PBM can take an active role in monitoring physician and dispenser behaviors as well.

Most importantly, the PBM has the opportunity to educate the injured worker, empower them to take an active role in their recovery and focus on function improvement. For example, PMSI offers the Pain Management Resource Center, an online resource for patients, doctors and payors, to understand the treatments available for pain. Also, a mobile app will be available that assists injured workers with managing their workers' compensation claim, tracking their medications and getting access to information on the medications they are taking.

The solution to the opioid problem in workers' compensation isn't in one provider, law or stakeholder. It's only through involving all stakeholders, being proactive, intervening and monitoring progress, and providing education to injured workers that we can begin to heal from the clutches of opioid abuse.

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Early Intervention is Key to Controlling Claims Costs and Leveraging Settlements

Over the past several years, the Centers for Medicare and Medicaid Services (CMS) have imposed stricter Medicare Set-Aside (MSA) guidelines as part of its ongoing effort to preserve the Medicare trust fund. Combine this change with the rising cost of medical treatment and the outcome is a noteworthy increase in reserves and settlement values. Because of this, cases are remaining open longer or not settling at all.

Payers need to look at claims with a clinical lens, not only for cost containment but also for medical appropriateness. Early intervention is key to driving down high medical costs and obtaining optimal outcomes for the injured worker. How you approach this is dependent upon the timeline of settlement. If a claim is more than 12 – 18 months from settling, there is more time for clinical recommendations to be implemented. However, if a claim is on the verge of settlement, your options need to be more focused, yet can be very impactful.

Approaching Settlement

In the case of claims greater than 12 months from settlement, early intervention by health professionals can mitigate high cost drivers prior to setting lifetime reserves or evaluating the claim for settlement. PMSI's Clinical Cost Containment Review applies claim settlement and clinical management expertise where necessary to address ongoing medical and/or drug therapies with high utilization levels.

Using data analytics, claims can be identified as at-risk for over-utilization and high medical spend. These claims should be analyzed for therapeutic appropriateness, duration of therapy, and future medical needs to develop recommendations for treatment modifications. Then, discussion between a specialty matched physician and the treating physician can facilitate changes at an earlier stage—positively influencing injured worker outcomes while positioning claims for settlement or reduction in reserves.

Ensuring Progress

Follow up after a peer intervention is essential to ensure that the modifications to the treatment plan are carried out, allowing the injured worker to benefit from the most clinically appropriate treatment and the payer to benefit from reduced costs. At PMSI, we do this through our Nurse Progress Monitoring Program, in which a nurse will continuously assess the injured worker's treatment plan through regular phone contact with the treating physician(s). This increases the likelihood of implementing the agreed-upon changes to the treatment plan.

At the Time of Settlement

For claims that are ready for settlement, clarification of future treatment plans from the treating physician is essential prior to submitting the case to CMS for review. Securing an affidavit on the treating physician's letterhead on the intent of future implantable devices, generic equivalents, or the diagnosis for which a medication is prescribed can be enough to eliminate the costs in your MSA.

For example, PMSI was able to reduce a MSA allocation by $98,656 through its MSA Clinical Outreach program. Upon review of the claim, costs for a peripheral stimulator were included even though past trials had failed. After a peer-to-peer discussion with the treating physician, it was determined that the claimant was stable on the current medications and spinal cord stimulator; therefore, the peripheral stimulator was not medically necessary and was removed from the allocation.

Clinical re-evaluation can impact costs of future pharmaceutical and medical spend, and support positive health outcomes. Ideally, a proactive, early intervention approach can enable payers to mitigate high-cost drivers prior to MSA completion and CMS approval; yet both approaches can facilitate lower and faster settlement of claims.

