# DePaolo's Work Comp World

Thoughts and impressions regarding the workers' compensation industry throughout the United States including all state systems.

Thursday, July 17, 2014

## A Drug Testing Rebuttal

Last Friday I blogged a title, "Urine Is Big Money."

What I opined was that the very public lawsuits and jury verdicts in the cases between Ameritox, Ltd. and Millennium Laboratories, Inc. revealed unsavory marketing tactics that incentivized physicians to do drug testing and that there was a lot of money involved.

I called this "nonsense" because you and I pay for this surreptitiously through higher fees and greater utilization.

Specifically I said, "Drug testing may have its place in certain situations, but the incentives these companies throw at providers of care to initiate services is offensive to me, and should be to you."

Michael Gavin is president of Prium, a medical intervention firm that has particular expertise in providing tools for drug management.

He called me the other day to tell me that he a) enjoyed WorkCompCentral's new adaptive newsletter format (I know, shameless self-promotion) and that b) he had written a blog post rebuttal to Urine is Big Money but decided to run it past me rather than publish it publicly to deter the wrath of a potential counter-point.

Heck - I think dialogue is good! So with Michael's permission, I took the easy way out today and am posting his opinion with just a little editing for format and readability:

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When Ameritox purchased PRIUM, I did my own due diligence on the Ameritox management team. I believe I'm working for the good guys and we're genuinely trying to do the right thing.

I like David DePaolo. A lot. He is a voice of reason in our industry and I've enjoyed his musings, both personal and professional, for years.

But on the issue of urine drug monitoring, I think he's off the mark. On the one hand, I'm coming at this from an admittedly self-interested perspective (PRIUM is a wholly owned subsidiary of Ameritox), but on the other hand, the context and conclusions of David's recent post on drug monitoring beg for someone to clear up the confusion.

What did he miss? Nowhere in his piece did he mention several key facts. David knows all of these things, but critical context is missing from his view on Urine Drug Monitoring. Namely, he didn't mention that:

- **People are dying**. Overdose deaths from prescription opioids now outpace deaths from traffic accidents and have tripled since 1990;
- The CDC has identified the opioid crisis as an **epidemic,** a term the CDC does not use lightly;
- More than **12 million** people reported using prescription painkillers **nonmedically** in 2010;

- Urine drug monitoring technology is **relatively new**. David's quote from the CWCI data that suggests 192X growth in spend on urine drug monitoring in CA doesn't recognize the point at which the health care community sat on the adoption curve for this technology in 2004. Nor does it recognize that we still didn't realize the enormity of the opioid crisis in 2004. And don't tell me we knew in 2004 how bad this was going to get. I came into this industry in 2010 and spent my first two years here at PRIUM trying to convince payers there was an opioid problem in the first place.
- There's a distinction between point-of-care testing in a doctor's office and reference lab testing. Failing to make this distinction leads the reader to conclude that all inappropriate behavior rests with reference labs and fails to recognize that some physician practices are by themselves driving inappropriate utilization. Physicians who partner with experienced and capable reference labs that understand payers' perspectives and expectations can help align stakeholders (injured worker, physician, lab, and payer).
- There are guidelines for the appropriate use of urine drug monitoring and these guidelines are based on risk stratification of the patient. We follow these guidelines. We help payers follow these guidelines. Testing beyond the guidelines is as inappropriate as not testing patients that should be tested.
- Even in light of these guidelines, **WCRI data tells us that less than 25% of injured workers on long term opioid therapy are being tested at all.** David states "we know [the guidelines] are specific case recommendations particular to a certain set of medical facts, not to be applied universally." Agreed. Perhaps David doesn't realize how many injured workers fit that "certain set of medical facts." A lot more than he apparently realizes.
- Not all companies offer direct financial incentives to physicians. He lumps an entire industry together and does so just a couple of paragraphs after he details that Millennium's practices were found by a jury to be illegal and that all counterclaims against Ameritox were dismissed. Perhaps David missed the most important take-away: **there's at least one company trying to do it right**.

**Bottom line: what David blithely dismisses as "nonsense" is, in fact, a critical patient safety tool, a mechanism for effective claims management, and a necessary application of clinical technology that isn't going anywhere. To suggest otherwise in light of the largest man-made epidemic in the history of the world is simply irresponsible.**

Michael

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So I agree that drugs are a public health concern. I agree that drug testing can be an important part of patient care. And that Ameritox was found clean of engaging in questionable marketing tactics is comforting to me.

But Michael misses the theme of my post.

The point I was making was that the Millennium/Ameritox case simply provided insight into how medical supply businesses work, and how much money is involved.

This occurs inside, and outside, workers' compensation. And not just drug testing companies, but nearly all medical supply businesses have some marketing systems that provide physicians incentives to use and/or promote their products.

Marketing practices that improperly cause physicians to prescribe specific products or services should not be tolerated without full disclosure to the patient and the payer as to the nature of the incentives to the doctor.

That's the bottom line.

That Gavin's company, Prium, and it's parent Ameritox, don't engage in "direct financial incentives to physicians" is a good start. Next would be disclosure as to what incentives are placed in front of physicians so the people can make informed choices about whether prices and utilization are appropriate for any given case.

Thank you Michael for taking the time to write a rebuttal.