



Fighting the Rx Epidemic:

A Prescription for Workers' Comp



WHITE PAPER: KEY TAKE AWAYS

1. Find out how workers' comp has turned the corner toward building a durable remedy for prescription drug abuse and misuse.
2. Learn from America's best minds the multi-pronged approach that's driving change.
3. See how Rx Intelligence technologies are vital to the solution.

EXPERTS

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Christopher M. Jones, PharmD, MPH, Centers for Disease Control and Prevention (CDC)

R. Gil Kerlikowske, "Drug Czar," Director, Office of National Drug Control Policy (ONDCP)

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Joseph T. Rannazzisi, RPh, JD, Deputy Asst. Administrator, Drug Enforcement Administration (DEA) Office of Diversion Control

John Eadie, Director, Prescription Monitoring Program, Center of Excellence, Brandeis University

Mary Bono Mack, US Representative, California's 45th Congressional District; Co-Founder and Co-Chair of the Congressional Caucus on Prescription Drug Abuse

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The epidemic of prescription drug abuse and misuse has crossed all lines in our society: taking lives, dividing families, disrupting communities and robbing America's economy of productive workers.

From OxyContin to Opana, a new "drug of choice" emerges each time controls are put in place to curb the abuse of another. Clearly, the adaptability and complexity of this public health crisis is so large in scale that it defies all previous solution models.

Leadership in the private and public sector has been working together to fight this epidemic. Some of our nation's best minds demonstrate that the answer exists in a multi-pronged approach of *evidence, prevention, education, monitoring and Rx intelligence with rapid response*. It's an integrated approach that should be leveraged as both a public health initiative *and* a claims and managed care strategy.

THE EMERGENCE OF THE EPIDEMIC

Powerful painkillers have killed more than 100,000 people since 1999, a figure that exceeds the US military death toll during the Vietnam War. Between 1999 and 2009, drug-induced deaths claimed more lives than any other injury deaths, including injury by firearms, homicide, suicide and motor vehicle accidents.¹ In just five years, there has been a 345 percent increase in oxycodone deaths (Oxycodone is a powerful ingredient found in Percocet, OxyContin and other painkillers.). Recent studies show a dramatic increase in accidental deaths linked to the use of prescription opioids and an increasing average daily morphine equivalent dose (MED) of the most potent opioids since 1999.² Among patients who are prescribed opioids, 20 percent are prescribed at high doses of 100mg MED or over; these patients account for 80 percent of prescription opioid overdoses.³

“This all happened very deliberately.” - Gary Franklin, MD, MPH, Medical Director, Washington State Department of Labor and Industries

In addition to costing lives, it's costing money – particularly from non-adherence to medication instructions from the prescribing physician. Pharmacy-related waste accounts for \$408 billion of damage each year. Of that total, \$317.4 billion represents non-adherence⁴ in its many forms, from drug misuse *to* diversion.

How did this scourge start? “This all happened very deliberately,” says Gary Franklin, MD, MPH, Medical Director, Washington State Department of Labor and Industries and Research Professor, Departments of Environmental Health, Neurology and Health Services, University of Washington.⁵ Franklin is the co-author of a number of key initiatives on pain prescribing within the workers' compensation industry.

He pins what he calls our “public health emergency” on using medications that were initially used to treat cancer pain on non-cancer pain. He says, “The key problem is that these potent drugs, some synthesized to be chemically very similar to heroin, were pushed for chronic pain with no dosing

ceiling recommended and with the axiom that escalating doses were the best way to treat tolerance. This was a man-made problem.”

The similarity of these prescribed drugs to heroin is causing an alarming progression explains Joseph T. Rannazzisi, RPh, JD, Deputy Assistant Administrator, Drug Enforcement Administration (DEA) Office of Diversion Control, “OxyContin and hydrocodone and the rest of the opioids lead to heroin. They start

IN 2009, THERE WERE **15,500+** PRESCRIPTION PAINKILLER DEATHS, KILLING MORE AMERICANS THAN HEROIN AND COCAINE COMBINED.

with hydro but because you build up a tolerance, they go to the oxy combination products – they’re a little stronger. We will lose a whole generation to heroin because they started on hydro.”⁶ It’s a path we’re being led down, warn experts, with hydrocodone being the number one most prescribed drug in the nation at 131.2 million prescriptions in 2010.⁷

The effect of prescription drug misuse and abuse is also taking a severe toll on injured American workers. A recent national study shows that 71 percent of workers’ compensation claimants on chronic opioid therapy (> three months) aren’t taking their pain medication as prescribed.⁸ The study also found that after three months of an injured worker taking prescription drugs, the likelihood of them going back to their same job, or any job for that matter, substantially drops.