Optimal Candidates for Clinical Cost Containment Review

- Claim is within 12 – 18 months of potential settlement or creation of lifetime reserves
- Extended use and/or high dosages of opioids, skeletal muscle relaxants and/or sedative hypnotics
- Use of medications from 5 or more therapeutic classes
- Annual medication costs greater than $12,000 (or as defined by client)
- Concurrently taking 2 or more medications in the same therapeutic class (other than narcotics)
- Receiving medications from multiple prescribers or pharmacies
- Excessive use of Home Health Care services and/or DME
- Long-term use of wound vacs and/or electrical stimulator devices

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Examining High Exposure Claims for Missed Savings

Ninety-three percent of workers' compensation spend is comprised of less than a quarter of all cases (NCCI). Within this set lie cases that involve more severe injuries with higher levels and length of care.

These extreme cases—often called high exposure claims—can reach well into the hundreds-of-thousands of dollars each year, and account for millions of dollars in medical spend across the life of the injury.

Ensuring appropriate care while minimizing cost is paramount to managing any claim. Strong clinical controls need to be emphasized at the initial point of injury, and therapy regularly reviewed for appropriateness of care. However, in cases where long-term utilization is needed, regular review of prescribed therapies can be overlooked. This lack of ongoing assessment and coordination around utilization at this level may result in excessive and inappropriate utilization and failure to reach clinical goals—as well as exorbitant costs.

There are several tools and resources which can make an impact in both spend and quality of care for long-term injured workers, including:

Predictive Risk Modeling: Knowing that claim age, cost and transaction volume alone are not sufficient for determining when therapeutic issues may be present, predictive risk modeling can identify areas within a payor's population that may have utilization that is inconsistent with best-practice clinical guidelines and evidence-based medicine. By applying a risk-profiling methodology, you can uncover situations that might go unnoticed at the individual prescriber or pharmacy level.

Clinical Programs: Ongoing assessment is needed in high exposure cases around the continued use of medications and multiple services and equipment. Such clinical oversight can be as simple as generic conversion or product substitution programs to drive low cost alternatives. Drug Testing and Monitoring can also be a valuable clinical tool to mitigate risk, reduce costs, and improve long-term injured worker care.

Home Health Care: In-home care is not the only cost driver for home health patients. Complex and severe cases have interconnected cost drivers—38% of home healthcare cases require durable medical equipment and 21% require medical supplies. Utilization as well as unit cost needs to be constantly monitored and assessed for appropriateness per the injury.

Catastrophic Programs: Catastrophically injured workers have unique and complex healthcare needs that require expert coordination and execution, especially for medical services and equipment. Appropriate products and services for the injury should be prescribed for injured workers from discharge from the acute-care setting to the home environment, and continuously monitored for utilization and cost effectiveness.

Fraud, Waste and Abuse: According to NCCI, more opioids are used in long-term cases than in newer cases, making fraud, waste and abuse an elevated risk in high exposure claims. Implementing a fraud, waste and abuse program that identifies, alerts, intervenes, and monitors injured workers, their physicians, and dispensing pharmacies for high-risk behaviors can mitigate this high-cost situation.

Audits: Clinical case reviews and peer-to-peer collaboration can ensure home healthcare and pharmacotherapy treatment plans are effective and follow industry guidelines. Injury-specific formularies can enforce appropriate utilization of services, products and drugs for managing the injury type.

Pre-Settlement Tools: Having historical clinical case reviews and peer-to-peer outreach documentation can support an on-going, streamlined treatment plan, which you can use to better negotiate settlement.

Diligent application of clinical oversight and periodic analysis of therapy and care progression throughout the claim lifecycle can make a major difference in high exposure claims. PMSI performed High Exposure Case Audits on qualified cases, showing an average of $8,566 in immediate annual unit-cost savings.

A comprehensive program that leverages proactive clinical and cost control programs early in the lifecycle and follows through with continuous monitoring and evaluation for appropriateness throughout the life of the claim can reduce costs and improve quality of care in high exposure cases.

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Mail Order Helps Contain Pharmacy Costs

Over the past five years, pharmacy costs have continued to increase, and now represent 15—20% of medical spending in workers' compensation.

