Where Chronic Pain Management Meets Mental Health

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Chronic Pain

Pharmacy

Case Management

Disease Management
Pharmacy

- Prescriptions
  - Frequency
  - Type
  - Volume
  - Number of providers

- Pharmacies
  - Comparison to standards
  - BOB volume
Case Management

- Pharmacy referrals
- Number of scripts
- Quantity of scripts
- Number of providers prescribing
- Clinical data: ER visits, admissions, injections
- HR referrals
- Inpatient and outpatient admissions
- Self-referrals
Disease Management

• Disease management identifies conditions not symptoms
• Certain diagnostic groups are associated with high opioid abuse
  – Orthopedic (back pain, leg pain, musculo-skeletal)
  – Trauma
  – Diabetes
  – Neurologic
Fraud and Abuse Unit

- Take referrals from case management, disease management, and pharmacy
- Outreach with network to engage and educate providers
- Suspend or eliminate frequent or egregious over users
Prescription Drug Addiction—A Growing Epidemic

Source: IMS Health 2015 data
The Facts

• More than 2.1 million Americans are addicted to OxyContin, Vicodin, Demerol and other similar drugs without a prescription, according to the National Survey on Drug Use and Health
• Another 2.5 million or more are pain patients who may be suffering from an opioid use disorder, but have legitimate prescriptions for the drugs
• Death from opioid analgesics far exceeds deaths from any other drug or drug class, licit or illicit

Sources:
The Facts

• Doctors prescribed approximately 249 million opioids in the United States in 2015, up from approximately 113 million in 1992.
• The U.S. is the world’s largest opioid consumer, accounting for almost 100 percent of hydrocodone and 81 percent of oxycodone use.

Sources:
# Opioid Prescription Drugs

## Opioid Pain Relievers

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<tr>
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<td></td>
<td>Lorcet</td>
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<tr>
<td>Hydromorphone</td>
<td>Dialaudid, Exalgo</td>
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<td>Opana</td>
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The Addiction and the Abuse

• Systematic reviews and multiple studies have concluded that the effectiveness of prolonged opioid treatment for chronic non-cancer pain is unknown.

• Opioids do generate a sense of euphoria that can be extremely addictive.

• This leads some patients continue to crave opioids and go to great lengths to procure them even long after any pain has passed.

The Addiction and the Abuse

- Many doctors are unaware that their patients have become addicted to the pain relievers.
- Some opioid addicts “doctor shop,” obtaining prescriptions from several different doctors at the same time.
- Another issue is opioid diversion, where a legally prescribed opioid is transferred or sold illicitly to someone other than the patient for whom it was initially prescribed.

Financial Implications for Health Plans

- A Segal study employed data analytics to review individual physicians that had prescribed a greater than 500-day supply of opioids to individual participants.
- The cost of this to the plan was more than $600,000 over 12 months.
- One doctor had prescribed one patient a 1,576-day supply of opioids, which cost more than $85,000.
- Other costs arise when opioid-addicted participants become ill (e.g., severe dependence, drug overdose, severe side effects) as a result of the abuse.
- Some may require emergency treatment for overdoses.

Source: Segal Consulting Proprietary data 2016
## Sample Study of Large Opioid Prescriptions

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Source: Segal Consulting

Proprietary data 2016
Other Cost Drivers

- Regulations under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- As a result of this expanded access, new substance-abuse treatment centers have entered the marketplace to take advantage of the increased volume of treatment and potential revenue opportunities.
- Many of these centers have mass-marketed themselves using television and other media to encourage patients to travel out-of-state for treatment.
- These centers very expensive (e.g., demanding comprehensive drug testing, at a rate of $5,000 or more daily, for many consecutive days).

Source: Segal Consulting Proprietary data 2016
This Is What They Look Like!

Why Cliffside?
The answer is simple. We want you to go to treatment once and recover for good.

View Our Facility
Cliffside Malibu is a beautiful luxury estate, situated on two acres, overlooking Zuma Beach.

Life at Cliffside
Cliffside Malibu have been designed to provide everything required for a full recovery from addiction.

Life After Cliffside
The goal of treatment is to create within you the skills and ability to remain clean and sober at home.
In vs. Out-of-Network Cost Differential

- The cost differential for treatment at in-network and out-of-network/out-of-state recovery centers can be astounding.

