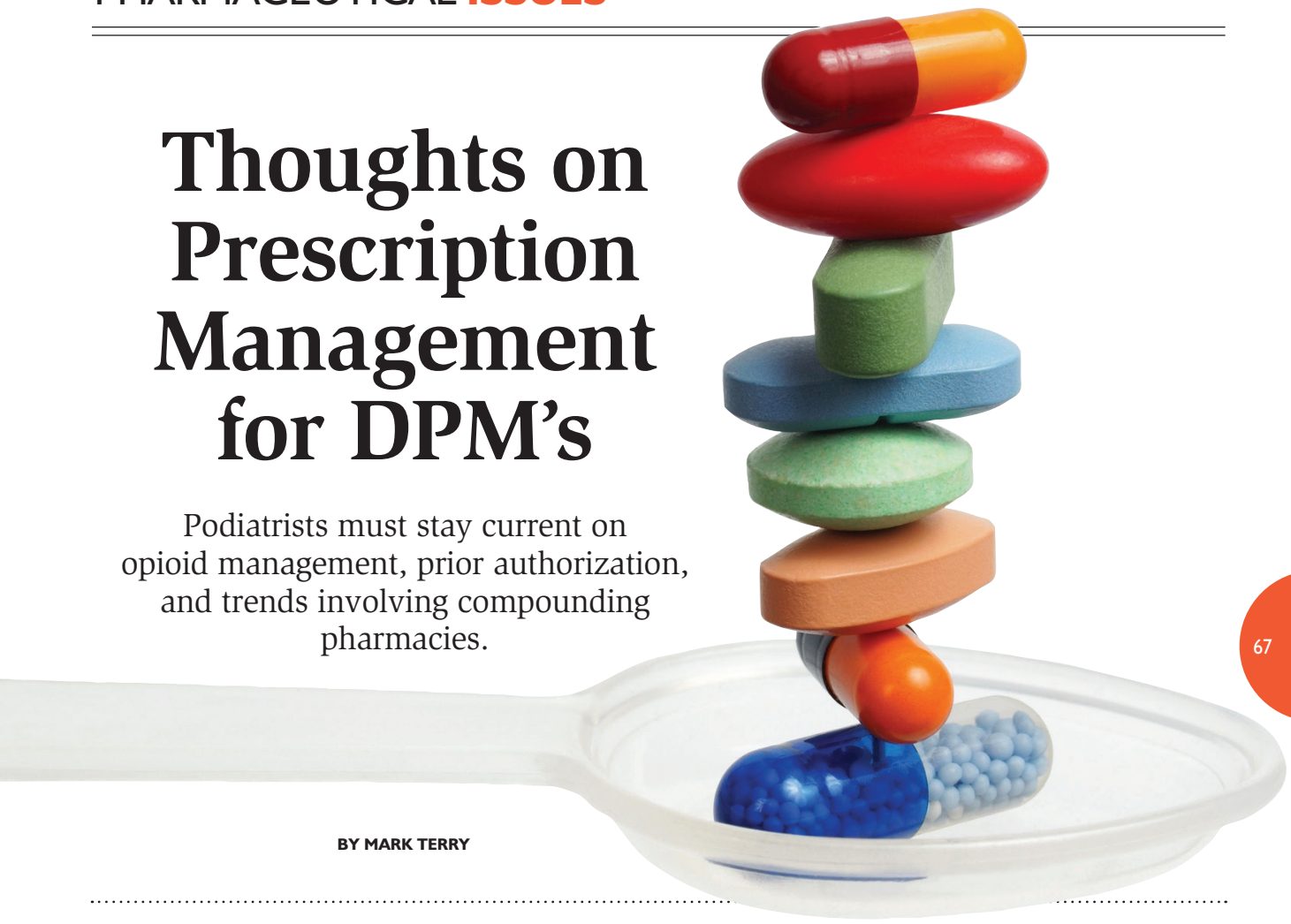
Thoughts on Prescription Management for DPM's

Podiatrists must stay current on opioid management, prior authorization, and trends involving compounding pharmacies.



BY MARK TERRY

Originally, the concept for this article was "streamlining prescription management." Interviews with podiatrists led to a broader discussion of issues related to prescriptions in podiatry, with efficiency much further down on the list of concerns for podiatric physicians than it is for family practitioners. What follows is a discussion of some of these broader issues the medical community is facing in terms of the opioid epidemic and prescription efficiency. Equally relevant to podiatric physicians is the brief exploration of issues regarding prior authorization and compounding pharmacies.