Another study, conducted by the Workers’ Compensation Research Institute (WCRI), found that injured workers in New York, Louisiana, Pennsylvania and Massachusetts whose injuries caused seven days or more of lost work time used more than twice as many narcotics than their counterparts in Iowa, Michigan, Minnesota and Indiana. Comments Richard Victor, PhD, JD, WCRI’s Executive Director, “Our research on narcotics shows tremendous variation from state to state in physicians’ prescribing patterns for pain medication – narcotics or not. We’ve

Rx EPIDEMIC RUNS DEEP

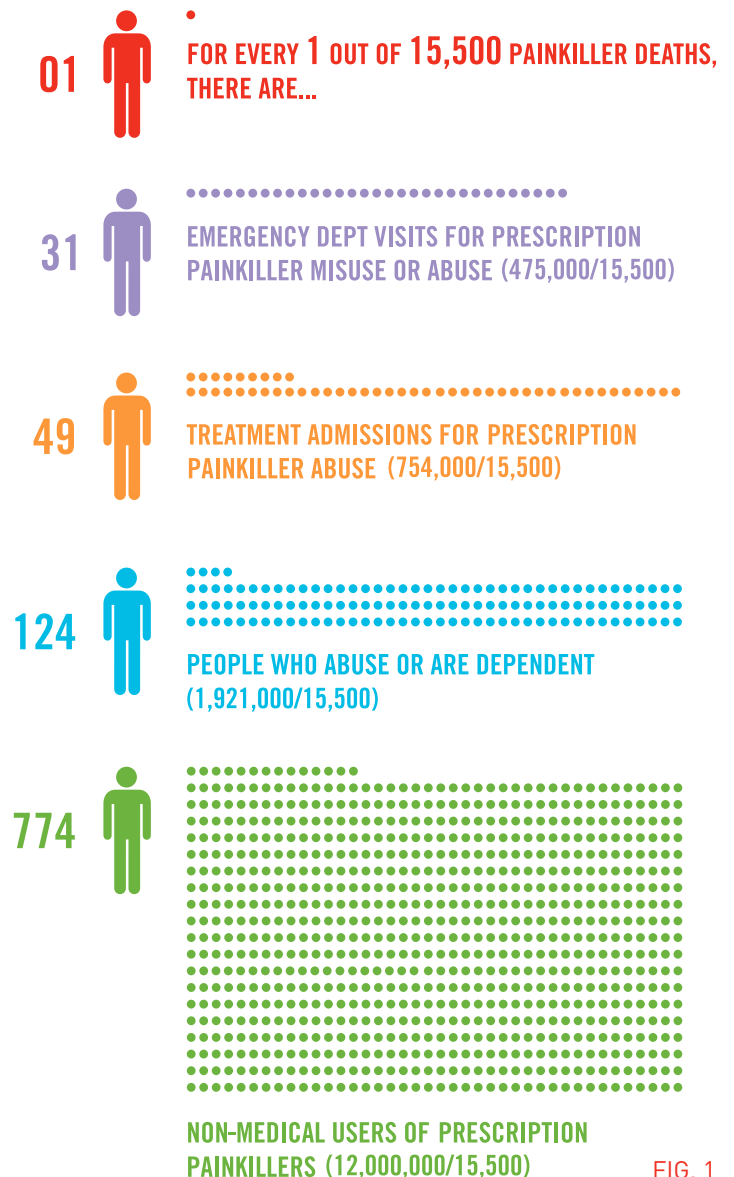


FIG. 1

also seen with narcotics a variation in the strength and number of pills per injured worker. Since the average severity of injury does not vary much from state to state, a question arises about whether such differing local prescribing norms all represent appropriate care."⁹

MEDICAL EVIDENCE

As recently as five years ago, someone interested in the use of prescribed opioids had a daunting time sorting out reliable versus questionable research reports. Dependable information on actual use patterns and physician prescribing behavior was virtually unavailable. Now, the quality and accessibility of this information has vastly improved, notably within the workers' compensation community.

As recently as five years ago, someone interested in the use of prescribed opioids had a daunting time sorting out reliable versus questionable research reports.

Research has addressed a host of questions about safe and appropriate use of prescribed opioids. Certainly, some questions remain unanswered, such as the benefits and risks of long-term opioid use. But progress is being made, as reflected in the following pain treatment recommendations by the Centers for Disease Control and Prevention (CDC) in 2010:¹⁰

- Use opioid medications for acute or chronic pain only after determining that alternative therapies do not deliver adequate pain relief. The lowest effective dose of opioids should be used.
- In addition to behavioral screening and use of patient contracts, consider random, periodic, targeted urine testing for opioids and other drugs for any patient less than 65 years old with non-cancer pain who is being treated with opioids for more than six weeks.
- If a patient's dosage has increased to ≥ 120 mg morphine equivalents per day without substantial improvement in pain and function, seek a consult from a pain specialist.
- Do not prescribe long-acting or controlled-release opioids (e.g. OxyContin, fentanyl patches, and methadone) for acute pain.
- Periodically request a report from your state prescription drug monitoring program on the prescribing of opioids to your patients by other providers.

