

## Physician dispensing on the rise

Prescription drug costs are rising in part because in virtually every state, including North Carolina, physician dispensing is on the rise, warns NCCI in a recent report.

NCCI says physician-dispensed Rx dollar share of all prescription spending increased from 10% in 2006 to 23% in 2009 (excluding California, which can throw off statistics because of its size and other unique factors.) An earlier NCCI study found the share of workers' compensation Rx costs associated with physician dispensing had been very stable until 2008, when it increased sharply.

North Carolina is one of 30 states where physician dispensing accounts for greater than 15.5% of prescription dollar share of all prescriptions written for workers' compensation. In California, physician-dispensed drugs accounted for nearly 50% of the prescription drug costs in 2007, prompting the state to address the problem.

John Robertson, one of the researchers of the NCCI study, said perhaps it was inevitable the practice would spread from California to other states. "We knew that California had taken some steps to reduce the amount of repackaged drugs sold, and we kind of expected the repackagers would try to start selling them in other states," he commented to Risk & Insurance Online.

"I personally had expected it to be a few states. I was surprised to find it was practically every state," he added.

NCCI lists several reasons why a physician office would sell a drug directly to a patient:

- The physician wants the patient to start taking the drug immediately

- The physician cannot be sure what the right medication or dosage should be and dispenses a few days' supply to determine an appropriate course
- Convenience to the patient
- Desire to maximize revenues.

The cost per unit of physician-dispensed drugs tends to be higher than the cost per unit of the same drug dispensed by a pharmacy.

For instance, in a report on South Carolina's experience with physician-dispensed drugs, NCCI reported the unit cost of Carisoprodol, a muscle relaxant, is \$0.42 when dispensed/non-repackaged by a pharmacy and \$2.78 when dispensed/repackaged by a physician.

NCCI adds that in some states, Georgia, for one, physicians have shifted to dispensing more expensive drugs. In 2005, the average cost of a prescription written by a physician was \$24 and it increased to \$39 and \$41 in the next two years. In 2009, the most recent year for which figures are available, the average cost of a prescription written by a physician in

Georgia had jumped to \$76.

Advocates of physician-dispensing note patients are more likely to take medications if their prescriptions are filled at the doctor's office. Studies have shown more than 20% of first-time prescriptions are never filled. At Kaiser Permanente in California, where prescriptions are filled at the doctor's office, only 5% of initial prescriptions were not filled.

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## President's Note

### Annual conference 2012



We are putting the finishing touches to the program for our 2012 annual conference scheduled for March 28-30 at Wrightsville Beach in North Carolina. Among several topics, we will examine the early impact of workers' compensation reform legislation passed earlier this year.

Our three-day annual conference is an ideal venue for networking, and for exchanging news and views about workers' comp. Also, each year we get approval for continuing education credits for claims adjusters and lawyers. The North Carolina Association of Self-Insurers is unusual, if not unique, in that we also pay for these education credits earned by registrants.

One issue we are grappling with as an association is how much of a price differential we should maintain between members and non-members when setting registration fees and exhibitor fees for the conference. Since members pay \$350 in annual dues, it does not make sense for us to charge them the same fees as non-members, who obviously don't pay any dues.

In any event, we will have worked out these details by year's end when we expect to send out the program announcement. We look forward to seeing you in Wrightsville.

With very best wishes,

Jay Norris

## CASE LAW UPDATE

By Joe Austin



### Suitable Employment

In the past, the Industrial Commission has generally taken the position that, prior to the time of MMI, an employer could insist that an injured employee return to any type of work, regardless of whether the work represented a job available in the competitive labor market. However, the Commission recently adopted a different approach to that issue.

In *Wynn v. United Health Services*, the employee was recuperating from a compensable injury when the employer offered a light-duty job that was only available to injured employees. The job paid 40% less than the employee's regular job, offered no chance of advancement, and had been modified to meet the employee's physical restrictions. The employee accepted the position, but later advised that she could not keep it because of child-care issues.

The employer terminated her employment. The Commission ruled that the employee was justified in refusing the job on the grounds that it was not suitable. On appeal, the Court of Appeals affirmed the Commission's ruling, reasoning that the employee was not required to accept any job that was not suitable to her capacity, regardless of whether she had reached MMI.

NOTE: The General Assembly passed legislation this summer which provides that "non competitive employment with the employer of injury approved by the employee's authorized health care provider" is deemed to be suitable in claims where the employee has not reached MMI. However, that definition only applies to claims arising on or after June 24, 2011. Thus, for claims arising prior to that date, an employee may decline to accept a modified position if it does not represent competitive employment, even if the employee has not reached MMI.

### Contract Employees

Claims involving employees who work intermittently can present challenges in calculating average weekly wages (AWW). For example, in *Thompson v. STS Holdings*, the employee performed airline maintenance work under contracts with different companies. In the year before his injury, he earned \$7.50 per hour under 5 separate contracts with the employer, which covered a total of 14 days. The employee argued that the Industrial Commission should consider the wages he earned from all of his contract work during that year, instead of only his earnings from the employer.

Nevertheless, the Commission calculated the AWW by taking the employee's earnings from the employer, and dividing the total by 52. Citing the language of the Workers' Compensation Act and prior case law, the Court of Appeals affirmed the Commission's ruling. The Court admitted that it was sympathetic to the employee's plight, but observed that it is up to the legislature to make such policy determinations.

*Joe Austin leads the workers' compensation practice group at Young Moore and Henderson in Raleigh. A graduate of Davidson College, Joe received his law degree from Wake Forest University.*

# Alarm over abuse of narcotics

Many physicians who prescribe narcotics to injured workers are not using the recommended tools to monitor use, abuse, and diversion, according to a study by the Workers Compensation Research Institute.

