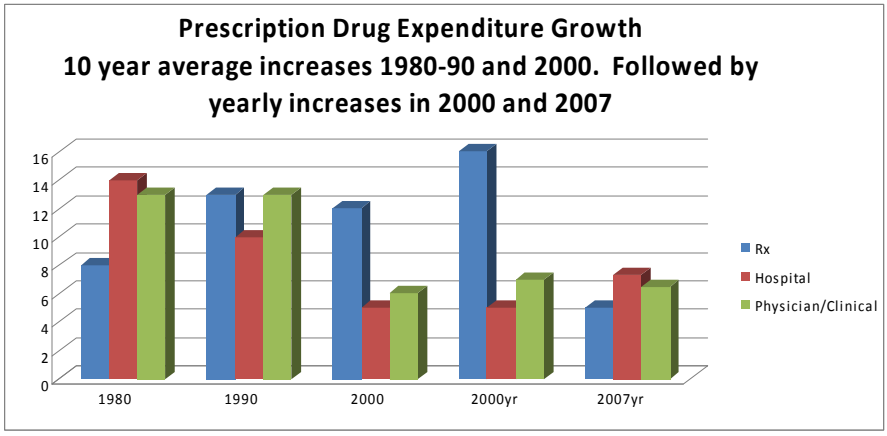
LITIGATION ASPECTS OF OFF-LABEL USE: QUALITY OF CARE, GENERALLY ACCEPTED MEDICAL PRACTICES & EMERGENCE OF COST CONTAINMENT

Raul A. Tabora, Jr.

With my prior experience at the New York State Department of Social Services—we regulated the Medicaid program that is now undertaken by the State Department of Health—I think I may be the only advocate of more regulation in this area, or more restraints of some sort, as we'll get into shortly. Let's start off with a graph. This graph shows essentially the growth in prescription drug reimbursement by all sectors, by the insurance companies, the Medicaid program, and Medicare over the course of the last several decades. I think it provides an indication of why there has been so much concern with regard to prescription drugs in general, and specifically with regard to off-label uses of these drugs.



The three categories of cost are essentially hospital costs, which are reflected as the middle bar. The physician and clinical cost is the third bar, and the one at the left that you can't see too

well, in blue, is prescription drug cost. It calculates the average annual growth in terms of pricing and cost and reimbursement for these items. You can see that from 1980 through 1990, and then through 2000, prescription drug costs have grown higher than any other cost category. By the year 2000, I mean it's just an astronomical growth, up to 16% in terms of that particular year. It has gone down between the year 2000 and 2007 to a lesser of an annual increase. And I don't know what the basis for that is. As I'll discuss later in my presentation there has been passage of the Medicare Part D Program, but I'm not sure if that's solely accountable since there're many restraints with regard to the off-label reimbursement within the Part D Program. But I think a lot of the tort actions and governmental claims involving inappropriate marketing for off-label uses has probably had an impact between the year 2000 and 2007. It's been an incremental slide down from the year 2000 down to 2007.

I once saw a book called *How to Lie with Statistics*. I, of course, immediately bought it, because, you know, when you look at the information that this is derived from the Centers for Medicare and Medicaid Services CMS website, you can just plug in national health expenditures and you'll get a lot of data that you can then manipulate in whatever way you want to make your point. But there's no doubt that prescription drugs have increased astronomically.

Now in my practice, I come at these issues more from the frontend as opposed to the backend in terms of litigation. I represent mostly long-term care facilities that deal with special populations such as geriatric patients and children who are in chronic need and are institutionalized. Office of Mental Health-regulated facilities (OMH), for the most part, these facilities have to deal with daily issues involving the needs that the patients have. When I view the term litigation, I view it as more of a solution. There is a problem and oftentimes we have to deal with reimbursement issues, so we have to commence litigation to try and fix that problem.

I'll just give you one example having to do with a pharmaceutical issue. We had a specialty nursing home for children that strictly admitted children between the ages of three and twelve. Most of these children are institutionalized and have chronic care needs and the predominant treatment was an anti-seizure drug called Depakote. Now, this is in the year 2000, this

particular facility has massive costs in the area of prescribing Depakote. The reimbursement system for facilities of this nature in New York gauged the cost that would be paid to the facility based on what was spent in 1983. But in 1983 the predominant standard was Phenobarbital for anti-seizure medications. So you have a situation where, in the year 2000, this facility is being paid based on 1983 standards of practice in terms of prescribing issues.

We obviously started litigation against the State Department of Health requesting that our rates be changed. They said, essentially, that "You get your 1983 costs, it's up to you to contain those costs and provide effective treatment." There is a concept known as an inflation factor, so what the Health Department and the State would say under these circumstances is that, "Okay, we're paying you based on your expenses having to do with Phenobarbital back in 1983, but we've inflated that, so you get the standard consumer price index inflation factor for that cost," which does not address what's on this graph, which shows that pharmaceuticals have increased in terms of their cost, far outpacing any type of consumer price index increase. The case was settled using more current pharmacy costs.