The CDC further recommends that each state should ensure its medical providers follow evidence-based treatment guidelines for chronic pain and opioid prescribing.¹¹ The very significant advance of using such guidelines began about five years ago. Well written guidelines permit a nurse, physician, adjuster, attorney or judge to access quickly credible medical information at a very low cost in time, effort and money.

For the workers' compensation community, the more noteworthy guidelines include the Colorado Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines, the Chronic Pain Medical Treatment Guidelines of the California Division of Workers' Compensation (Medical Treatment Utilization Schedule), the American College of Occupational and Environmental Medicine's Guidelines for Chronic Use of Opioids, and chronic pain guidelines included as part of ODG Treatment, published by the Official Disability Guidelines. Massachusetts recently issued workers' compensation chronic pain guidelines. For the entire healthcare community, the American Pain Society has issued treatment guidelines.

In addition, information about actual prescribing activities among physicians for work injured patients has greatly improved in recent years through the efforts of insurers, managed care companies and workers' compensation research organizations.

For example, the National Council on Compensation Insurance (NCCI) has published a number of important studies on drug utilization and cost. One study reports that prescription drugs make up 19 percent of all workers' compensation medical costs.¹² The study also shows that the longer the claim, the higher the Rx costs; on claims more than 11 years old, prescription drugs make up more than 40 percent of all medical costs.

A 2011 report from the California Workers' Compensation Institute (CWCI) states that 55 percent of all Schedule II narcotics (oxycodone, methadone, fentanyl and codeine) prescribed to workers' comp patients are coming from just three percent of physicians.¹³ The report cites that these physicians – about 279 physicians – are responsible for two out of every three workers' comp opioid dollars spent in California. The CWCI also states that injured workers taking these types (Schedule II) of powerful painkillers need about 119 percent longer to recover than workers receiving low or no doses of the narcotics.

WORLDWIDE OPIOID CONSUMPTION

Americans make up only 4.6% of the world's population, yet consume 80% of its opioid supply.

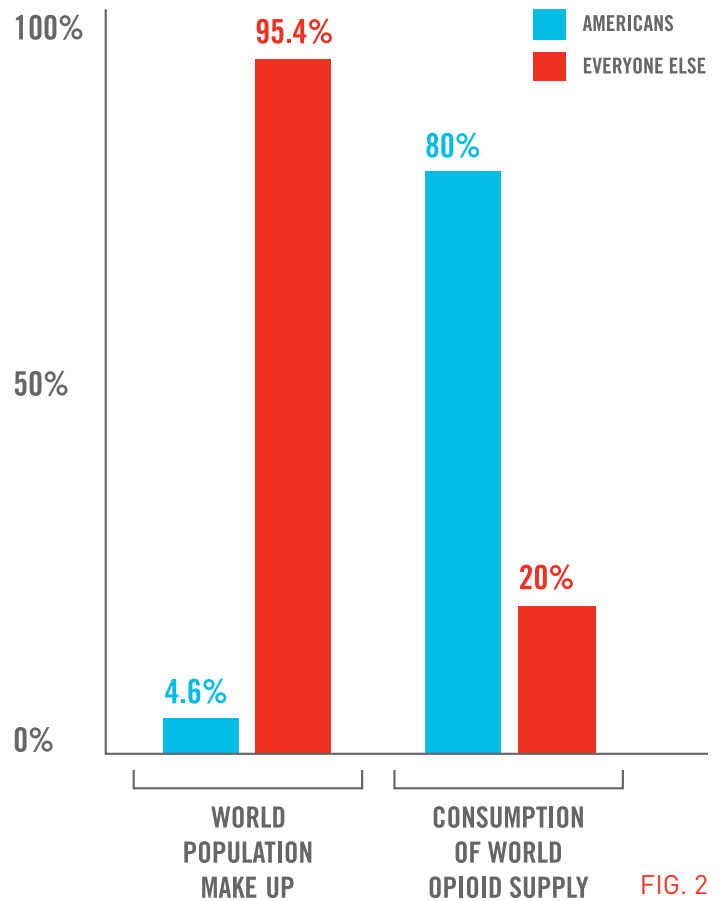


FIG. 2

PREVENTION

“Prevention is critical,” says “Drug Czar” R. Gil Kerlikowske, Director, Office of National Drug Control Policy (ONDCP). “It reduces costs, saves lives and improves quality of life.”¹⁴ Excessive use of pain medications is fundamentally a national health crisis, requiring public health prevention campaigns to shift popular expectations and behavior.