<table>
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<td><strong>In-Network</strong></td>
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</table>
| **Out-of-Network/Out-of-State** | California: $108,500  
                          | Florida: $42,000    |

Source: Segal Consulting Proprietary data 2016
What Can Plan Sponsors Do

1. Institute an enhanced fraud and abuse program that uses data analytics to identify and manage fraudulent drug use. Clues to look for include unusually large daily dosages of opioids per patient, multiple providers combined with excessive doses and duplicate claims from multiple pharmacies.

2. Require prior authorization for opioid prescriptions of more than 15 days for all outpatient pain-management prescriptions.

3. Monitor hospital discharges and conduct patient oversight to look for prior drug-abuse events (e.g., overdoses or substance-abuse treatment). Capturing all prior events will help plan sponsors evaluate the appropriateness of newly prescribed medications and avoid relapses.

4. Develop plan strategies to cover abuse-deterrent opioids (e.g., require written permission from the provider before an abuse-deterrent prescription can be switched to a non-abuse-deterrent prescription).

Source: Segal Consulting Proprietary data 2016
What Can Plan Sponsors Do

5. Work with the PBM to establish a fraud tip hotline. In most cases, the PBM will monitor the hotline each day. Tips are triaged, investigated and referred to plan sponsors as appropriate.

6. Offer alternative treatment for pain management (e.g., osteopathic manipulative treatment).

7. Train and educate prescribing physicians. This should include instituting multi-disciplinary condition-management programs that address co-morbid conditions (e.g., SUDs and mental health issues).

8. Communicate and educate participants about the addiction aspects of opioids.

Source: Segal Consulting Proprietary data 2016
Overview

• The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Act), as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical (med/surg) benefits.

This is commonly referred to as providing such benefits in parity with med/surg benefits.
Overview

- There are requirements for determining parity with respect to financial requirements (such as copays) and for treatment limitations, which limit the scope or duration of benefits for treatment.

- Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements).
  - The rules for financial requirements and QTLs are different from the rules for NQTLs.

- The Act applies to both grandfathered and non-grandfathered plans, self-insured and insured.
Parity With Respect to Aggregate Lifetime and Annual Dollar Limits

- The Act requires parity with respect to the aggregate lifetime and annual dollar limits imposed by plans in connection with mental health and substance use disorder benefits and medical/surgical benefits.
- Different lifetime/annual limit rules apply depending on the extent to which such limits are applied to med/surg benefits.
- In the preamble of the implementing regulations, the Departments acknowledge that the Affordable Care Act prohibits lifetime and annual limits on the dollar amount of “essential health benefits,” which include “mental health and substance use disorder services, including behavioral health treatment.” The Departments confirmed the MHPAEA concerns only lifetime and annual dollar limits on mental health and substance use disorder benefits to the extent they are not essential health benefits.
Classifications

• The Act does not require a plan to provide any mental health or substance use disorder benefits.

• However, if a plan provides mental health or substance use disorder benefits in any “classification of benefits,” the mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.
  – Exception for ACA mandated preventive services.

• A plan must apply the same standards to medical/surgical benefits and to mental health and substance use disorder benefits in determining in which classification a particular benefit belongs.
The six classifications are as follows:

- Inpatient, in-network;
- Inpatient, out-of-network;
- Outpatient, in-network;
- Outpatient, out-of-network;
- Emergency care; and
- Prescription drugs.
Financial Requirements and Quantitative Treatment Limitations

- A plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or quantitative treatment limitation in any of the classifications that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
  - “Financial requirements” include deductibles, copayments, coinsurance, or out-of-pocket maximums.
  - A “quantitative treatment limitation” is a limit on benefits based on the frequency of treatment, number of visits, days of coverage, or days in a waiting period, or is a similar limit on the scope or duration of treatment that are expressed numerically.
Financial Requirements and Quantitative Treatment Limitations

- A financial requirement or quantitative treatment limitation is considered to apply to “substantially all” plan payments for medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification.
  - If a type of financial requirement or quantitative treatment limitation (co-pay, co-insurance, ...) does not apply to at least two-thirds of all medical/surgical benefit payments in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.
Financial Requirements and Quantitative Treatment Limitations

• If “substantially all” test is met—what is the predominant (applies to 50% or more claims) financial requirement/limitation in the classification (e.g. $20 copay)?

• If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits (i.e., self-only, family, employee-plus-spouse), this inquiry is made separately for each coverage unit.
  – Limitation/requirement on mental health/substance abuse disorder can be no more restrictive than predominant requirement/limitation.
Prescription Drugs

- If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the parity requirements of the final rule.