I'll give you another example of the type of litigation that arises in this area. We may have a patient in a nursing facility who has multiple sclerosis, and for MS the drug cost may be anywhere from $100 to $3000 per-month in terms of the cost needs for that patient. The average amount of reimbursement that a facility will receive for prescription drugs for the average geriatric patient may be $200 to $300 per month. So there's a big gap in terms of the reimbursement for that particular drug. And when you—I don't know if you've dealt with individuals or families who have MS, but the type of drugs that are received by those family members are very important to them—deal with the effects of that illness that the drugs ameliorate, for the most part, are the effects of MS. So it's dear to the family's heart and there's no way that you can deny that type of a care.

So we started up litigation in federal court dealing with the lack of funding for that particular drug that I believe was an off-label use. Here you should note that most litigation projects that we undertake are designed to result in a settlement as opposed to going to trial. The last thing we want in this area is to be encumbered by a trial. Usually we'll bring—and this involves litigation against the State of New York or CMS—a case

designed to educate the regulators and say "You should fix this problem. Here are the affidavits from the attending physician, the affidavits from clinicians involved, experts, which say: here you go, now fix the issue." What they did here was develop or add the MS drug to a list of what are known as pass-through drugs. These are drugs that are passed through the system and paid directly regardless of what the nursing home might get paid on an average basis per month.

What I've tried to do in this area is provide an analytical framework. What is important with regard to prescribing practices, where I primarily concentrate, which again is at the front end, is the immediate impact on care. You have the following questions that are raised by off-label uses at the frontend, basic common sense questions that are asked by the caregivers: Is there proven evidence that the prescription will help the patient's condition? How will the prescription avert further damage to the patient and/or surgery to the patient? What are the possible side effects, contraindications, and interactions? Are there too many unknowns given the cost of a particular drug or its limited supply to warrant an off-label use? And who will decide these issues if not the FDA?

Now, we've heard already today that doctors are not getting enough information, and I think that that's true. When I walk into a doctor's office, the last thing I want to see are materials from pharmaceutical companies as the predominant source of the doctor's information. There are a wealth of sources of information that doctors and we—in representing predominately facilities who have a majority of medical staff policies that are applicable to doctors—can use to coordinate for the care that needs to be provided. And I think that that's one of the unregulated areas here. You talk about the FDA providing some sort of a control mechanism in terms of clinical trials, but, aside from the FDA, it's really unregulated except by the payer sources, which we'll get into in a minute, Medicaid, Medicare, and the insurance companies.

When you look at issues involving off-label use, the analytical framework revolves around several points.

First, there's either an actual or a perceived deviation from quality of care. And from a lawyer's perspective, when there is an off-label use, it just magnifies the likelihood that there is a sub-standard care issue, so that's kind of a red flag. "Okay, this was used on an off-label basis, so something must have happened

with regard to the damage that has occurred to the patient."

The next inquiry then is: "What is the generally accepted medical practice? What is the standard of care, which oftentimes is different than what the FDA has approved?" We will not go over the U.S. Supreme Court Decisions because they've already been mentioned, but just sticking with the issue of generally accepted medical practices. When I was with the state Medicaid audit group, it became apparent to the audit supervisors that the physician is a very important actor and stakeholder here. Out of the hand of the physician, millions of dollars are paid by the Medicaid program. We used to analyze that data and then have the top-prescribing doctors set for audit. These audits would look at whatever they had listed as a medically indicated reason for prescribing the types of drugs that they were prescribing.

I'll just give you an example. Back in the 1980's, Dwight Gooden was a popular pitcher and there was an article that he insured his arm for millions of dollars. We had one physician who had the million-dollar arm because through his prescribing arm he would cause the Medicaid program to spend millions of dollars of reimbursement. When we finally caught up with the doctor, we found that he had some pretty strange notions of what was medically indicated. He would, for example, prescribe Buspar in the morning, Xanax in the afternoon, and then Valium at night to all of his patients that had an indication of alcoholism. He said, "I've cured all of my patients of alcoholism." And of course, all of that was off-label use.

When I had that case, what we used to do initially was bring the *Physician's Desk Reference* and use that as the primary resource—the *Physician's Desk Reference* is a publication that has all of the approved FDA indications, uses, and contraindications for drugs. So you'd get the *PDR* out, I wish I had it with me, because that's a good prop to use, and we'd look it up. "Okay, for Valium, this is what it's used for, it's generally supposed to be prescribed for a minimum period of time, a month to four months, no longer. Xanax, this is what the uses are, etcetera." There's nothing in there about alcoholism and curing alcoholism.

So then I said, "Well, I think we've got millions of dollars at stake, so we should have peer reviewers take a look at these issues." These are doctors that generally are peers to the physicians that are being reviewed. We'll go back and ask the peer. Of course, the peer says this is crazy. Not being satisfied, I

went back to the medical text, and clinical trials to look into the actual chemical uses of Xanax, Valium, and Buspar in terms of how they actually may inhibit certain serotonin levels and other aspects which might be useful in terms of curing alcoholism. And I did find some evidence there. However, as the peer reviewer ultimately said, "The doctor got them hooked on these drugs as opposed to alcoholism." So they just replaced what the patient was afflicted with previously.