One successful prevention model was led by Fred Wells Brason II, Executive Director of Project Lazarus. He addressed the problem of Medicaid patients shopping for prescription meds in Wilkes County, North Carolina Emergency Departments (EDs). “We literally had some Medicaid patients with 50 ED visits a year,” says Brason.¹⁵ So the ED and North Carolina Medicaid flagged these “frequent fliers” and used case management protocols to refer them to an appropriate care provider. Opioid-related deaths in Wilkes County decreased by 69 percent between 2009 and 2011. Just prior to this pilot program, in 2007, Wilkes was the third worst county for Rx-related deaths in the nation. The program is now being implemented across all of North Carolina, and Brason says this type of prevention could be adapted easily from a Medicaid population to a workers’ compensation population.

For a case study on how to develop and apply evidence-based, opioid treatment guidelines, there is no better example than Washington State. In 2007, Franklin helped put into place the Washington State Agency Medical Directors’ Group (AMDG) Opioid Dosing Guideline with a 120mg MED “yellow flag” threshold. If the patient wasn’t getting better on 120mg MED, then the physician should obtain a consultation with a pain management specialist.

Immediately after the dosing guidelines were released, Franklin says he received a three-page letter from Purdue Pharma (the makers of OxyContin) stating how wrong it was to set such limits. Purdue stated it’s not overprescribing that’s causing the problem, it’s misuse and drug diversion - redirecting drugs from the original purpose to recreational use. At the same time, Purdue was getting a lot of heat for falsely marketing OxyContin as “safe.” In 2007 Purdue pled guilty to misleading the public about the safety of its painkiller OxyContin and was fined \$634.5 million. It’s one of the largest financial penalties ever imposed on a drug company. Simultaneous to this, the Washington Opioid Dosing Guideline was not implemented for two years as Franklin and the AMDG battled in court against a lawsuit to prevent its use. A judge eventually dismissed the case in 2009 and, in 2010, the Guideline was revised to enforce universal precautions and best practices.

Since Washington put into place the 120mg MED dosing guidelines, they published the country’s first information showing a substantial reversal of high doses and a drop in deaths in the workers' compensation system.

Franklin concludes that multiple entities, not just workers’ compensation regulators in isolation, must work together to solve this problem. “I think that insurers can work with care management companies, especially if they are working with state agencies to identify your high-dose patients and

your high-roller doctors.” Franklin has been proactive on this front. “We send out letters to doctors who are prescribing more than 120mg MED and offer to help with these patients.”

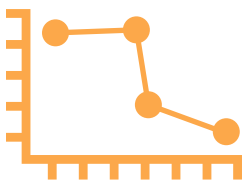
Now other states are following Washington’s lead with Ohio and New Mexico putting in place similar dosing guidelines; and the New York Workers’ Compensation Board putting into place a 100mg MED dosing guideline, a dosage that has proven to increase the risk of morbidity and mortality 8.9 fold.¹⁶

In Texas, the Department of Workers’ Compensation (DWC) has begun using a drug formulary, developed by ODG Treatment, as a prevention measure. It includes all FDA-approved drugs (except for investigational and experimental drugs) and excludes “N” (not recommended) drugs contingent on certain patient parameters. When the formulary went into effect in September 2011, there was great uncertainty among claims payers as to whether the formulary would make an impact or be severely challenged.

The results are in. The Texas DWC recently compared injuries that occurred between September and November 2011 with injuries that occurred during the same timeframe in 2010. The study found that, under the formulary, a significant decline in prescribing patterns was demonstrated as shown in Figure 3. Reportedly only a handful of prescribing physicians have appealed.

TX DRUG FORMULARY RESULTS

In Sept 2011, TX launched a formulary targeting “N” (not recommended) drugs. Its impact:



- Prescription drug costs for N drugs declined by 75%
- Claims receiving N drugs were reduced by 54%
- Frequency of opioid prescriptions dispensed to injured employees decreased by 10%
- Costs associated with opioid prescriptions dropped by 17%

FIG. 3

EDUCATION OF CLINICIANS

Many experts state that prevention starts with education and education starts at the graduate school level, yet it is sorely lacking. On average, medical schools offer seven hours of pain management training, compared with 75 hours in US veterinary schools. “You have a lot of physicians trying to do the right thing without the proper training,” says Nora Volkow¹⁷, MD, Director, National Institute on Drug Abuse (NIDA).