This increase has brought the topic of pharmacy cost containment to the front and center of the industry.

While there are many ways to combat rising pharmacy costs, one of the most effective approaches is the appropriate use of mail order. Unlike group health, there are limited incentives for an injured worker to agree to mail service. Providers need to properly educate the injured worker as well as complete all of the tasks associated with delivering medications to an injured worker's home. However, when successful, a mail order program that is fully integrated into the overall PBM network penetration strategy can yield significant savings, especially for long-term and high-cost claims.

According to PMSI's *Annual Drug Trends Report*, the average mail order cost per day of supply in 2011 was approximately 21% less than the average retail cost per day of supply. Additionally, every 10% shift in days of supply from retail to mail order resulted in a 0.5% reduction in spend. Since claim costs increase as a claim ages, converting retail transactions to mail order for older claims in particular can significantly impact cost savings.

The benefits of an integrated Pharmacy Mail Order program include:

Discounted rates

Prescriptions filled via mail order are offered at a much lower rate than retail primarily because of the reduction of overhead, such as brick-and-mortar locations. Plus, 90-day supplies save on billing and dispensing fees. The convenience of mail order encourages in-network participation, which helps reduce the high costs associated with out-of-network bills.

Elevated clinical oversight

When prescriptions are obtained from one source, it's easier to ensure appropriate utilization, control costs and reduce risk. PMSI's Mail Order Pharmacy program provides the benefit of in-house registered and clinical pharmacists who monitor prescriptions to guarantee accuracy and clinical safety. Staff pharmacists are available to counsel an injured worker or claims professional on any medication issue or question.

Broader inventory

Mail order pharmacies have far greater inventories of medications than retail outlets—as much as three to five times more. Injured workers can avoid out-of-stock delays and adhere to their prescribed therapy without interruption.

Improved compliance = Faster return to work

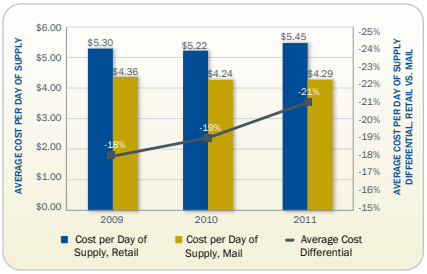
Compliance improves with mail order because injured workers receive their medications at home and do not have to worry about running out of medications or getting to the pharmacy on time. Consistent therapy and compliance lead to a faster return to work.

PMSI ships more than 300,000 prescriptions through its Mail Order Pharmacy program every year. PMSI embeds mail order as an integrated part of managing the pharmacy claims process. As a result of integrating mail order into a robust retail and specialty network program, significant savings and maximum clinical outcomes can be obtained.

The Facts About Mail Order

- The rise in retail cost per day of supply continues to outpace the increase in mail order, with the average cost spread reaching 21% in 2011.
- Mail order transactions are processed in-network, saving as much as 30% on out-of-network transactions.
- Ideal participants have stablized conditions, take two or more medications on a regular basis, and expect to continue on a long-term drug therapy program.
- Clinical oversight reduces waste, and ensures appropriate therapy for the type and severity of injury.

AVERAGE COST PER DAY OF SUPPLY, RETAIL VS. MAIL



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DME Program Strategies: Looking Beyond Unit Cost

Clinical Strategies Drive Appropriateness and DME Utilization Effectiveness

According to the National Council on Compensation Insurance (NCCI), medical services, including durable medical equipment and supplies, make up nearly 23% of a claim.

Traditionally, the focus has been on the unit cost of equipment in order to contain costs, primarily through initiatives related to network penetration, product substitution, and re-coding programs. While these programs are important for cost containment, they don't address the utilization of medical equipment that drives the full cost of DME.