Now we'll talk about regulations, before we get into just generally the preemption issue. In terms of how serious this was relating to prescriptions for non-indicated symptoms, I remember that the director of audit operations said we've got to get a handle on this. The issue was how the Medicaid program could press upon the doctors, the primary defense in the care that's provided to patients, to assure that there is some cost containment. Can we sue them—the prescribing doctors—because they caused us to pay all this money to the pharmacy? You got the pharmacy, the pharmacy says we have to dispense what the doctor tells us to dispense, and we have no choice about that. "We get a prescription, we've got to fill it, that's what we do." So we can't go after the pharmacy to recover the money, but we could go after the physician.

So I researched it, and I said, "Well, it's going to be a tough row to hoe in terms of common law issues, going after the physician." But, guess what, we're the State of New York. We can just pass a regulation. Which is just what we did. We passed a regulation making the physician financially liable for drugs, supplies, PET Scans, CAT Scans—whatever the doctor ordered—if there was no medical necessity for what the doctor had ordered. And that proved to be pretty effective.

We've gone over these Supreme Court cases. In *Wyeth v. Levine*, we've had mention of the impact of that issue in terms of allowing common law tort suits, which I think is a fantastic result, and I think that the U.S. Supreme Court kind of identified the issue—a close decision I think—as what does the FDA really do? Should we have a pre-emption of common law suits regarding the warnings that are placed on labels when we have an FDA really that has not taken up the vacuum in this area?

The FDA, since the time of Teddy Roosevelt, has really gone away from what people primarily thought that they were going to address, and that is public safety. It appears that now all that they do is review and approve labels. So I think that the

Supreme Court is absolutely correct in its analysis. And that case was particularly egregious in that it involved Phenergan and the warning as to the IV-push method as opposed to the IV-drip method of administration. With the IV-drip method, there's a saline solution that's used to avoid potential gangrene, which I think is what ultimately occurred to the individual in that case. She got irreversible gangrene because the IV-push method was used and she lost her arm. In this case, the plaintiff was a violin virtuoso. So it's just an egregious situation, and I think that there is a definite role to be played by mass tort litigation.

However, often you have to wait five or six or seven years before you even get a result from the mass tort litigation realm. Talking from the frontend in terms of advising clients today, I'll have a client that'll call me up from an HIV specialty facility; when all they deal with is AIDS patients, where there is a lot of experimentation going on. And the question will be, "Can we do this?" We've had a finger prick happen to a nurse and whenever there's a finger prick situation when the nurse is trying to administer a drug to the AIDS patient there is potential transmission of the AIDS virus. Well, there's a prescribed course of treatment that has to be immediately followed right that day or the very next day as a prophylactic measure. After maybe six years of litigation perhaps we'll have an answer. But I think we need some additional guidance and regulation in terms of what the accepted uses are much more in advance of that time period.

I'm not going to go through these other cases shown on this slide because they've already been discussed. This is the Zyprexa products litigation that has been going on for many years. However, I thought that the following statement from Judge Weinstein was appropriate. Here he essentially criticizes the third-party payers, the FDA, and he says, quote,

> They've all arguably failed consumers and physicians by over relying on pharmaceutical companies to provide supporting research for new drug applications by allowing them through law enforcement to conduct off-label marketing, by acquiescing an industry pressure on drug labels, by not requiring doctors, the main line of defense against misusing prescriptions, to be adequately informed, and by leaving information dispersal and control largely to industry influence medical journals and non-governmental associations.

I think that sums it up in terms of the dysfunction in this area.

Now, moving onto the next slides dealing with payor issues,

what I usually deal with in my practice is a statutory labyrinth. There are a variety of statutory prescriptions that depend on who your payer source is. So if your payer source is Medicare Part D, for example, then you have a specific set of standards and you have to comply with the compendium that was mentioned earlier. If the drug is on the compendium then you're okay. There are "call letters" that are issued every year by CMS that advise Part D insurers what they need to comply with. If on the other hand you're reimbursed by Medicare Part A there's a completely different set of rules. Medicare Part D and Part B, again, are a completely different set of rules. Of course, often you're talking about these Medicaid limitations and statutory requirements, and your mind starts to go numb. Well, maybe not my mind, but the mind of the people that are listening to me.

Essentially what you get out of the Medicaid and Medicare limitations is that they are trying to institute controls over off-label uses of drugs through their status as the payers of these drugs. I'll just go through to the most recent example. For example, the Medicare Improvements and Patient's Providers Act of 2008. Prior to this act, there was a lawsuit that had been commenced in 2006–2007 by the Medicare Rights Center regarding restrictions on the payment for anti-cancer medications that was being used off-label. I think as a result of that litigation—now that litigation never resulted in a decision—but it did, I think, result in a significant factor in changes in the law, which forced Medicare to develop specific compendia and specific procedures for allowing anti-cancer medications as off-label uses. So I think the net result goes back to my main point that litigation should have more of an expansive picture. Often litigation, even though you never get to a decision or you never get to a jury, will have important and long lasting effects, especially in the area of regulatory reform.

With that I'll close. Thank you.