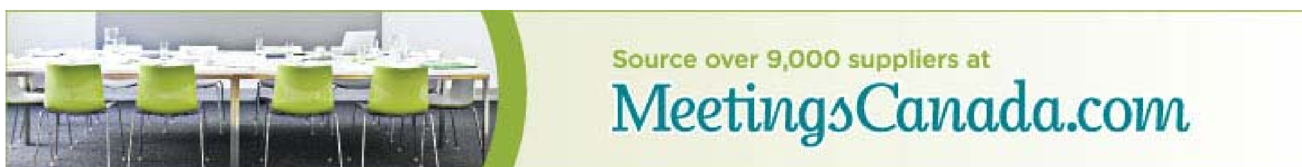

Benefits CANADA

Narcotic abuse and drug diversion inside your plan

Mike Sullivan | August 20, 2009

It might come as a surprise to most plan sponsors how much the abuse and diversion of narcotics and controlled drugs can be an issue inside their plan.

Some plan sponsors assume that there is a method for pharmacies, insurance carriers and/or claims processors to deal with this issue at the point of sale, but that is not always the case. Even provinces that have triplicate prescriptions for narcotics (where copies of the prescription are kept with the pharmacy, College of Pharmacists and College of Physicians) are not immune to these issues. In some cases, these provinces have the biggest problems we have ever encountered.

This is a sensitive issue for plan sponsors because there is no upper limit for narcotic dosing. You can effectively take as much narcotic as you need to relieve the pain, up until the point that your lungs stop functioning. That point is different for all people—it depends on how you metabolize drugs, how long you have been taking them, and what doses you have been taking previously. Much like with alcohol, you begin to develop a tolerance over time.

While narcotic controls are not a black and white area to manage, it doesn't excuse the current system from having incredibly poor controls in place. Consider the following examples of narcotic "use" by plan members who all have a pay-direct drug (PDD) plan (i.e. where the claims are processed real-time through a claims processor at the point of dispensing in the pharmacy) yet were still allowed to walk away with incredible and dangerous amounts of narcotics. In all cases, guess who was paying the vast majority (if not the entire) bill? The answer: the private plan sponsor who has the individual enrolled as an employee or spouse within the plan.

Plan member 1: The Dilaudid wholesaler
Dilaudid 4mg is a medium potency narcotic. It is often used to treat breakthrough pain for patients while chronic or palliative pain conditions who are also taking long-acting narcotics two or three times daily.

• In Year 1, the Dilaudid Wholesaler (DW) claimed for 9,500 tablets of Dilaudid 4mg which equates to 26 tablets per day. Curiously, this individual had no other claims on his/her profile which would suggest a chronic pain condition.

• In Year 2, the DW expanded business and managed to get his/her plan to pay for 30,700 tablets of Dilaudid 4mg—**an astonishing 84 tablets per day**. Imagine how you would feel if you ate 84 Pez candies every day for 365 days, let alone that much Dilaudid? Unless this plan member is a 7 ton circus elephant, there is no way to explain this kind of consumption. This plan member claimed 2,900 tablets in a 28 day period in Year 2.

• In July 1998, the Canadian Medical Association Journal (CMAJ) published a list of street prices for narcotic and control drugs. Even 11 years ago, the average street price for Dilaudid 4mg was $25/tablet. So let's assume that DW took 700 of these him/herself as a reward for all of their hard work and pain, and sold the remaining 30,000 tablets at $25/dose, that's a tidy income of $750,000. With an employer like this, how can you afford to retire?

Plan Member Two – The OxyContin Seeker
OxyContin has become a household name in recent years given that it has become one of the most widely abused drugs on the market. It is a potent, long-acting narcotic.

• In Year 1, this plan member claimed for 1,960 OxyContin 40mg tablets. That's a large quantity, but not necessarily a problem depending on the situation.