Today, cost control in DME demands the same critical focus on data, clinical interventions and protocols as in pharmacy. Uncontrolled utilization can significantly unravel the effectiveness of unit cost control and reduce the efficacy of treatment—further increasing the total cost of a claim. Many questions need to be asked and answered with clinical expertise, such as:

- **Is the frequency of treatment/equipment use appropriate for the injury and the stage?**
- **Would more frequent use reduce the duration of time the equipment is needed?**
- **Would less frequent use of the treatment/equipment reduce supply cost and still provide appropriate care?**
- **Is the treatment plan effective for the injury?**

Through clinical oversight, treatment or use of medical equipment can be reduced and/or adjusted where it is no longer appropriate, effective or necessary, potentially reducing costs and providing the most effective care. The challenge is ensuring that the clinical oversight is rooted in sound, workers' compensation-focused clinical guidelines and evidence-based medicine protocols that address product necessity, appropriateness, duration, and frequency of use in controlling utilization.

PMSI's DMEComplete™ is a comprehensive solution that increases network penetration and delivers a clinically managed approach for consistent and positive outcomes by controlling appropriateness, frequency and duration of therapy. Through this total care strategy, prospective orders increase dramatically so that clinical interventions can be applied throughout the claim duration. Together with effective vendor management, costs are significantly reduced and utilization is managed on routine to high-cost, chronic claims—generating savings over 20%.

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Moving the Needle with Your Pharmacy Program

According to the National Foundation for Unemployment Compensation and Workers' Compensation, total workers' compensation payments (indemnity and medical) increased by $6 billion over the past decade and total medical benefits increased more than 20%. A major factor contributing to this increase is pharmacy costs. Formerly a much smaller part of a payor's medical spend, pharmacy costs are now approaching 20% of workers' compensation medical costs.

As a result, payors have placed increased focus on pharmacy costs and have come to expect high levels of performance and cost containment from their Pharmacy Benefit Manager (PBM). Today's PBM must look beyond the pharmacy network and find ways to control other factors influencing spend, as well as methods to improve outcomes for injured workers. Specifically, a strong payor-PBM partnership includes:

Collaboration. Working together, the PBM and payor need to establish a clear set of goals for the workers' compensation program. Payors need to select a PBM they can rely on for its expertise, recommendations and guidance—one that understands the unique nature of administering pharmacy benefits for workers' compensation claims. A strong PBM can pave the way in delivering a competitive advantage for their customers through innovation, program customization, and technology integration.

Data intelligence. Collecting data is essential but even more important is knowing how to interpret it, take action on it and drive impactful results. Relying on data obtained through industry benchmarking, predictive modeling, statistical analyses, historical data and performance metrics – creates a meaningful dashboard and roadmap. This information facilitates insightful business reviews and ad-hoc analyses between the payor and PBM for proactive claims management.

Network penetration. A true network penetration strategy addresses all potential sources of a pharmacy transaction—retail, mail order, as well as physician dispensers, occupational health clinics, compounding pharmacies and third-party billers. By bringing all of these entities in network, the PBM improves insights into transactions, which help drive clinical interventions and allow for point-of-sale adjudication edits that reduce utilization.

Clinical oversight. Workers' compensation claims involve pain from physical injury with narcotics becoming the industry's most frequent treatment approach. However, mismanagement of opioid therapy has the potential for fraud and abuse as well as hindering, not helping, clinical progress and outcomes. With proactive PBM clinical oversight, potential issues can be resolved sooner, utilization can be controlled, outcomes can be improved and costs contained—all for the benefit of the injured worker.

Compliance. Changes in state laws and regulations affect every stakeholder. As costs have grown, states have attempted to take actions to control both unit and administrative costs associated with providing pharmacy benefits. A strong PBM will participate in and shape the debate of pharmacy regulations around the country, help payors understand the impact to their costs and their injured workers, and work with payors on the activities needed to achieve compliance.

By partnering with a comprehensive, customer-centric PBM that understands the workers' compensation industry, payors can leverage the PBM's expertise to control pharmacy spend and reduce administrative costs—without waiting years to realize bottom-line results.

