Healthe SYSTEMS

Physician Dispensing Concerns

in Workers' Compensation

Physician dispensing has been an ongoing and growing challenge for today's workers' compensation payers. It is a significant hurdle to optimizing network penetration and managing prescription drug costs and makes it difficult to proactively ensure patient safety and appropriateness of care for injured workers.

Rules regarding physician dispensing vary by state and may impact payers differently depending on their populations and where they conduct business. Despite the disparities, physician dispensing activity remains a focus for many in the industry, with one out of three participants in the *2024 Workers' Comp Industry Insights Report* selecting it as a top priority in their pharmacy management programs. In fact, physician dispensing ranks highest on the list for claims- and medically focused roles.[1]

Proponents often cite the benefits of physician dispensing for injured worker patients as improved access to medications, convenience, and medication adherence. But in workers' compensation, physician dispensing also creates some serious concerns not only from a cost perspective, but from clinical and safety perspectives.

This is largely because the management of prescription drug therapy in injured worker populations can be complex due to the nature of injury and pain management, as well as the risks inherent to some of the drugs commonly prescribed to injured workers – opioids, benzodiazepines, muscle relaxants, and anticonvulsants, among other therapies.

Retail pharmacies play a central role in the safe dispensing of these drug therapies to injured worker patients. They are in the unique position to view a patient's complete drug regimen and apply comprehensive safety checks to prescriptions at the point of sale. Physician dispensing bypasses this important pharmacy process since there aren't any prospective "checks and balances" being made before the prescription is dispensed, introducing significant safety risk to patients.

Additionally, physician dispensing can be financially advantageous to physicians, introducing a conflict of interest. This is because physicians may profit by dispensing medications at a much higher cost than the same drug would be provided at a retail pharmacy.

While there may be justified applications for physician dispensing when patient-specific barriers exist, in most cases, the concerns far outweigh the benefits.

Patient Safety and Appropriateness of Care

Concern: Physician dispensing undermines the physician-pharmacist partnership, which is designed to identify drug safety issues.

Pharmacists are trained to help optimize treatment options, manage medication side effects, and maintain the tools and knowledge to identify the potential for patient harm. It is because of this specific expertise that physicians can view pharmacists as a complementary partner in patient management. Regarding the relationship between physicians and pharmacists, the World Medical Association states that "collaboration between these professions is imperative, including with respect to the development of training and in terms of information sharing with one another and with patients."

When a physician dispenses medication directly to a patient, he or she bypasses this partnership and removes the safeguard of having a licensed pharmacist act as a "second line of defense." There is no opportunity for the pharmacist, along with the advanced clinical systems they use, to review the prescription for concerns, or the potential for that prescription to interact negatively with the patient or that patient's larger drug regimen.

As a central point of drug dispensing, the pharmacy can apply safety edits to a workers' compensation prescription in the context of the patient's full medication history to identify concerns such as:

- Drug-drug and drug-disease interactions
- Duplicate therapies
- Patient-specific allergies
- Potentially inappropriate drugs or dosages
- Early refill

Each year, the U.S. Food and Drug Administration receives over 100,000 reports of medication errors.[2] What's more, medication errors generally result in up to 7,000 to 9,000 deaths annually and over $40 billion in costs. Prescribing errors account for approximately 50% of medication errors.

Data shows that nurses and pharmacists identify anywhere from 30-70% of medication-ordering errors, underscoring the criticality of partnership and collaboration in the drug prescribing, review, and dispensing process.[3] Resulting errors and adverse events due to physician dispensing can cause further downstream negative effects – from patient harm to the necessity of additional therapies.

When it comes to injured worker patients, physician-dispensed opioids are of particular concern due to their high potential for addiction and abuse. Because physician dispensing bypasses the pharmacy, there is no one to monitor a patient's overall drug regimen, allowing physician-dispensed opioids to fly under the radar. In the most egregious situations, this could open the door to highly problematic scenarios such as "doctor shopping" – where opioid abusers visit multiple providers to obtain prescriptions. Prescription opioids were involved in nearly 24% of all opioid overdose deaths in 2020, a 16% increase from 2019.[4]

Right-Time Injured Worker Education

When physician dispensing does occur, pharmacy benefit managers (PBMs) can provide right-time education to injured workers on potential safety concerns and the benefits of using a retail pharmacy. For example, when physician dispensing activity occurs on a claim, Healthesystems has the ability to quickly disseminate information to gently remind the injured worker of safety concerns with physician dispensing – as well re-send them their drug benefit information in an effort to redirect their workers' compensation prescriptions to be filled at a retail pharmacy.