Another active player in the Rx epidemic solution: the dispenser. Pharmacists, the last line of defense, also are not receiving adequate training, with 29.2 percent receiving no addiction training and 67.5 percent receiving two hours or less of training in pharmacy school. Pharmacists who have more addiction-specific education tend to counsel patients more frequently and feel more confident doing so.¹⁸

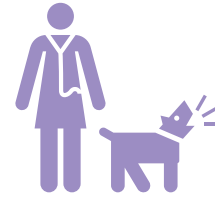
Despite the clear need for clinician education, just this July, the Food and Drug Administration, backed by the American Medical Association, rejected its own expert panel's recommendation that physicians receive mandatory opioid training. Fortunately, the workers' compensation community has responded appropriately with some states developing incentives and rules that steer physicians to pain management training.

For instance, the state of Washington is giving free education to physicians. In 2011, it changed the Continuing Medical Education (CME) offering for opioid and pain management training from three to four hours. While the four hours are not mandatory, the state's dosing requirement, via its regulations, is mandatory. "We have thousands of doctors who have taken advantage of the free CME. Doctors know the new regulations, and the AMDG Opioid Dosing Guideline, reflect best practices that will allow those who choose to use opioids to do so safely and more effectively," says Franklin. "This is why even the state's biggest malpractice insurer has encouraged physician education regarding universal precautions when using opioids for chronic pain. We have to do both education and enforcement. While the vast majority of doctors are well intentioned and welcome new tools, some doctors never participate in these learning opportunities. If you don't enforce the use of best practices, some [doctors] won't do it."

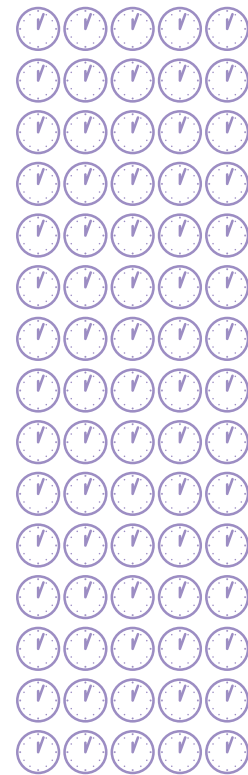
Colorado workers' compensation regulators took tremendous strides in the way of fee-based incentives for training. "We can't expect doctors to do things they are not getting paid for," says Kathryn Mueller, Professor, University of Colorado at the School of Public Health.¹⁹ "We've been educating doctors since 2003. What we discovered in 2009 is that they weren't doing it in an organized fashion where they were actually performing all of the required activities in the guidelines. So we said, 'Let's pay them.' We had prior experience incentivizing doctors by compensating them for time spent performing disability management and that seemed to have paid off with better managed cases."

Using that idea, Colorado now requires that when physicians prescribe a long-term opioid treatment, they must use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and the Chronic Opioid Management Report. Physicians receive a payment of \$75 when

AVERAGE HOURS OF PAIN MANAGEMENT TRAINING



VETERINARY SCHOOL



75



MEDICAL SCHOOL



7

FIG. 4

they provide this separate Report with the following services completed and documented: (1) ordering and reviewing drug tests, (2) ordering and reviewing a search of the state's prescription drug monitoring program database, (3) reviewing medical records, (4) reviewing the injured worker's current functional status, (5) determining what actions, if any, need to be taken, and (6) applying the appropriate Chronic Pain Diagnostic Code (ICD).

“There needs to be a psychological switch where doctors are looking at function numbers rather than pain numbers, focusing on function to create the best quality of life.”

- Kathryn Mueller, Professor, University of Colorado at the School of Public Health

Insurers cover the cost of this Report fee and Mueller indicates there has not been a backlash because insurers understand that identifying patients who should not be on opioids will save money and increase quality care. She says other states can leverage this fee-based incentive approach to educate providers. “We want them to learn how to manage these cases properly. Doctors are treating pain as the most important outcome. There needs to be a psychological switch where doctors are looking at function numbers rather than pain numbers, focusing on function to create the best quality of life.”

In 2011, California's State Compensation Insurance Fund (State Fund) launched a coordinated strategy of enforcing evidence-based drug prescribing guidelines for physicians enrolled in its Medical Provider Network (MPN), while offering a program of peer-to-peer consultation with prescribing physicians. First, it released the prescribing guideline:

“The physician shall limit prescribing opioid medication to a two-week increment for severe acute pain, and agrees to limit prescribing opioid medication for no more than sixty (60) days. Exceptions require pre-service approval from State Fund or by WCAB [Workers' Compensation Appeals Board] order.”