• In Year 2, our friend became slightly more greedy and decided to claim for 10,900 OxyContin tablets, of which over 9,000 of those were for the highest strength OxyContin 80mg. There is no rational reason why anyone would be on **nearly 30 OxyContin tablets** daily—especially at this strength, with nothing in their profile to suggest an impending death.

• Amazingly, this plan member was able to receive one prescription for 1,440 OxyContin 80mg tablets, and another prescription for 1,000 tablets. Given that each stock bottle contains only 50 tablets, can you imagine the absurdity of dispensing nearly 29 full stock bottles to someone at one time. That aside, can you imagine the even greater absurdity of allowing a claim for over $6,000 for a narcotic to be filled? That happened to be the third most expensive claim of the year for the plan. So when all the attention gets paid on the expensive biological drugs and the impacts they can have on plan costs, isn't it curious nobody flags a $6,000 narcotic claim as cause for concern?

• According to the CMAJ article from 1998, back then MS Contin 100mg and 200mg (the closest comparators on the CMAJ list to OxyContin 80mg) were selling for anywhere between $40 – $60 per tablet 11 years ago. That makes 10,000 OxyContin tablets look pretty good.

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Plan Member Three – The Larry Hagman Fan Club
The man better known as J.R. Ewing underwent a liver transplant back in 1995. This plan member obviously has a desire to continue down that same path to the operating room (assuming he or she is consuming and not selling the following):

• In Year 1, this plan member claimed for 3,700 tablets of Percocet, a moderate-potency combination narcotic that contains 5mg of oxycodone (the same ingredient as OxyContin) and 325mg of acetaminophen (Tylenol). Percocet is not intended to treat significant chronic pain conditions—these patients need to be moved up the ladder to higher potency narcotics.

• In Year 2, this plan member claimed 4,850 Percocet tablets—the equivalent of 13.25 tablets per day. That works out to over 4.3 grams of Tylenol daily. Doses of Tylenol above 4 grams per day for any extended period of time can lead to liver failure, and can be fatal.

• Generic Percocet is dirt cheap and will never flag as a high cost drug (it's approximately 15 cents per tablet), but if abused, the results can be devastating. Hard to believe that a patient could receive enough Percocet through the plan in one year to join Larry Hagman (circa 1994) on the transplant list.

• On the positive side, the CMAJ article only quoted the street value of Percocet in 1998 at an average of $4 per tablet, so this isn't going to contribute to an enormous retirement nest egg if in fact this person was smart enough to protect their liver by selling and not consuming most of the 4,850 tablets.

In all three cases above, I am not suggesting that there was not a valid prescription for each claim. I'm sure there was.. One can assume all claims processors will at least validate the existence of a legitimate prescription. That is not the concern. The problem is that for those people seeking out multiple narcotic prescriptions from one or more physicians that lead to extremely high or dangerous patterns of utilization, the system as it is structured today is not catching and addressing these problems.

The issues here for plan sponsors are significant. A major side effect of narcotic abuse is sedation. This can be a health

and safety issue for some plan sponsors that operate in a manufacturing or manual labour based industry. There is also a potential legal liability issue if a plan is allowing its members to claim and receive as many narcotics as they choose.

Solutions

The solution is very simple: take a look at your blinded claims data (i.e. no personal information included) to determine if suspect cases of narcotic or control drug abuse exist, and in what form. Develop a targeted therapeutic limit program that will only ever be encountered by a fraction of one percent of plan members that provides an opportunity for plan member education (i.e. cases where a plan member with significant chronic pain needs to be moved up to a more potent narcotic), discussion with the prescribing physician(s) in those cases where utilization is very suspect, and suspension of coverage for narcotics in cases where the utilization is not warranted and supported by the physician.

Too often these days it seems like stakeholders in benefits management and administration get distracted discussing macro-level topics like proposed changes to government legislation, and don’t bother focusing on critical issues like this happening in plans across the country as you read this. These are issues where practical, easy to implement solutions exist. If narcotic abuse is happening in your plan, you need to be aware of it, and you need to have a practical solution to address the problem in a responsible and respectful manner.

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