- The MHPAEA applies to any benefits a plan may offer for Medication Assisted Treatment (MAT) for opioid disorder. MAT is any treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment in combination with behavioral health services.
Financial Requirements and Quantitative Treatment Limitations

- A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

- Thus, a plan would violate the final rule if it imposed an annual deductible on all medical/surgical benefits and a separate annual deductible on all mental health and substance use disorder benefits, regardless of whether the separate deductible is lower than that for the medical/surgical benefits.
Nonquantitative Treatment Limitations

• A plan may not impose a nonquantitative (e.g., preauthorization) treatment limitation with respect to mental health or substance use disorder benefits in any classification unless...
  - Under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.
The final rule provides the following non-exhaustive list of nonquantitative treatment limitations:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers, network tier design;
Nonquantitative Treatment Limitations (continued)

- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective; (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.
MHPAEA Audits

• The DOL has been instructed by the President and Congress to begin MHPAEA enforcement audits.

• A bill is also pending in the Senate to improve MHPAEA compliance and enforcement.

• In January 2016, the DOL issued a MHPAEA enforcement fact sheet ("Warning Signs") summarizing their findings in enforcement actions.
Warning Signs

• The U.S. DOL recently issued “Warning Signs” for plans regarding compliance with the MHPAEA.

• According to the DOL, stakeholders have requested examples of plan provisions that might trigger careful analysis of the coverage side in order to ensure MHPAEA compliance.

• It is important to note that the plan/policy terms listed in the warning signs do not automatically violate the law. Key compliance question remains...Is there parity?

• The DOL emphasized the categories and examples are not exhaustive.
I. Preauthorization & Pre-service Notification Requirements

- **Blanket Preauthorization Requirement:** Plan/insurer requires preauthorization for all mental health and substance use disorder services.

- **Treatment Facility Admission Preauthorization:** Plan/policy states that if the participant is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, participant will be responsible for the cost of services received.

  **Examples:**
  - Plan states that for inpatient mental health precertification is required.
  - Plan requires pre-notification or notification ASAP for non-scheduled mental health/substance abuse disorder benefits (MH/SUD) admissions and reduces benefits 50% if pre-notification is not received.
  - Plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.
  - Plan requires preauthorization or concurrent care review every “x” days for MH/SUD services but not for med/surg services.
Warning Signs

- **Medical Necessity Review Authority:** Plan’s/insurer’s medical management program (precertification and concurrent review) delegates its review authority to attending physicians for med/surg services but conducts its own reviews for MH/SUD services.

- **Prescription Drug Preauthorization:** Plan/insurer requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.

- **Extensive Pre-notification Requirements:** Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.
11. Fail-First Protocols

- **Progress Requirements:** For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.

- **Treatment Attempt Requirements:** For inpatient SUD rehabilitation treatment plan/insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.

For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.
III. Probability of Improvement

- **Likelihood of Improvement:** For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement.

  Plan/policy only covers services that result in measurable and substantial improvement in mental health status within 90 days.
IV. Written Treatment Plan Requirement

- **Written Treatment Plan**: For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.

- **Treatment Plan Required within a Certain Time Period**: Plan/insurer requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex biopsychosocial evaluation. Plan needs to be reviewed at least one a week for progress.

- **Treatment Plan Submission on a Regular Basis**: Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months.
V. Other

- **Patient Non-compliance:** Plan/policy excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.

- **Residential Treatment Limits:** Plan/policy excludes residential level of treatment for chemical dependency.

- **Geographical Limitations:** Plan/policy imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on med/surg benefits.

- **Licensure Requirements:** Plan/policy requires that MH/SUD facilities be licensed by a state but does not impose the same requirement on med/surg facilities.
Court-Ordered Treatment Exclusion

- Common provision in plans—exclude reimbursement for any services mandated by court.
- Protests, nothing formal, no known lawsuits.
- Some states prohibit such exceptions for insured plans.
Are You Paying a Huge Price for the Opioid Drug Abuse Epidemic?

by Sadhna Paralkar, M.D., and Eileen Flick
Millions of health plan participants are addicted to or misusing opioid painkillers, leading to suffering, deaths and huge costs. Plan sponsors can take steps to try to protect themselves and participants.
The United States is struggling with an opioid drug abuse epidemic, and one often-overlooked impact is the huge additional—and often undetected—costs incurred by health plan sponsors. Inappropriately prescribed opioids, or opioids obtained through fraudulent practices, can cost plans tens of thousands of dollars. Plans also incur costs for emergency room visits and hospitalizations due to overdoses.