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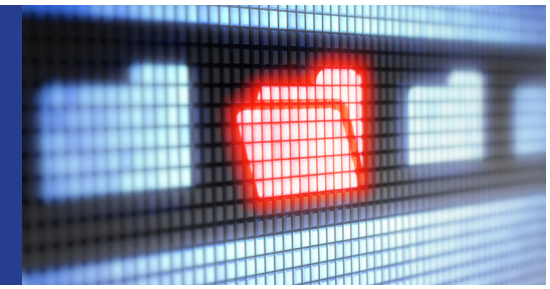
Identifying High-Risk Behaviors in Workers' Compensation Claims

Predictive analytics can provide earlier insight for intervention



Do you have a clear picture of your population's medication risk?

What percent of your injured workers have duplicate or inappropriate therapeutic regimens?

Are your data tools able to analyze against statistically valid benchmarks?

Traditionally, medication risk has been reported on an individual injured worker basis. However, today's payors need population-level risk assessment tools to provide insight on their overall workers' compensation risk. The goal is to pinpoint potential high-risk behaviors and intervene earlier with clinical programs in order to drive optimal health outcomes, mitigate risk and lower pharmacy spend.

Preventing Risk through Predictive Modeling

One of the challenges of predicting risk in workers' compensation is the lack of standard methods and easily recognizable markers for identifying high-risk medication usage and high-cost pharmacy claims. Although the age of a claim, total prescription spend, or number of prescriptions can be good indicators of inherent medication issues, they should be supplemented with additional clinical criteria to develop a more complete picture of risk. Other markers that can be used include:

- Indicators that signal inappropriate treatment plans, such as the utilization of drugs that are not intended for long-term use in the treatment of pain or physical injuries
- Criteria which demonstrate that the injured worker is not responding to recommended first-line drugs, necessitating the use of second-line medications, including compounds
- Indicators of inappropriate utilization, such as the use of multiple pharmacies and physicians, exceeding recommended dose limits or duplication of therapy
- Criteria to detect highly complex cases that utilize medications for conditions typically unrelated to workers' compensation claims

It is important to have a workers' compensation-specific model that can not only track data, but intervene and provide feedback on a continual basis to further refine outcomes over time.

Applying Analytics and Clinical Guidelines

Utilizing millions of pharmacy transactions, PMSI's MedAssess Risk IS™, our predictive modeling tool, evaluates a payor's pharmacy claims against our proprietary methodology of clinical guidelines and algorithms, producing a Population Risk Scorecard. This scorecard provides visibility into the comparative levels of medication risk in a payor's book of business and recommends clinical interventions that will help reduce risk and pharmacy spend. As a result, payors have greater insight into their high-risk claims within their population to proactively apply clinical interventions where they will be most effective.

View the video below for more information on the Population Risk Scorecard.

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Overall Pharmacy Spend Increased Only 3.2%, Narcotics Utilization Dropped in 2011

PMSI's 2012 Annual Drug Trends Report reveals latest industry insights

In the *2012 Annual Drug Trends Report*, PMSI reveals many insightful trends in workers' compensation. The *Report* focuses on 10 notable areas influencing pharmacy spend within PMSI's customer base and the industry as a whole, such as Average Wholesale Price (AWP), Brand and Generic Mix, Mail Order Utilization, and Narcotics Utilization. Here's a quick synopsis of some of the more interesting findings:

Overall Pharmacy Spend Increased Slightly But at a Rate Much Lower than AWP

Average spend per injured worker increased only 3.2% in 2011. Interestingly, this rate of increase was far less than the 2011 average AWP increase of 6.3%. AWP continued to be a major driver of pharmacy cost increases, with an average brand AWP increase of 3.9% and a generic AWP increase of 8.3%.

Cost Savings from Mail Order Continued to Outpace Retail

Mail order utilization continues to be a major cost containment program for pharmacy. The average mail order cost per day of supply in 2011 was approximately 21% less than the average retail cost per day of supply. As a result, every 10% shift in days of supply from retail to mail order during the year resulted in a 0.5% reduction in spend. PMSI's clients continued to aggressively use mail order in 2011, and achieved an average mail order penetration of 27.5%.

