




**GENERAL DYNAMICS**  
Health Solutions

Opioid Abuse:  
Scripting the Way to Addiction

May 2017



## Introduction

The launch of the 1983 Drug Abuse Resistance Education, or D.A.R.E., program aimed to prevent children from using drugs and joining gangs. However, the family medicine cabinet often times proved a more effective way for children to obtain narcotics, rather than common illicit street drugs, such as crack and cocaine. A study published by the Partnership for Drug-Free Kids and MetLife Foundation found that the availability of prescription drugs makes them much easier to abuse. The survey found that, "...teens are more likely to abuse RX medicines if they think their parents 'don't care as much if they get caught using prescription drugs, without a doctor's prescription, than they do if they get caught using illegal drugs.'"<sup>1</sup>

From Elvis Presley to Prince, more and more celebrities die from prescription opioid overdoses; their deaths cast a bright light on opioid abuse, but pale in comparison to the deaths of average Americans. The Centers for Disease Control and Prevention (CDC) reports that since 1999 overdose deaths involving prescription opioids have quadrupled, along with the sales of these prescription drugs. From 1999 to 2014, more than 165,000 people died in the U.S. from overdoses related to prescription opioids.<sup>2</sup>

This paper will cover a history of the opioid abuse epidemic and recommendations that can be used in lead generation or from a payer's claims data:

- [The Growing Epidemic](#)
- [Combatting Drug Seekers: The Houston Cocktail](#)
- [Claims Data Lead Generation: CDC and Other Recommendations](#)
- [Conclusion](#)

## The Growing Epidemic

In 2015, the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) testified that between 2006 and 2014, spending for commonly abused opioids grew by 156%, reaching \$3.9 billion in 2014.<sup>3</sup> The OIG also identified that the number of users receiving prescriptions for these drugs rose 92% over this period.<sup>4</sup>

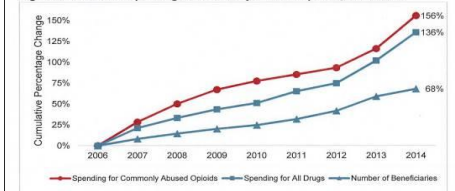
To combat this growing epidemic, stronger payment controls are needed to ensure individuals have valid needs for these drugs and they are obtained from a single appropriate source. In part, states and payers have controls better known as "lock-in" programs that restrict certain patients to a limited number of pharmacies or to a limited number of prescribers. However, these prescription monitoring programs are state-based and should be revised, according to General Dynamics Health Solutions' Chief Medical Officer Dr. John Maguire.

While state-based controls are relatively effective, true drug seekers find ways to obtain prescription narcotics. For example, Northern Virginia is only 30 minutes from the District of Columbia and Maryland

### Spending for commonly abused opioids grew at a faster rate than spending for all drugs

Between 2006 and 2014, spending for commonly abused opioids grew from \$1.5 billion to \$3.9 billion, an increase of 156 percent. (See Figure 2.) Growth in spending for these opioids outpaced both the growth in spending for all Part D drugs (which grew 136 percent) and the growth in the number of beneficiaries receiving Part D drugs (which grew 68 percent).

Figure 2: Growth in Spending of Commonly Abused Opioids, 2006–2014



Source: OIG analysis of Medicare Part D data, 2015.

The increase in spending for commonly abused opioids appears to have been driven by an increase both in the number of beneficiaries receiving these opioids and in the average number of prescriptions per beneficiary. Both of these numbers have increased faster for commonly abused opioids than for all drugs. The total number of beneficiaries receiving these opioids grew by 92 percent, compared to 68 percent for all drugs, while the average number of prescriptions for commonly abused opioids per beneficiary grew by 20 percent, compared to 3 percent for all drugs.

Part D spending per beneficiary for commonly abused opioids was highest in Alaska, Oklahoma, and Tennessee. Nationally, Part D spending averaged \$105 per beneficiary for commonly abused opioids in 2014. However, the average in Alaska was 77 percent higher, at \$187 per beneficiary. In Oklahoma and Tennessee, the average was more than \$165 per beneficiary. Spending was also high in other States; in North Carolina, Alabama, and Utah, the average was at least \$140 per beneficiary.