Some Disconcerting Statistics

In 2015, according to the Centers for Disease Control and Prevention (CDC), more than 50,000 people in the U.S. died from drug overdoses. Eighty percent of those involved opioids. Those opioids weren't just heroin, but includedalso Vicodin and Percocet. Between 2014 and 2015, the death rate from synthetic opioids other than methadone increased 72 percent.

Prescription Efficiency

In 2012, Thomas Sinsky and Christine Sinsky, both family physicians, wrote an article in *Family Practice Management* titled "A Streamlined Approach to Prescription Management." The theme of the article was that a patient on five medications would generate three to four phone calls or faxes annually as medications randomly came due for renewal. With 500 to 1,000 patients with chronic illness in a typical primary care practice, that meant 1,500 to 4,000 phone calls or faxes annually. Broken down further, two

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According to a 2008 study, 40 percent of patients over age 65 are on five or more medications. According to a 2010 Wall Street Journal article, more than 25 percent of pediatric patients take at least one chronic medication.

The bottom line is that many of your podiatric patients are already on medications and some of those patients may be abusing opioids.

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to three minutes per call could hit 200 hours a year, or five hours of potentially unnecessary work each week. In other words, a family physician was hiring almost a full-time employee just to handle prescription renewals.

This is apparently not nearly as big an issue for podiatric physicians. Larry Maurer, of Washington Foot & Ankle Sports Medicine (Kirkland, WA), says, "I'm not constantly handling prescription refills. I don't manage a lot of diabetics; I don't manage a sick population. I manage a very young, healthy population, so it's the simplest practice in terms of interactions, phone calls and prescriptions. In general, podiatry will be a lot simpler than primary care." As Maurer notes, the primary physician is the quarterback. Podiatric physicians, as secondary specialists, need to understand a patient's prescription history, but otherwise they're not generally managing the patient's overall prescriptions.


Larry Maurer

One area that the American Medical Association (AMA) has been pushing is "synchronized prescription renewal." This is an approach to renewing all of a patient's stable medications for the generally maximum duration of 12 to 15 months. The 12 to 15-month period varies from state to state. Broadly speaking, there are three steps to synchronized prescription renewals. Although most likely not directly applicable to podiatry, it's potentially useful information in understanding what's going on with your primary physician colleagues.

1) At a dedicated annual comprehensive care visit, all medications for chronic illness are renewed for the maximum duration allowed by state law.

2) Instruct the patient's pharmacy on all modifications and renewals; for example, "Don't fill until patient calls."

3) When you receive a prescription renewal request, take the opportunity to renew all the patient's prescriptions for chronic conditions.

Electronic Health Records Do the Heavy Lifting

In many ways, electronic health records (EHR) have made it easier for all physicians, podiatric physicians included, to track the medications a patient is taking. There are at least two caveats to that. They do a great job of tracking the medications if they're entered appropriately by the primary physician, if the patient is honest and complete about what they're taking—including supplements—and if all the involved EHRs are communicating with each other.

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Larry Kosova, of Family Podiatry Center (Naperville, IL), says, "Things are definitely easier now. It's easier to see cross-activity—probably too much, because everything seems to have cross-reactivity. It's much easier and simpler. You're just pushing buttons. The error rates have gone down. It's pretty simplified right now."


Larry Kosova

One thing, however, that a podiatric physician—and all physicians—can and should do is what is known as "medication reconciliation." That is a formal, standardized process of verifying and documenting patient prescriptions. MagMutual Insurance has an article on its website, "Maintaining a Medication List in the Podiatric Record" that lists five steps for medication reconciliation. They are:

1) Develop a medication form or format most workable for your group.

2) Engage the patient in the process.

3) At each patient visit, obtain a complete, accurate list of the medications the patient is taking, and compare this list to the list documented in the medical record.

4) Ask the patient about medications he/she may be taking from other providers and add these to your list.

5) Ask the patient about medications he/she may no longer be taking and delete these from your list.

They also suggest that a comprehensive medications list should include "all prescription medications, herbals, vitamins, nutritional supplements, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive medications, parenteral nutrition, blood derivatives, and intravenous solutions." The medications most likely to be overlooked include birth control pills, inhalers, eye drops, patches, herbal medicines, and anything prescribed by other healthcare providers.