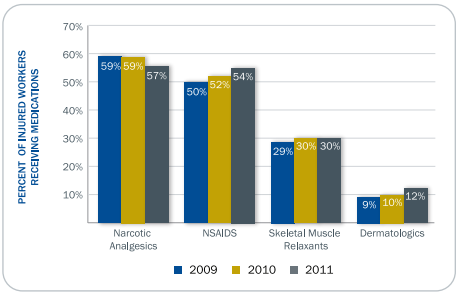
Narcotics Utilization Decreased

In 2011, the use of narcotic analgesics decreased by 1.7%, as measured by morphine equivalent dose (MED) per injured worker per day. The largest reduction occurred in the area of long-acting narcotics, which saw a utilization decrease of 68 mg to 64 mg MED per day.

Additionally, PMSI found a decrease in the use of narcotic analgesics within the first year of injury—a trend that has continued over the last three years. The percent of injured workers using narcotic analgesics in the first year after injury dropped from 59% in 2010 to 57% in 2011, as illustrated below.

Since narcotics make up more than a third of all workers' compensation prescriptions dispensed, this decline demonstrates the effectiveness of PMSI's MedAssess™ clinical programs by addressing issues with appropriate narcotic selection, dose, and duration of therapy.

Changes in Utilization within the First Year After Injury



2012 Annual Drug Trends Report now available

Every year, PMSI analyzes the transactions from its book of business and reports the results in the *Annual Drug Trends Report*. This year's report is a reliable resource for industry trends and also a testament to PMSI's cost containment strategies and clinical programs.

Request an electronic or print copy at: www.pmsionline.com/Annual-Drug-Trends-Report

Learn more about other findings in this year's *Annual Drug Trends Report* by viewing Dr. Maria Sciame in the accompanying video.

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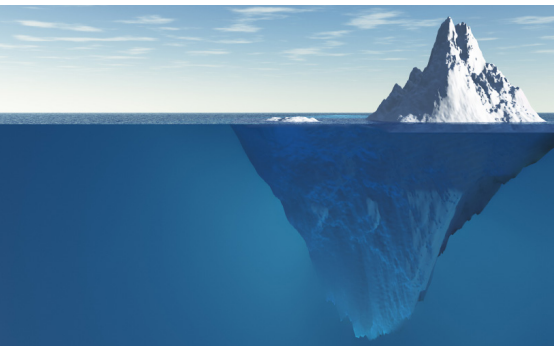
The Full Story on Network Penetration

There's More than Meets the Eye



Maximizing network penetration is one of the ways a Pharmacy Benefit Manager (PBM) can manage workers' compensation pharmacy costs. The higher a PBM's network penetration rate, the greater the opportunity to gain insight into utilization patterns and control costs. Yet, because there is no industry standard on calculating network penetration, each PBM seems to have its own method. As a result, payors struggle to measure network penetration success.

The industry has changed dramatically over the past few years however, many of the reporting methods have stayed rooted in the past. Specifically, here are three major issues that affect the calculation of network penetration today:

Controllable vs. uncontrollable costs

It was common at one time to label billings from third party specialty providers, such as clinics, doctors' offices and hospitals, as "uncontrollable," simply because converting them to in-network transactions was so difficult. As a result, these billings are often removed from the network penetration calculation, resulting in an artificially inflated network penetration rate. Doing so also ignores a significant portion (up to 30% for some payors) of the total spend for the client. It is to the advantage of the payor to bring these transactions in-network so the entire therapeutic regimen can be properly managed.

Dollar vs. transaction

Many PBMs calculate network penetration based on the dollar amount of in-network billings divided by the entire dollar amount billed, including all non-contracted pharmacies and specialty networks. However, the difference between an in-network and an equivalent out-of-network pharmacy bill is the benefit of applying contract rate savings to in-network transactions. Therefore, comparing the two based on dollar amount is an "apples to oranges" comparison, as out-of-network bills will naturally be weighted more due to the absence of the contracted rate savings.