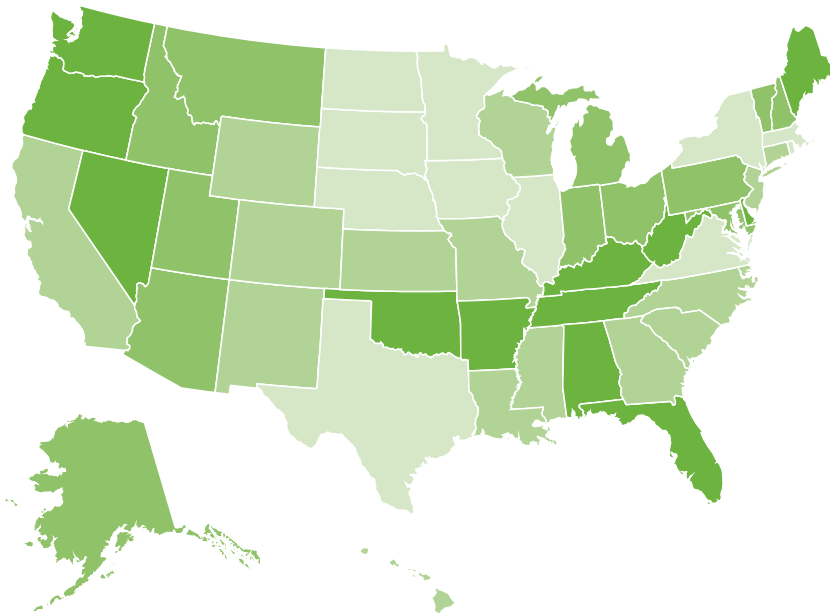
The State Fund's MPN physicians are also subject to California's Chronic Pain Medical Treatment Guidelines, as are all prescribers in the state.

Second, the State Fund's medical director, Bernyce Peplowski MD, introduced an outreach service to prescribing physicians. The target physicians are those prescribing more than 120mg MED in pain medications, those whose patients are on an opioid regime but not improving, and physicians themselves who wish to discuss their patients. The consultation is strictly peer-to-peer. The State Fund's consulting physician is authorized to approve non-medication treatment that the prescribing physician thinks might be useful, from acupuncture to Weight Watchers (but no medical foods). The peer consultant might educate the prescriber about cognitive behavioral therapy for his/her patient and the best techniques for weaning a patient off a high-opioid dosage.

GETTING MONITORING OFF THE GROUND

More and more states are attempting to curb the epidemic at the monitoring level. Prescription Drug Monitoring Programs (PDMPs) – state-run programs that help track vital prescription data so physicians and pharmacists know when a prescription is being abused and investigators can identify over-prescribing problems – are currently operational in 41 states, with legislation enacted or pending in nine other states and one US territory.²⁰ Per state law, PDMPs monitor controlled substances as defined by Federal and State Controlled Substances Laws. Most PDMPs collect data on drugs included in Federal Schedules II-IV.

State law dictates who will have access to PDMP information. Most states allow practitioners and pharmacists to obtain PDMP reports on patients under their care. Many states also provide PDMP information to other authorized groups, including law enforcement for drug investigations, licensing and regulatory boards for investigating healthcare professionals who prescribe or dispense prescription controlled substances, medical examiners or coroners for cause of death investigations and state Medicaid Programs for Medicaid member or provider reviews.



THE AMOUNT OF PRESCRIPTION PAINKILLERS SOLD IN STATES VARIES

The quantity of prescription painkillers sold to pharmacies, hospitals and doctors' offices was four times larger in 2010 than in 1999. Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month.

Kilograms of prescription painkillers sold, rates per 10,000 people



Unfortunately, only about half of the states' PDMPs proactively analyze their data to identify questionable activity, then send prescription histories or alert letters to prescribers and/or pharmacies used by flagged patients. Criteria for identifying questionable activity varies by state. For example, Massachusetts' PDMP uses the following criteria to measure questionable activity: obtaining Schedule II prescriptions from four or more prescribers and filling them at four or more pharmacies in a six-month period.

Members of Congress have taken action to strengthen PDMPs with proposed legislation to make PDMPs interoperable. In March of this year, Representatives Hal Rogers of Kentucky, Frank Wolf of Virginia and Senators Rob Portman of Ohio and Sheldon Whitehouse of Rhode Island introduced

bipartisan legislation to fight prescription drug abuse. The Interstate Drug Monitoring Efficiency and Data Sharing (ID MEDS) Act, H.R. 4292, would create an efficient, cost-effective system that facilitates the interoperability of states' PDMPs.