Making matters worse, a new generation of broadly marketed substance abuse treatment centers is taking advantage of opioid addiction by charging outrageous fees, a percentage of which plans generally must cover.

Plan sponsors need to take steps to protect themselves from what has become a widespread and insidiously expensive public health problem. They should actively identify potential prescription drug misuse and develop solutions to minimize fraud and abuse. Data analytics, a process used to discover trends and patterns in claims data, can be used to help develop and support health plan strategies and improve the likelihood that any actions taken will have the intended impact.

What’s Going On?
More than 2.1 million Americans are addicted to OxyContin®, Vicodin®, Demerol® and other similar drugs (see Table I for a list) without a prescription, according to the National Survey on Drug Use and Health. Another 2.5 million or more are pain patients who may be suffering from an opioid use disorder but have legitimate prescriptions for the drugs. Deaths from opioid analgesics far exceed deaths from any other drug or drug class, licit or illicit.

The problem often starts when a doctor prescribes an opioid for a patient with a toothache, an athletic injury or pain from surgery. Such prescriptions have become extremely common. Opioids are widely accepted by the public, and patients seeking pain relief have come to expect them. As a result, doctors prescribed approximately 249 million opioids in the United States in 2015, up from approximately 113 million in 1992 (see the figure), although the number of opioid prescriptions has begun to fall in recent years. The U.S. is the world’s largest opioid consumer, accounting for almost 100% of hydrocodone and 81% of oxycodone use.

Oddly enough, systematic reviews...
and multiple studies have concluded that the effectiveness of prolonged opioid treatment for chronic noncancer pain is unknown,5,6 but opioids do generate a sense of euphoria that can be extremely addictive. This leads some patients to continue to crave opioids and go to great lengths to procure them even long after any pain has passed. Many doctors are unaware that their patients have become addicted to the pain relievers. Some opioid addicts “doctor shop,” obtaining prescriptions from several different doctors at the same time.

Another issue is opioid diversion, where a legally prescribed opioid is transferred or sold illicitly to someone other than the patient for whom it was initially prescribed.

**What Are the Financial Implications for Health Plans?**

Several Segal Consulting clients have observed higher health plan costs for prescription opioids. Because most opioids are low-cost generics, the high costs typically are driven by high-volume dispensing, which is also often an indication of potential abuse.

One sample study employed data analytics to review individual physicians who had prescribed a greater-than-500-day supply of opioids to individual participants. It found these physicians had cost a plan more than $600,000 over 12 months (see Table II). One doctor had prescribed one patient a 1,576-day supply of opioids, which cost more than $85,000.

Other costs arise when opioid-addicted participants become ill (e.g., severe dependence, drug overdose, severe side effects) as a result of the abuse. Beyond this, some may require emergency treatment for overdoses.

Also driving costs are regulations under the Mental Health Parity and Addiction Equity Act of 2008 (MH-PAEA). MH-PAEA requires group health plans and health insurance issuers to ensure that the financial requirements (e.g., copayments and deductibles) and treatment limitations (e.g., visit limits) applicable to mental health or substance use disorder (SUD) benefits (e.g., treatment for opioid addiction) are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

As a result of this expanded access, new substance abuse treatment centers have entered the marketplace to take advantage of the increased volume of treatment and potential revenue opportunities. Many of these centers have mass-marketed themselves using television and other media to encourage patients to travel out of state for treatment. Not only are these centers very expensive (e.g., demanding comprehensive drug testing at a rate of $5,000 or more daily for many consecutive days), they impede family involvement in recovery, a vital element of successful treatment protocol. Moreover, the cost differential for treatment at in-network and out-of-network/out-of-state recovery centers can be astounding (see Table III).

### Table I

**Opioid Pain Relievers**

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**Sample Study of Large Opioid Prescriptions**

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*Note: The first ten prescribers listed represent physicians who had the ten largest average day supplies of opioids prescribed. The grand total includes results for 65 prescribers.*

*Source: Segal Consulting.*
Congress also has recognized the national epidemic of prescription opioid abuse. In March 2016, the Senate passed legislation that would authorize grants for states to address the prescription opioid epidemic.\(^7\) In addition, the legislation would require the Department of Health and Human Services (HHS) to convene an interagency task force to develop best practices for pain management and prescribing pain medication. The House passed similar legislation in May.\(^8\) As of mid-June, the legislation was being considered by a conference committee charged with working out the differences between the Senate and House versions.