Several of the States with high per-beneficiary Part D spending also had high proportions of beneficiaries receiving commonly abused opioids. Alabama had the highest proportion, with 43 percent of its beneficiaries receiving a commonly abused opioid in 2014. Tennessee and Oklahoma each had 41 percent, while Alaska had 40 percent. Nationwide, 32 percent of beneficiaries received at least one prescription for a commonly abused opioid in 2014.

<sup>1</sup> <http://drugfree.org/newsroom/news-item/national-study-teen-misuse-and-abuse-of-prescription-drugs-up-33-percent-since-2008-stimulants-contributing-to-sustained-rx-epidemic/>

<sup>2</sup> CDC, Prescription Opioid Overdose Data, <http://www.cdc.gov/drugoverdose/data/overdose.html>

<sup>3</sup> <https://oig.hhs.gov/testimony/docs/2016/maxwell0216.pdf>

<sup>4</sup> <https://oig.hhs.gov/oei/reports/oei-02-15-00190.asp>

– logging into and reviewing these systems to monitor state-to-state activity takes time – drug seekers know this and take advantage. Drug-seeking patients also visit multiple emergency rooms or urgent care facilities to obtain opioid prescriptions, some visiting for chronic pain and demanding their drug of choice (i.e., a drug that works for their pain). Some patients prick their finger and add a bit of blood to their urine sample while complaining of kidney stones. As drug seekers become more creative, the healthcare industry must find new and effective ways to combat their efforts.

## Combatting Drug Seekers: The Houston Cocktail

General Dynamics Health Solutions remains vigilant and proactive in addressing the opioid epidemic, to include implementing various rules and algorithms into, STARS*Sentinel*, proactive lead-generation software. A key focus became The “Houston Cocktail” – a mixture of three prescription drugs including Oxycodone, Soma, and Alprazolam (Xanax), is known for its euphoric effects similar to Heroin. Highlighted as a growing illegal prescription problem in Harris County, Texas, it remains difficult to conceive of any legitimate medical reason that a doctor would collectively prescribe the trio.

However the issue is not limited to the three name brand medications for “The Houston Cocktail.” Abusers can obtain the same ‘high’ from combining any opiate (a narcotic), muscle relaxant and benzodiazepine (anti-anxiety) – making it harder to spot drug seeking and/or doctor shopping behavior. Although a new Oxycodone formulation was introduced into the marketplace in 2010 that is more difficult to snort or inject, it does nothing to prevent oral abuse.

With so many variants of Oxycodone, including Percocet, Percodan, and Tylox, it remains imperative to monitor all prescription drug activity. In conversations with U.S. Drug Enforcement Agency special agents, General Dynamics Health Solutions investigators confirmed that drug seeking patients will purposely attempt to get a lower dose/version of Oxycodone in an effort to not alert pharmacy staff. Patients may also attempt to obtain a prescription for one part of the cocktail from one prescriber, the second part from another, and so on, increasing this difficulty of identifying this behavior.

Since there could be valid medical reasons for physicians to prescribe a narcotic pain reliever and a muscle relaxant together, below are some key indicators for which investigators should look:

- A “pain-scale” response document in the providers’ medical records and/or a declination in the prescriptions’ occurrences (i.e., the patient’s condition should be improving so they’ll be taking less drugs)
- Patients obtaining these drugs without a urinalysis. Some patients will obtain the drugs and then resell them on the black market. They don’t take a urine test because it would likely provide a negative result
- Doctor shopping (i.e., a patient obtaining controlled substances from multiple healthcare practitioners without the prescribers’ knowledge of the other prescriptions)<sup>5</sup>.