> **If a prescriber bypasses a state's Prescription Drug Monitoring Program, they won't see if a patient is already being prescribed controlled substances by another doctor. From a compliance standpoint, it also bypasses utilization review that may be needed with certain state formularies."**
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> ***- Jeanette Connelly, PharmD, Healthesystems***

https://healthesystems.com/clinical-minute/

Injured Worker Outcomes

Concern: Physician dispensing can lead to longer periods of disability for injured workers.

Long term, the increased safety concerns presented by physician dispensing can often lead to a delay in recovery. Claims that involve physician dispensing have been associated with more lost time from work and higher claim cost compared to pharmacy dispensing.

For physician dispensing claims, the average days of lost time per claim was 73% higher than for non-physician dispensing claims.[5] And according to a study on claim outcomes in Illinois, the number of prescriptions per claim, as well as time out from work, were significantly higher in claims where a medication was dispensed by the physician within 90 days of injury than in claims where physician dispensing did not occur.[6] When opioids were dispensed by the physician, the medical costs were 78% higher and the number of days off work were 85% higher than pharmacy dispensations.[7]

When physician dispensing activity occurs, PBMs can step in to educate the physician about the negative impacts on patient outcomes. And to help avoid physician dispensing before it even starts, payers can work with their customers, their PBM, and other stakeholders to get workers' compensation prescription benefit information into the injured worker's hands at the earliest possible opportunity to drive fills in-network.

Healthesystems has multiple strategies in place to intervene with prescribers when there is physician dispensing activity on the claim or any additional clinical concerns based on the medication being dispensed. This is an effort to steer the prescriber away from physician dispensing on future scripts. Healthesystems also has various digital tools and processes to proactively get pharmacy fill information to injured workers sooner.

Additionally, Healthesystems gives all physician-dispensed prescriptions the same drug utilization review and clinical edits that are applied to prescriptions processed online via a retail pharmacy, ensuring the drugs are reviewed for both treatment and cost appropriateness. As a result, many problematic prescriptions may be flagged for authorization approval and can ultimately be denied if they do not meet a payer's formulary or other drug review edits.

Cost

Concern: Physician dispensing bypasses traditional cost controls and leads to higher drug costs.

In workers' compensation, medications dispensed by physicians typically come with higher costs than those dispensed by pharmacies. This is partly because physician dispensing bypasses the traditional cost and utilization controls applied by PBMs before prescriptions are dispensed.

Physician-dispensed drugs have been shown to cost as much as 60-300% more for workers' comp patients.[8] In the first quarter of 2020, physician-dispensed prescriptions accounted for more than half of total workers' comp drug payments in Florida, Georgia, Illinois, and Maryland. In several other states – Connecticut, Louisiana, Michigan, Missouri, South Carolina, and Virginia – 31-44% of all drug payments were paid to physician dispensers.[9]

Physician dispensing also increases the likelihood that over-the-counter (OTC) medications are prescribed at a higher cost. One medication class driving costs in physician dispensing is dermatologicals. In most states, dermatologicals represent a greater share of total prescription payments than other drug groups.[10] And in some states, such as Florida, 50-70% of topical analgesics are physician dispensed.[11]

Much of the increase in dermatological costs can be attributed to private-label topicals (PLTs). These are expensive pain creams that share many of the same ingredients as OTC products (such as Voltaren or Icy Hot) available on the shelf at retail stores but come with a significant price mark-up. Average wholesale prices for PLTs often exceed $500, while comparable OTC products retail for $10 or less.[12] Making matters worse, from a patient safety standpoint, PLTs have not undergone controlled studies to support their clinical efficacy or safety and have not been approved by the U.S. Food and Drug Administration.

PLTs, along with compounds, are one physician dispensing trend that warrants tighter clinical management due to these patient safety concerns. PBMs should have clinical logic and workflow support in place to help bring scrutiny to these therapies in terms of appropriateness of care and patient safety – as well as the ability for the claims professional to intervene with the prescriber to challenge clinical appropriateness, such as sending a Letter of Medical Necessity.

Controlling utilization of these therapies is much easier in states that have adopted a mandatory drug formulary. Having such a formulary in place allows for external review for anything prescribed off-formulary – regardless of how it was dispensed.