WCRI's study also identified states where injured workers who began treatment with narcotics were more likely to end up using narcotics on a longer-term basis. North Carolina is one of those states, along with California, Louisiana, Massachusetts, New York, Pennsylvania, and Texas.

“One of the most important, and troubling, areas for workers’ compensation systems is to find the appropriate ways to use narcotics – and to discourage abuse and diversion,” says Richard Victor, WCRI’s executive director. According to the 2010 Progressive Medical Drug Spend Analysis, narcotic spending accounts for 34 percent of workers’ compensation medication expenses.

“The longer an injured worker is on narcotics, the longer the delay in the injured worker’s ability to return to work in a timely fashion,” notes a recent paper by Progressive Medical on reducing narcotics abuse in workers’ compensation. “There is also an increased likelihood the payor will need to pay for rehabilitation programs for addiction,” Progressive adds.

“Narcotic abuse poses serious legal risks for workers’ compensation payors. While much of the litigation to date has been targeted against physicians and pharmacies, there are many experts who believe workers’ compensation payors will be next. This is because payors have access to data showing patterns of abuse and misuse and may have the duty to warn injured workers and prescribers in cases involving potential misuse,” the paper notes.

“Workers’ compensation payors not taking proactive measures to monitor utilization or communicate with physicians could face lawsuits for negligence. This is especially critical in cases where one or more narcotics are prescribed for more than six months at a time,” Progressive says.

Abuse of narcotics is not confined to workers’ compensation. The number of deaths from prescription drug overdoses tripled between 1999-2008, according to the Centers for Disease Control and Prevention. In 1999 there were 4,000 deaths related to painkillers. By 2008 that number had risen to 15,000 deaths.

One problem is the sheer increase in supply. Between 1999 and 2010, the amount of opioid painkillers sold to pharmacies,

hospitals, and doctors increased fourfold, according to the CDC. “Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month,” the agency noted in a recent alert.

Some observers foresee a growing role for sophisticated urine analysis of injured workers taking narcotic medications. “Twenty years ago, it would take me 30 days to dig Fentanyl out of your system,” Frank Fornari, CEO of Dominion Diagnostics, commented to *Risk & Insurance Online*. “Now it takes me 1.2 minutes.”

His lab employs a technique known as liquid chromatography tandem mass spectrometry, used by Marriott International, among others, for employee drug testing. Bob Steggert, vice president, casualty claims, for Marriott, told *Risk & Insurance Online* his company’s drug testing revealed widespread non-compliance.

Only 36% of patients who underwent urine analysis were found to be taking medications in the manner in which they were prescribed, he said. Also, 52% of patients had “not expected” results, which meant that they either didn’t have all of the drug in their system or they had other drugs in their system which hadn’t been prescribed.

In its recent paper on best-practices in controlling narcotics use, Progressive Medical says the number one step should be to have a well-defined strategy for tackling the problem. “The first step in this process is for the PBM (pharmacy benefits manager) to review prescription history. Once the history is reviewed, it should be used to develop a customized narcotics strategy for each medication plan,” the paper noted.

These plans identify which medications are appropriate for the injury type and body part. They also account for proper duration of use and quantity limits. By defining a narcotics strategy, the workers’ compensation payor will have put into place the proper mechanisms to begin controlling narcotic use,” Progressive says.

Other steps employers/pharmacy benefits managers can take is capturing prescriptions at first fill. “Often these early prescriptions begin telling the story of the medication history and medication therapy to come,” it says. Joe Paduda, well-known workers’ compensation consultant and blogger, says on his blog says there is far too little use of drug-testing in workers’ compensation.

“The overuse and abuse of opioids in workers comp is a disaster - economically, financially, and socially,” he writes, in arguing for more drug-testing.

# coming up

March 28–30, 2012

North Carolina Association of Self-Insurers. Annual Meeting & Educational Conference.

Holiday Inn Resort, Wrightsville Beach.

April 11–13, 2012

Members-Only Forum. South Carolina Self-Insurers Association.

Litchfield Beach & Golf Resort.

April 15–18, 2012

RIMS 2012 Annual Conference & Exhibition.

Pennsylvania Convention Center, Philadelphia.

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*The employers' voice in workers' comp*

## In South Carolina

### Labor department seeks to annex comp agency

Faced with cuts in state appropriations that threaten South Carolina's OSHA program, the state labor department says South Carolina can find the money by folding the Workers' Compensation Commission into the labor department.

The merger would net the state over \$1 million annually, not counting the savings from economies of scale from the merger, says Catherine Templeton, director of Labor, Licensing and Regulation. She adds for South Carolina to use state appropriations to attract federal matching funds for its OSHA program the workers' compensation commission and LLR must be part of the same agency.

It is not unusual for workers' compensation agencies to be placed under the umbrella of the labor or insurance department. Nationwide, workers' compensation is administered by an independent agency or board in only 25 states.

The proposed change would have a major impact on workers' compensation commissioners and the workers' compensation commission. The seven commissioners are the governing authority of the agency, with the commission chairman designated the chief executive officer. The change would effectively take away the commission's administrative authority and the chairman's executive duties. Also, the commission's budget would be controlled by the LLR director.

The workers' compensation commission says a merger would threaten "the clear line of impartiality, provided by the Canons of Judicial Conduct." If the two agencies are merged, commissioners may have to recuse themselves from hearing workers' compensation claims filed by LLR employees, who would be their colleagues.