## Claims Data Lead Generation: CDC Recommendations<sup>6</sup>

The aforementioned recommendations help to identify opioid and “cocktail” seekers, but that alone will not combat the epidemic. In March 2016, the CDC issued new guidance for prescribing opioids for chronic pain. While most of this guidance is directed towards the philosophical decision to begin opioid

<sup>5</sup> The Centers for Disease Control and Prevention, [http://www.cdc.gov/homeandrecreationalafety/Poisoning/laws/dr\\_shopping.html](http://www.cdc.gov/homeandrecreationalafety/Poisoning/laws/dr_shopping.html)

<sup>6</sup> <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

therapy for a patient, there are various recommendations that can be utilized in a lead generation or from a payer's claims data when looking for potential fraud, waste or abuse. For example:

### CDC RECOMMENDATION 3

Before starting and periodically during opioid therapy, clinicians should discuss with patients: known risks and realistic benefits of opioid therapy, and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type: 3).

**Summary:** Investigators can review patient claims data to determine that there is a regularly occurring evaluation and management visit to discuss these issues.

### CDC RECOMMENDATION 4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).

**Summary:** Payers/investigators can review a patient's onset of opioid therapy and determine if the appropriate type of opioid was prescribed.

*Some examples of immediate and extended-release opioids include:*

| IMMEDIATE-RELEASE     |
|-----------------------|
| Codeine               |
| Buprenorphine         |
| Morphine              |
| Oxymorphone           |
| Oxycodone (Percocet)  |
| Tapentadol            |
| Hydrocodone (Vicodin) |

| EXTENDED-RELEASE                                      |
|---|
| Transdermal systems with fentanyl (Duragesic patches) |
| Buprenorphine patch (Butrans)                         |
| Extended release morphine (Kadian, Avinza)            |
| Extended release oxymorphone (Opana ER)               |
| Extended release oxycodone (Oxycontin)                |
| Levorphanol (Levo-dromoran)                           |
| Methadone   |

### CDC RECOMMENDATION 5

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/day (recommendation category: A, evidence type: 3).

**Summary:** Investigators can analyze the units billed to determine the lowest effective dosage was actually prescribed.

### CDC RECOMMENDATION 6

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4).

**Summary:** Investigators can review patient diagnosis codes to determine acute versus chronic pain conditions.

## CDC RECOMMENDATION 7

Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).

**Summary:** Investigators can review patient claims data to determine that there is a regularly occurring evaluation and management visit to discuss these issues.

## CDC RECOMMENDATION 8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).

**Summary:** Investigators can determine if alternative treatment methods were used and/or discuss with physicians whether these alternatives are offered.

## CDC RECOMMENDATION 9

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months (recommendation category: A, evidence type: 4).

**Summary:** During on-site audits, physician interviews would determine if this recommendation is being followed.

## CDC RECOMMENDATION 10

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).

**Summary:** Similar to the Houston Cocktail, urine drug tests should be regularly conducted.

## CDC RECOMMENDATION 11

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3).

**Summary:** Similar to the Houston Cocktail scheme.

## CDC RECOMMENDATION 12

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).

**Summary:** Investigators can review long-term opioid patients' claims data to determine if alternative treatments have occurred, including behavioral treatments.

### U.S. Food and Drug Administration Updates

The U.S. Food and Drug Administration (FDA) issued strong warnings and labeling changes to "...prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these medications at the same time."<sup>7</sup>

### General Dynamics Health Solutions Chief Medical Officer Recommendations

Since acute care providers can only write a prescription for a limited amount of a medication:

- all medications should be written by that provider and follow the patient, typically their primary care physician (see lock-in information); and
- all prescriptions should be coordinated by a single pharmacy.

Lastly, the prescription monitoring program should be proactive and not rely on the provider to take the time to search the system; it should be coordinated with messaging through a health exchange.

### Conclusion

Only time will tell of the effectiveness of these recommendations and additional controls on the opioid industry and opioid prescribing patterns. However, General Dynamics Health Solutions continues to update its products with these regulatory changes and suggestions to better root out fraud, waste and abuse. For more information about how General Dynamics Health Solutions can help you fight opioid fraud, waste and abuse, visit [www.gdhealth.com](http://www.gdhealth.com) or e-mail [info@gdhealth.com](mailto:info@gdhealth.com).

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<sup>7</sup> FDA, FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use, August 2016