“We need to, at least on a trial basis, find a state or states willing to share data with people in the private industry to see what kind of an impact we can make on this epidemic.” - John Eadie, Director of the Prescription Monitoring Program, Center of Excellence, Brandeis University

While steps like the ID MEDS bill are helping streamline the solution to the prescription drug epidemic, there are some key stakeholders that still have been left out of the equation. John Eadie, Director of the Prescription Monitoring Program Center of Excellence at Brandeis University is working on a way to link more stakeholders into the monitoring process. “We need to, at least on a trial basis, find a state or states willing to share data with people in the private industry to see what kind of an impact we can make on this epidemic. It is just too huge, too big, too many people being harmed not to use every resource available.”²¹ Private industry, which is not permitted access, could utilize the information from PDMPs in constructive ways. Eadie continues, “It’s very tricky and there are a lot of legal issues involved. However, I think given the number of people dying, the number of people injured by overdoses, and the number of family members being harmed that we need to find a way to address this epidemic as hard and fast as we can.”

US Representative Mary Bono Mack of California, the Co-Founder and Co-Chair of the Congressional Caucus on Prescription Drug Abuse, maintains we can head in the right direction with doctors by adjusting our dialogue. She says, “[We need to] change our rhetoric and offer PDMPs as a good tool, not as a punitive tool.”²²

Rx INTELLIGENCE WITH RAPID RESPONSE

Another essential piece of the solution is to identify cases spiraling out of control due to prescription drug overuse and to respond quickly.

Managed care organizations in the workers' compensation industry need to respond aggressively to this challenge, and one strategy must include the skillful application of medical intelligence to claims information. Experts outside the industry see the value of mining claims information. Christopher M. Jones, PharmD, MPH, Centers for Disease Control and Prevention says, “One of our policy recommendations is leveraging insurers and managed care mechanisms. This can include prospective or retrospective claims review programs to identify patients at the point of dispensing, or identify patient claims histories with patterns of inappropriate use. Other mechanisms include formulary development, quantity limits, and prior authorizations.”²³

Jones' policy recommendations are in fact being executed in workers' comp, with the development of detection systems and rapid response protocols. Rising Medical Solutions (Rising) is using data

analytics to monitor an injured worker's prescription profile and proactively alert users to "at-risk" cases. These analytics, in the form of a web-based Rx Dashboard, provide a big picture of all the drugs a worker is taking, not just opioids. "In any pharmacy review, if a person is taking one drug they are taking ten. You cannot just deal with opioids in a vacuum because there are other drugs that are impacting how they're used and what the impact is on their use," says Anne Kirby, RN, Rising's Chief Compliance Officer and Vice President of Medical Review Services. "We experimented with this and realized that by only tracking opioids you are really missing the boat."²⁴

Through the Rx Dashboard, users can see the prescription activity of an injured worker for a range of drugs including opioids, antianxiety agents, hypnotics and muscle relaxants. It tracks information such as fill dates, urine drug screenings, number of fills, number of usage days, average fill interval days, dosage amounts and costs. The Rx Dashboard can flag any medication type and utilize any formulary, including: state-specific formularies, payer-specific formularies, Rising's formulary, or a blended formulary.

Perhaps the most important industry development in curbing prescription drug misuse is the significant reduction of time and effort necessary to identify the claimant population that needs pharmaceutical intervention. The pharmacy review process used to require manual case evaluations that often resulted in excessive man hours with few cases on which to take action. Now the workers' compensation community is gaining efficiencies through technologies that deliver actionable claims intelligence and allow users to respond quickly to questionable prescription activity.

Of course, not all cases flagged by data analytics will result in a consultation between the prescribing physician and a peer review physician but, when they do, Kirby's experience has been that about one in every three prescribing physicians responds with the following: "Thank you for calling, I've really been struggling with how to manage this patient's pain medications."

Kirby believes the work of our industry's care management companies is to help at the physician level. "We are the extra set of eyes in the process that see patient behavior that's inconsistent with what a physician may have prescribed. Our interventions should respect physicians' knowledge while providing them with case information and/or pain management protocols they may not be aware of."