The MagMutual article also suggests giving the patient an updated copy of the medication list after each visit, and looking for chances of further educating patients about their medications. They point out that "In emergency situations, the podiatrist's records may serve as the only source of information of a patient's medications, thereby performing a critical function in that person's care."

The Opioid Epidemic

As the earlier statistics indicated, the U.S. has a problem with opioids and the Centers for Disease Control and Prevention (CDC) have declared it an epidemic. A 2010 study found that 30 percent of the U.S. population experienced chronic pain, with low

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back pain and osteoarthritis the most common causes.

Generally, podiatrists don't typically treat chronic pain. Annette Joyce, DPM of Freedom Foot and Ankle and Carroll Foot and Ankle Surgery Center (Sykesville, MD), who specializes in podiatric dermatology, says, "Podiatrists over the years have tried to avoid medicines that can have systemic implications, like opiates. We don't manage the entire patient's body. Our review systems are focused on foot and ankle, or our scope of practice. It's not that we can't write an antibiotic to treat something with the foot, but we're not usually hospital-based. I'm not going to write a narcotic knowing we have to deal with psychological issues, systemic issues, liver issues. There's a whole range of issues you have to deal with when you prescribe narcotics."

Dr. Joyce

Broadly speaking, then, podiatrists are more likely to prescribe opiates for acute pain for a limited period after surgery. And even there, Maurer tends to be a skeptic re: opioids. "I do a fair amount of surgery and I think your prescription, your opioid-writing habits, are tied to your post-operative management and they can't be separated. Your post-operative management is tied to your pre-operative patient education, and those two can't be separated."

Overall, Maurer says, the emphasis is on treating whatever is causing the pain. Often, if a patient calls in before an appointment complaining of pain, he or she is more likely to suggest that it probably means the patient spent too much time on their feet that day and is reluctant to prescribe short-term pain medications.

Kosova agrees, saying, "We get a lot of people who go to multiple doctors, their orthopedist, podiatrist, general doctor, and it seems like everyone's handing them a prescription. And around our office, our thinking is, if you don't get off your foot, it's not going to get better. You can have the strongest anti-inflammatory and the strongest narcotic, but if you're walking around with a tendon tear, you're not letting it heal."

In March 2016, the CDC published its "Guideline for Prescribing Opioids for Chronic Pain." Intended for primary care physicians, it's important that podiatric physicians and foot and ankle surgeons be aware of those guidelines, not only to understand chronic opioid management, but also to be aware of the impact of prescribing opioids for acute lower extremity injuries and post-operative pain management. As such, the twelve guidelines are:

1) "Use non-pharmacological and non-opioid pharmacologic therapy.

2) Establish treatment goals for long-term opioid therapy.

3) Prior to starting and periodically during treatment, clinicians should discuss the risks and benefits of opioid therapy.

4) Prescribe immediate-release opioids whenever possible, especially when starting opioid therapy.

5) Start opioid therapy at the lowest effective dose and gradually increase the dose with caution if needed.

6) For acute pain, prescribe the lowest effective dose of immediate-release opioids for only the expected duration of severe pain (three to seven days).

7) One should frequently monitor the benefits and harms of opioid therapy.

8) Evaluate risk factors for opioid-related harm and incorporate strategies to decrease these risks.

9) Review state prescription drug monitoring program (PDMP) data.

10) Use urine drug testing prior to starting and at least annually when prescribing opioids for chronic pain.

11) Avoid concurrent prescribing of opioids and benzodiazepines.

12) Offer evidence-based treatment for patients with opioid use disorder."

In terms of the use of opioids for post-surgical pain management, the CDC recommends following the Washington State Agency Medical Directors' Group Interagency guidelines on Prescribing Opioids for Pain.

They include five broad steps:

1) Preoperative education and perioperative pain management planning.

2) Multimodal therapy for the management of postoperative pain.

3) Use of physical modalities.

4) Use of systemic pharmacological therapies.

5) Use local pharmacological therapies and peripheral regional anesthesia.

Broadly speaking then, podiatrists are more likely to prescribe opiates for acute pain for a limited period after surgery.

It's also worth pointing out that prior to leaving office, President Obama signed the 21st Century Cures Act. Part of the bill included one billion dollars in funding for the treatment of opioid addiction. $500 million went for each of the next two years for states to fight opioid addiction and abuse, and the Secretary of Health and Human Services will distribute the funds to states.