Regulations Around Physician Dispensing

Physician dispensing trends and the associated costs vary by state and depend on the various rules each state has in place. However, most states do not regulate physician dispensing. For those that do, regulation may include rules that define a window of time following the date of injury in which physician dispensing is allowed; limit physician dispensing to the first fill; and set fee caps and days-supply limits for specific drug classes.

These regulations balance injured worker access to prescription drugs for their work-related injury while helping to manage potentially abusive or wasteful prescription dispensing practices. Healthesystems is very active in advocating for regulations that will help manage prescription dispensing concerns in states that currently do not have these measures in place.

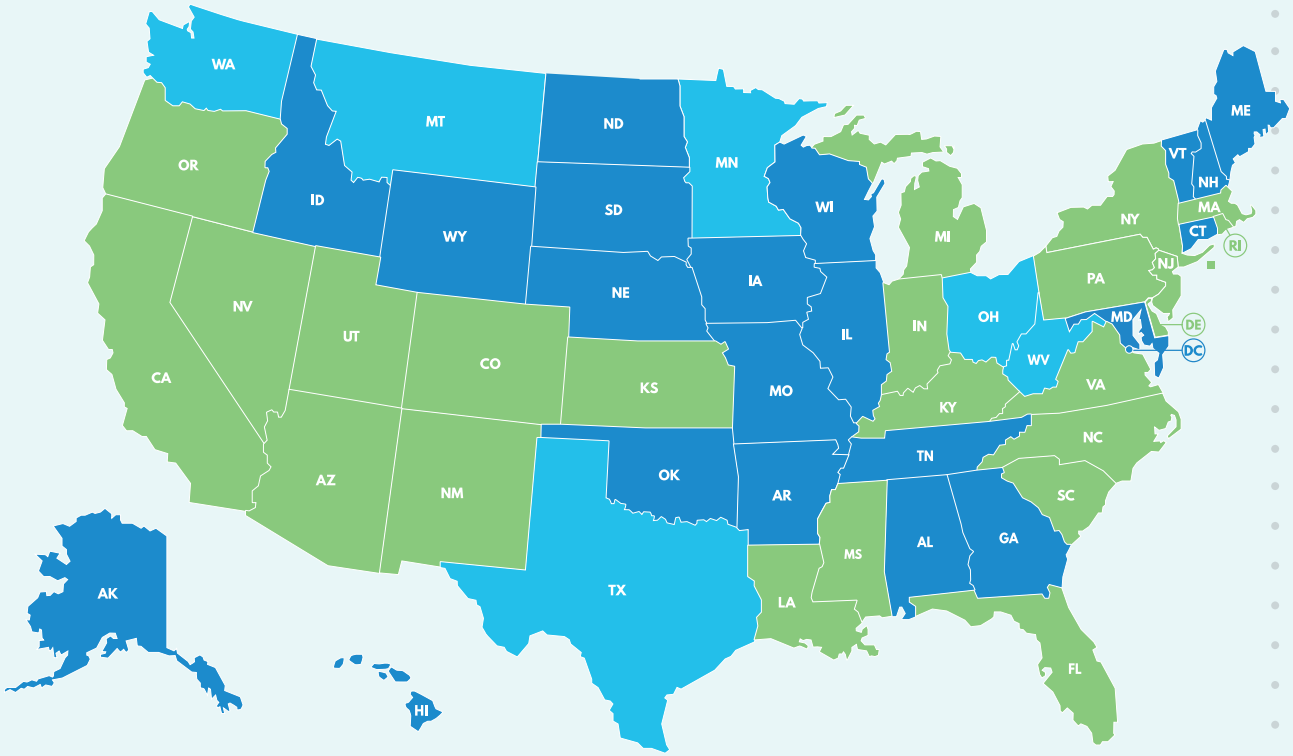
To minimize the negative effects of physician dispensing and improve retail pharmacy utilization, Healthesystems recommends:

- In rare circumstances when physician dispensing occurs, limiting physician-dispensed medications to the initial fill, within the first 14 days from the accident
- Requiring patients to obtain all prescriptions after the first 14 days from a pharmacy that serves the general public
- Implementing a fee cap and days-supply limit for topical analgesics and patches
- Consider implementing a nationally recognized drug formulary, e.g., ODG or the American College of Occupational and Environmental Medicine (ACOEM)

Physician Dispensing Rules

Physician dispensing regulation in workers' comp varies from state to state.

MAP KEY: Prohibited | Permitted | Permitted with restrictions



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