INTERACTIVE Rx DASHBOARD

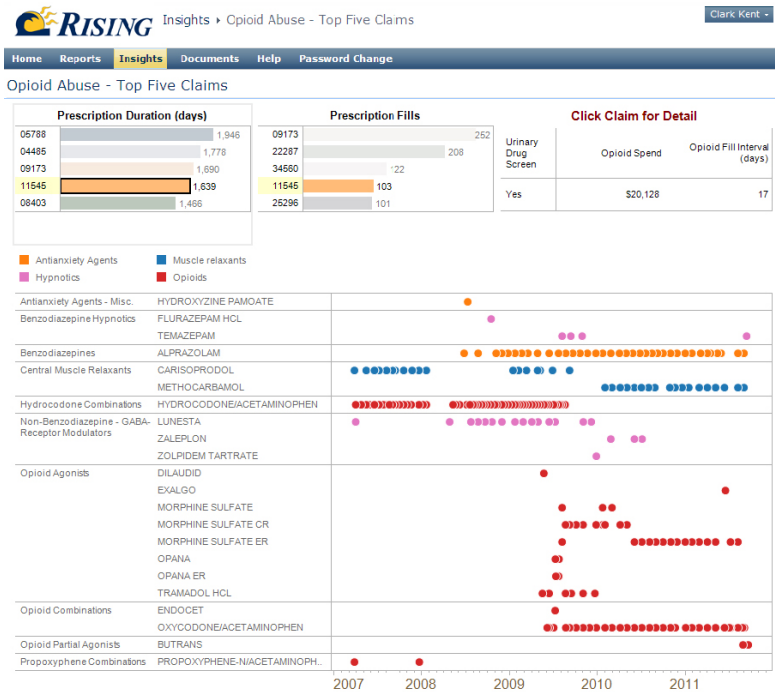


FIG. 6

TURNING THE CORNER IN WORKERS' COMP

According to a drug utilization study²⁵ published by the California Workers' Compensation Institute (CWCI) in July 2012, the use of Schedule II opioids has finally declined, after growing five times between 2002 and 2010. There have been no recent changes in law or regulations to explain this reversal. The CWCI concludes that "increased public awareness of the dangers of Schedule II drugs, as well as enhanced medical management and pharmaceutical controls implemented by the payer and medical provider communities" drove the change.

This is the most recent proof that a multi-pronged approach of evidence, prevention, education, monitoring and Rx intelligence is the remedy that will cure America's prescription drug scourge. It's a remedy that will ensure painkillers are prescribed and dispensed only when necessary and that patients are monitored closely.

No one is disputing the fact that pain is real, but with pain there must come alternatives to treating the pain and triggers in place to stop the further progression of drug misuse or abuse. Through the work of various stakeholders, the workers' compensation field is building a durable Rx remedy so America's workers are ensured quality treatment while curbing the risk of addiction.



QUICK Rx INTELLIGENCE SURVEY

5 KEY QUESTIONS TO ASK ABOUT YOUR Rx INTELLIGENCE SOLUTION

1. Does it provide a complete medical picture or is it limited to Rx fill information?
2. Is it proactive and actionable? Does it identify questionable activity early in the claim?
3. Are drug screens included in your dataset, and does your solution show if drug screens are being over or underused?
4. Does it show the prescribing activity for all drugs, not just opioids, and identify escalation or weaning patterns?
5. Can you easily see prescriptions from multiple providers?



CONTACT US

If you think there might be gaps in your Rx intelligence solution, email Rising at info@risingms.com to set up a 30 minute strategy call.



CITATIONS & FIGURE SOURCES

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- ²² Keynote Presentation, "A National Awakening." Mary Bono Mack, US Representative, California's 45th Congressional District; Co-Founder and Co-Chair of the Congressional Caucus on Prescription Drug Abuse. National Rx Drug Abuse Summit. Orlando, Fla., April 11, 2012.
- ²³ Christopher M. Jones, PharmD, MPH. Interview with Leslie Yeransian, Rising Medical Solutions, Orlando, FL, April 10, 2012.
- ²⁴ Anne Kirby, RN. Telephone interview with Leslie Yeransian, Rising Medical Solutions, May 4, 2012.
- ²⁵ California Workers' Compensation Institute (CWCI), Changes in Schedule II & Schedule III opioid prescriptions and payments in California workers' compensation. July 2012.

Figure 1 – Adapted from the Centers for Disease Control and Prevention

Centers for Disease Control and Prevention

<http://www.cdc.gov/vitalsigns/MethadoneOverdoses/index.html>

<http://www.cdc.gov/vitalsigns/PainkillerOverdoses/>

http://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html

Substance Abuse and Mental Health Services Administration

Drug Abuse Warning Network: selected tables of national estimates of drug-related emergency department visits. Rockville, MD:

Center for Behavioral Health Statistics and Quality, SAMHSA; 2010.

Results from the 2010 National Survey on Drug Use and Health: volume 1: summary of national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2011.

Figure 2

Pain Physician Journal 2010; 13:401-435.

Figure 3

Texas Department of Insurance, Division of Workers' Compensation

<http://www.tdi.texas.gov/news/2012/news201225.html>

Figure 4

Research Keynote, "It's Not What the Doctor Ordered." Nora Volkow, MD, Director, National Institute on Drug Abuse (NIDA). National Rx Drug Abuse Summit. Orlando, Fla., April 10, 2012.

Figure 5 – Adapted from the Centers for Disease Control and Prevention

Centers for Disease Control and Prevention. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. Morbidity & Mortality Wkly Rep 2011; 60: 1-6.

Figure 6

Rising Medical Solutions' proprietary Rx analytics

OxyContin® is a registered trademark of Purdue Pharma

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Percocet® is a registered trademark of Endo Pharmaceuticals

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