The one billion dollars in funding will go to improvements to prescription drug monitoring programs, prevention programs, and research on prevention strategies, training to prescribers to follow opioid prescribing guidelines and to receive instruction on safely managing pain, and the best ways to refer patients to treatment. It will also expand access to addiction treatment. Funding can also go to other public health activities related to fighting the opioid epidemic.

The Senate passed the bill 94-5,

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so it had basically bipartisan support. It's unclear as of this writing if President Trump, who plans $10.5 trillion in budget cuts over the next 10 years, as well as a "repeal and replace" of the Affordable Care Act, will take his ax to the 21st Century Cures Act or any other aspects of healthcare, public health, or addiction and mental health services.

Podiatry and Prior Authorization

Prior authorization, as every podiatric physician likely knows, is when the physician requires approval from the patient's health insurance plan to prescribe a specific medication. Maurer says, "It's a tool that is really upsetting to all doctors. It requires our staff to be on the phone trying to get paid. It's the bane of our existence. I don't deal with it much. I have a very narrow payer profile, so I get to know the insurance companies I deal with all the time. Ninety percent of my insurance companies are the same two. I know when they say, 'This requires prior approval,' what they really mean is: 'We're never going to get this thing approved.'"

He notes that it's possible that primary care physicians have better luck with this than he does, but he has gotten to the point where he just doesn't pursue it.

Because Joyce focuses on dermatology, she has noted a shift in podiatrists being visited by companies repping dermatological options, primarily topical treatments. She says, "The problem in the last year has been a shift in insurance coverages because these medicines we've been writing have been going through a lot of specialty pharmacies. We've been losing to dermatology companies like Valeant or PharmaDerm, which will offer coupons."

Those coupons are often only connected to specific pharmacies. For example, Valeant, after terminating a relationship with specialty pharmacy Philidor, created a deal with Walgreens, and these prescriptions could only be bought at Walgreens, because of the coupon relationship. Joyce says, "I think that's the challenge. We're becoming afraid to prescribe these because we might get denied, because we're seeing an extreme decline in coverage. Topicals and antifungals are a big area. These medicines are extremely expensive and it's up to the insurance industry whether they cover them or not. A specialty pharmacy can be an advantage because if they're able to get patient coverage for the co-pay, we all are happy; the patient gets the medicine, the doctor doesn't have paperwork. When it comes to paperwork, some family practices charge $30 to fill out a prior authorization for the drug, which puts the burden back on the patient. I don't know if that's the right answer."

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Compounding Pharmacies

Compounding pharmacies and compounded medications are of growing interest to podiatry. Topical compounding can deliver high doses of medications directly to an area of injury, such as Achilles tendinosis, plantar fasciitis, or after an injury.

Joyce notes, "Compounding is also considered specialty pharmacy. They're usually local, but that's where they're tailored to the individual patient. They can be covered fairly easily, but also be fairly expensive. There's a balancing act. All drugs are not bad. All drugs are not exactly right for every patient."

Kosova notes that he has had a lot of luck with compounding pharmacies, saying that he and his wife, Marlene Reid, also a podiatric physician, were trying one particular product themselves for Achilles' tendonitis and knee pain, and were so impressed that they tried it with a few patients. "I see a lot of dancers, gymnasts, and runners, and a lot of high school and middle school kids. You can't get easier than taking a cream and rubbing it on a spot and making the pain go away. We knew it was working when the dancers were literally passing it around and the families were coming in saying, whatever that magical cream was, we need some."

He also points out that it wasn't something he was looking forward to doing. "It wasn't something I really bought into as a physician. But patients were really requesting it and talking about how much better they were getting." But he also points out that it can be a tough sell with insurance companies. "There's a lot of fraud in it. There's a lot of fraud in everything that alternative medicine does, but honest companies are really doing a great job."

Conclusion

This article only touches on some of the complex issues revolving around prescription management. With Congress and the Trump administration already taking steps to repeal the Affordable Care Act, with no clear replacement plans, as well as dramatic changes in other areas of healthcare, including possible policy shifts with the Food and Drug Administration, we can count on plenty of change and uncertainty. Staying on top of changes in laws and regulations regarding opioid management, drug and healthcare services reimbursement, prior authorization, and trends with compounding pharmacies isn't just good business, it's good medicine. **PM**

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