### How Can a Plan Sponsor Take Action?

To protect themselves, plan sponsors need a strong preferred provider organization network for behavioral health services to properly treat opioid addiction and thoughtful utilization management controls that can ferret out fraud or abuse. The first step to uncovering fraud or abuse is to review the pharmacy benefit manager (PBM) clinical programs targeting this drug class.

Special care also needs to be taken in designing programs to treat opioid addiction, including the appropriateness of antiaddiction prescription drugs used for opioid addiction (e.g., naltrexone, buprenorphine). These drugs should be prescribed by physicians with special training and should be closely monitored for medical necessity, treatment adherence and appropriate dosage and delivery.

Of course, in developing protocols for utilization management controls with respect to treatment for addiction, plan sponsors need to comply with MHPAEA. Plan sponsors should develop a set of neutral, objective criteria to determine which classes of drugs should be subject to utilization management controls and which controls should apply to them. The same utilization management controls must apply on the medical side to any drugs that meet the established criteria.

General strategies for managing potential opioid abuse include plan design, vendor management and care management programs. Plan sponsors should consider the following eight solutions:

1. Institute an enhanced fraud and abuse program that uses data analytics to identify and manage fraudulent drug use. Clues to look for include unusually large daily dosages of opioids per patient, multiple providers combined with excessive doses and duplicate claims from multiple pharmacies.
2. Require prior authorization for opioid prescriptions of more than 15 days for all outpatient pain management prescriptions.
3. Monitor hospital discharges and conduct patient oversight to look for prior drug abuse events (e.g., overdoses or substance abuse treatment). Capturing all prior events will help plan sponsors evaluate the appropriateness of newly prescribed medications and avoid relapses.
4. Develop plan strategies to cover abuse-deterrent opioids\(^9\) (e.g., require written permission from the provider before an abuse-deterrent prescription can be switched to a non-abuse-deterrent prescription).
5. Work with the PBM to establish a fraud tip hotline. In most cases, the PBM will monitor the hotline each day. Tips are triaged, investigated and referred to plan sponsors as appropriate.
6. Offer alternative treatment for pain management (e.g., osteopathic manipulative treatment).
7. Train and educate prescribing physicians. This should include instituting multidisciplinary condition man-

### TABLE III

**Sample Plan Sponsor Recovery Center Cost Differential**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Average Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$13,500</td>
</tr>
<tr>
<td></td>
<td>Florida: $42,000</td>
</tr>
</tbody>
</table>

Source: Segal Consulting.

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agement programs that address comorbid conditions (e.g., SUDs and mental health issues).

8. Communicate and educate participants about the addiction aspects of opioids.

It is also important to pay attention to a participant’s psychosocial health\(^\text{10}\) needs (e.g., depression that results from the inability to manage pain). Ignoring these needs can lead to increased medical visits, hospitalizations and long-term chronic disease.

**Key Takeaways**

Although the opioid drug abuse epidemic is serious, it is far from hopeless. There are concrete and practical steps plan sponsors can take to identify fraud and abuse and help participants get the treatment they need for a reasonable cost. By using the strategies outlined in this article, plan sponsors can reduce the incidence of opioid drug abuse, ensure participants get better care and ultimately manage the plan’s overall costs.

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**Endnotes**


2. IMS Health.


7. The Comprehensive Addiction and Recovery Act (CARA) of 2016 (S. 524) passed the Senate by a vote of 94-1.

8. The House of Representatives passed similar legislation by a vote of 400-5 on May 13, 2016.

9. Abuse-deterrent properties meaningfully discourage abuse, even if they do not prevent it. For example, because opioids can be abused in a number of ways—swallowed whole; crushed and swallowed; crushed and snorted; crushed and smoked; or crushed, dissolved and injected—abuse-deterrent properties may make them difficult to snort or inject.

10. Psychosocial health includes mental, emotional, social and spiritual well-being.
Session #H16

Where Chronic Pain Management Meets Mental Health

Goals

• Identify members early and engage with case Management
• Identify local resources to assist members
• Interact with providers and pharmacies
• Support state mandates to limit overuse and abuse
• Assist with identifying quality inpatient recovery facilities when necessary
• Provide post treatment support

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