August 20, 2018

Jacqueline Kurth, Manager
Medical Resource Office
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Phoenix, AZ 85005-9070
Email: mro@azica.gov

RE: Reimbursement Guidelines for Physician Dispensing

Dear Jacqueline Kurth,

Please accept these comments on behalf of Healthesystems relating to the public hearing scheduled for August 23, 2018 to discuss the schedule of fees and consideration to adopt reimbursement guidelines for physician dispensing.

It has been more than eight years since the Commission took action on this issue and during this period, a significant body of evidence has been compiled with irrefutable data that demonstrates physician dispensing not only costs our system millions of dollars annually, but prolongs disability durations by nearly 10%, increases indemnity cost by 13% and incentivizes physicians to prescribe more medications, including opioids than are not necessary to restore the patient to function.

In order to prospectively manage opioids and chronic pain medications more efficiently, it is strongly recommended that the Commission:

1. Permit physician dispensing only during the initial visit within 7 days following a work injury,
2. Limit the days' supply for any physician dispensed medication to 7 days, which allows the patient ample time to visit a retail pharmacy and,
3. Where the payer has contracted for pharmacy services either directly or through a pharmacy benefit manager, require the injured worker to obtain their medications from a contracted pharmacy or network of pharmacies.

PBMs can work together to identify duplicative therapies, contraindications and drug recalls; none of these safety checks are built into the point of care (physician dispensing) model.

The technology that connects the pharmacy and PBM is built to ensure medications that are dispensed to the patient are done so within the best practices established by the Board of Pharmacy and in adherence to the adoption of ODG for treatment of pain at all stages and opioids. All these integrations exist to ensure the patient gets the right medications for their accepted injury, at the right time, and in the right setting; the pharmacy. To our knowledge, point of care dispensing technology does none of these safety checks or integrations.

Another benefit to the injured worker is that pharmacies who process online to PBMs are required by national telecommunication standards (called the NCPDP D.0 standard) to collect and transmit significantly more robust data about the medication and how it is to be used than a physician who dispenses the medication. For example, a pharmacy must indicate the days' supply of the dispensed drug, the Product Selection Code which indicates if a generic substitution was allowed and the method of administration,

indicating if a medication was to be taken orally, topical, inhaled, etc. Physician dispensed medications are not billed with this level of detail leaving payers to guess how to calculate the daily morphine e quivalent dosage threshold.

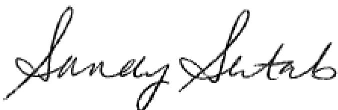
Without this information it is impossible for the payer to identify when a patient may be approaching the upper threshold of dangerous opioid dosing; this threshold is documented in the ODG opioid and chronic pain management guidelines. Because physician dispensers are not required to send this same level of detailed data, insurers are unable to easily identify claims which might need additional intervention or review.

In addition to the patient safety risks associated with physician dispensing, there are multiple studies published in recent years demonstrating pharmaceuticals dispensed by physicians are far more expensive than identical medications dispensed in a retail pharmacy. WCRI has reported on this and other cost drivers associated with physician dispensing in 2012 and 2016. In 2016, NCCI Senior Actuary Sean Cooper presented findings that indicated opioid utilization and costs are rising in disproportionate rates when physicians dispense medications from the office setting.

According to a 2015 WCRI study, three states have similar regulatory requirements which explicitly permit the employer to direct pharmaceutical care to a pharmacy network; they are California, Minnesota and New York. Many others have statutes which permit the payer to direct all medical services into a network, and yet others have case law which supports directing into a pharmacy network, even when the patient can choose their own physician. States like Minnesota and New York have minimal costs associated with physician dispensing as a result of these regulatory tools. California has recently taken steps to eliminate the prevalence of physician dispensing by including a mandatory preauthorization requirement for any physician dispensed medication into their formulary rule.

Our aim is to ensure injured workers have access to the right medications at the right time, and are protected from inappropriate prescribing, which is driven by prescriber incentives at the point of care. Healthesystems continues to support Arizona's Industrial Commission in its mission to ensure a fair and balanced system. Thank you for considering our input on this issue and please do not hesitate to contact me directly should you have any questions or comments on this information.

Sincerely,



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