A more accurate way to calculate network penetration is to look at all of the transactions that occurred, regardless of cost. This normalizes the differences in the average cost per transaction for in-network versus out-of-network bills. This method, along with traditional dollar-based approach, gives a full picture of spend.

Paid date vs. fill date

Another factor in calculating accurate network penetration rates is looking at the fill date as opposed to the paid date. For a variety of reasons, out-of-network transactions can take months, and in some cases, years to process. This delay relates to the paper nature of out-of-network bills, lack of connectivity between PBMs and out-of-network providers and re-bills/reconsiderations. In contrast, in-network transactions are real-time. Thus, network penetration can be impacted significantly using paid data as it contains old bills. The use of fill date provides a much more real-time and accurate view of the performance of the PBM and the current program that is in place.

Factors such as these can make comparing performance of PBMs difficult. While it's unlikely the industry will settle on one common definition for calculating network penetration, payors should be aware of these differences in calculating penetration in order to get the most accurate picture of their total workers' compensation pharmacy spend. Only then can payors effectively monitor PBM performance and make informed decisions on ways to increase network penetration.

In the accompanying video below, PMSI's president of Pharmacy, Lori Daugherty, addresses several ways to control out-of-network spend and increase network penetration. Access several related articles and perspectives regarding this important topic in the boxes to the right. You can also visit our website, www.pmsionline.com, for additional information.

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Data Scrubbing is a Must for MIR Compliance

Lessons Learned with Mandatory Insurer Reporting

Mandatory Insurer Reporting (MIR) compliance requires payers and their Reporting Agents to know and understand the latest rules and thresholds to identify and report only those claims which are necessary, and ensure that the correct and required data is present in the right format and fields. Failure to do so will result in non-compliance and possible fines.

It's very possible that 2012 will be the time when CMS imposes the $1,000 per day per claim fines for MIR. Since this reporting is quarterly, just one claim with errors could mean a $90,000 minimum fine. Errors can result from reporting unnecessary claims (non-Medicare beneficiaries, for example), missing data in required fields, incomplete or invalid data in required fields, and data in the wrong fields.

CMS has noted that data scrubbing can significantly lower the error rate of submissions. Proof of this is in PMSI's own book of business, which shows a 99.9% submission acceptance rate by CMS. Following are a few key points to consider with data scrubbing.

1. **Not all claims are reportable.** Gone are the days of giving every claim to CMS and letting them "kick back" the ones that aren't necessary to report. Reporting unnecessary claims increases the error rate and CMS can reject the entire report if it reaches 20%, leaving you in non-compliance.

2. **Data must be accurate prior to submission.** This means verifying that every reportable claim has valid and accurate data in all 250+ CMS-defined fields.

3. **Data will most likely be in multiple source systems.** Data will have to be compiled from these systems, validated and monitored—tasks legacy systems just weren't built to handle. This step is often skipped by Reporting Agents because it takes a significant amount of time and money to upgrade systems to accommodate CMS' specific and often changing requirements.

4. **Automated systems with built-in CMS rules can make data scrubbing a less tedious process.** With real-time reporting such as in PMSI's MedicareConnect℠, payers can have a clear idea of their level of compliance.

MIR is really still in its infancy. As of yet, CMS has not outlined how or when fines for non-compliance will be enforced. It is anticipated that this year, CMS will continue to evaluate the efficiency and effectiveness of the MIR process and continue to make modifications as necessary.

Continuing the conversation:
The video below features Pat Sullivan, PMSI's President of Specialty Services, who discusses MIR further. You can also access related materials in the links to the right.

Thought Leadership

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We look forward to sharing our more than 35 years of workers' compensation experience with you in this forum and through social media. Additionally, PMSI has a wealth of insights available on our website, including our ExpertInsights video library.

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