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August 22, 2018

Jacqueline Kurth, Manager
Medical Resource Office
800 W Washington St.
Phoenix, AZ 85007

Dear Mrs. Kurth:

Please accept my written comments with regards to the white paper authored by the Public Consulting Group for the ICA on July 11, 2018. As a point of introduction, I have been Board Certified in Physical Medicine and Rehabilitation since 2002 and have devoted my practice to the treatment of injured workers since that time and in Arizona since 2008.

Based on this, I am comfortable providing a voice from the physician community with regards to the “facts” presented in this publication. In an effort to provide a brief yet cogent response, I will point out the most salient points of this white paper that in my opinion, require feedback.

I will start by pointing out that many statistical facts cited in this study are based on WCRI statistical data between 2007-2011 in states where physician dispensing is common (Illinois, Georgia, Maryland, Louisiana) and notably not Arizona. Furthermore, a bulk of this paper cites information and statistics that are not applicable in Arizona due to either Arizona’s manufacturer-based AWP reimbursement, its enhanced restrictions on the physician dispensing of controlled substances, and/or its imposition of the ODG medication formulary. These actions by default limit the relevancy of several sections of this paper including “repackaging”, “unmanaged prescriptions”, and “physician dispensing and opioid use.”

In my opinion the “public health impact of physician dispensing” contains hollow arguments in stating that physician dispensing erodes the collective analysis for drug-drug interactions and undermines “the potential benefits that come with digitization.” Not only is the argument antiquated with advent of EMR, it is simply inaccurate. Physicians are responsible for tracking potential drug-drug interactions, not pharmacies, which has been made easier with the advent of EMR. Moreover, many patients choose separate pharmacies for injury vs. non-injury related medications because pharmacies, either accidentally or intentionally, take the path of least resistance for approval and payment of medications which most often is the patient’s private insurance regardless of whether the treatment is due to a work injury. I have received countless “requires pre-authorization” notices from all the well-known retail pharmacies who then either hold the prescription and wait for someone to get it approved or turn around and run it through the patient’s private insurance.

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Rarely have I received a notice from a PBM or pharmacy regarding potential drug-drug interactions, even though they may be present. When I have, it typically contains outdated information in which the medication or medications in question have already been discontinued or changed. I cannot recall a specific example where this process directed by either a PBM or pharmacy has been useful in my practice.

The additional scare tactic provided by this paper that "physician dispensing undercuts the ability of drug monitoring program to efficiently and effectively carry out their function" is simply inconsistent with Arizona law as it relates to physician prescribing and dispensing. Arizona already limits controlled substance physician dispensing, requires CSPMP reporting of what controlled substances are dispensed, and mandates review of the CSPMP prior to controlled substance prescribing or dispensing.

In summary the analysis provided by this white paper is skewed by the data compiled most of which appears to be generated by nationwide numbers, including states in which "physician dispensing is common (Illinois, Georgia, Maryland, Louisiana)." In my opinion many of the conclusions rendered by this publication have limited to no applicability in Arizona given the legislative changes described above. In other words, the statistical axiom of GIGO (Garbage In, Garbage Out) applies. It is unfortunate the Commission did not receive an analysis based solely on the corrective measures the state of Arizona already employs. It is also unfortunate that the undertone of the paper revolves around cost containment with retail pharmacies without an impartial discussion of the realities of cost shifting from pharmacies to PBMs.

I want to conclude by thanking the Industrial Commission for providing an open forum to discuss these issues. It continues to be in the best interest of the entire Arizona worker's compensation system to identify any specific areas of concern, particularly abuse, and address those concerns as they arise. As has been learned in other states, painting broad legislative or administrative brushstrokes over specific problems drives willing, well-intentioned, and ethical workers compensation providers out of the system.

Sincerely,

Jeffrey D. Scott, M.D.