Demystifying Drug Pricing in Workers' Compensation

2023 Report Series

Part Four: **The Current State of Physician Dispensing and Compounding**

The goal of this ongoing series has been to segment and analyze major contributors to pharmaceutical spending in workers' compensation. Especially in the past few years, prescription drug prices have received considerable attention from the media and in the health care and workers' compensation systems. Industry stakeholders are regularly encountering increased prescription drug prices and overall drug spending – often despite making gains in areas such as increased generic substitution and decreased opioid utilization.

By identifying and addressing the real cost drivers in workers' compensation pharmacy, claims professionals, payers and plan managers can develop and implement more effective cost-management strategies with the help of pharmacy benefit manager (PBM) partners.

Throughout this white paper series, we discussed traditional prescription drugs, looked at opioids as a subcategory and examined the growing impact of specialty drugs. With vigilant clinical management and an emphasis on generic substitution and efficiency, we concluded that aggregate spending is actually decreasing in the category of traditional drugs. This has largely been accomplished through proactive clinical management and cost-reduction strategies and interventions, such as opioid weaning.

In addition, with the proportion of specialty drug spend increasing in workers' compensation pharmacy, we reviewed the potential of strategies, including biosimilar interchangeability, to manage costs while supporting positive outcomes for injured patients.

This fourth and final part of the 2023 Demystifying Drug Prices series will examine the current state of physician dispensing and compounding. Physician dispensing has grown since 2016 to become a significant cost driver in workers' compensation drug spending, especially in states without laws limiting this practice to some degree. And although tremendous progress has been made in some states through legislative changes, compounding continues to require close attention and scrutiny, especially in the subcategory of private label topicals.

Key takeaways from Part Four of our drug pricing series:

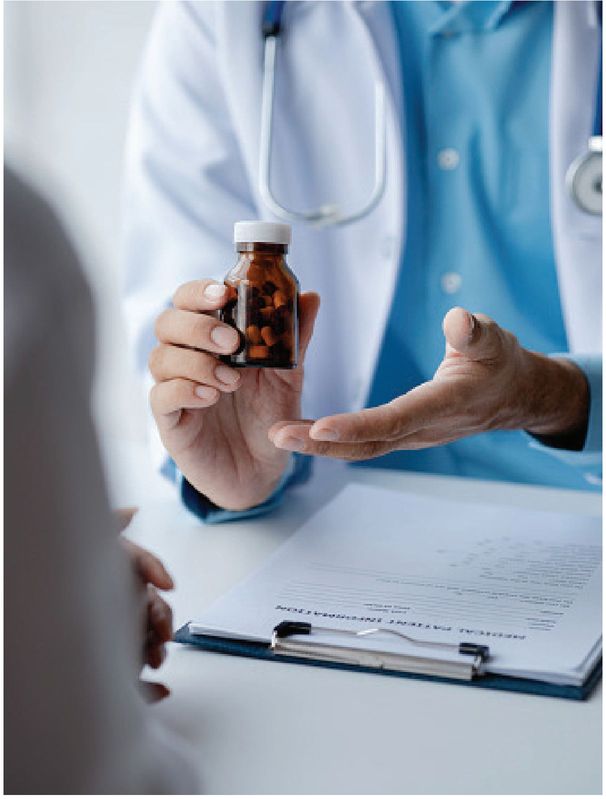
1 Physician dispensing has become pervasive in workers' compensation and other sectors where patients do not pay out-of-pocket costs.

2 Although there are multiple legitimate scenarios for physician dispensing, a large proportion of physician-dispensed prescriptions are dermatologicals or topicals. These either can require a prescription or are considered over-the-counter medications. Prescription topicals are typically marked-up medications that offer little to no clinical benefit over those dispensed through retail pharmacies.

3 Compounding has declined in workers' compensation, but a growing trend is an overlap of physician dispensing and compounding: private label topicals. These are independently manufactured products that are either identical to those available through retail pharmacies or have unique combinations of ingredients that are not available through retail pharmacies (hence, the overlap with compounding).

4 Legislative action has been a highly effective recourse against unnecessary physician dispensing, with noticeable reductions in spending in states that take steps to limit this practice.

5 Payers may choose to work with PBMs to request a clinical review of prescriptions dispensed by physicians for workers' compensation claims, either prospectively, if a state has a request-for-authorization requirement for medications, or retrospectively.

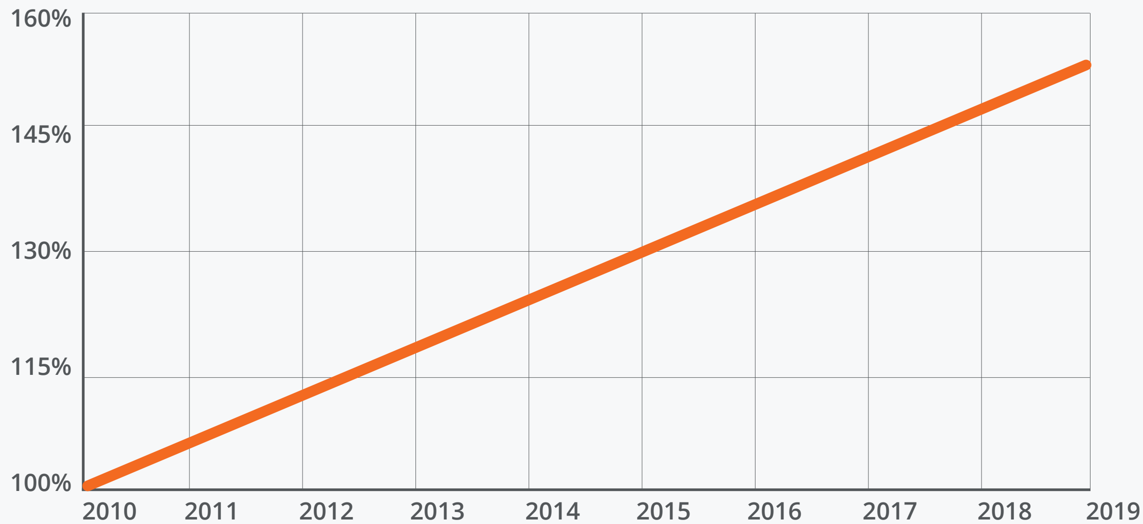


1. Physician dispensing in workers' compensation

Physician dispensing is essentially the practice of dispensing pharmaceuticals directly from a doctor's office, a clinic or another medical facility instead of writing a prescription to be filled at a retail pharmacy. In certain situations, physician dispensing is a vital and necessary service for patients. This includes rural areas without access to pharmacies and after-hours emergency facilities that provide care when pharmacies may not be open.

Despite being intended for limited use, physician dispensing has grown sharply over the last 10-plus years. According to one study, the number of dispensing practices has grown

151% increase from 2010 to 2019.*



In workers' compensation, injured patients do not incur out-of-pocket costs for care and treatment, including for prescription medications or topicals under a private label. Cost sharing by consumers is a critical component in the managed care model in controlling medical costs. The lack of this has contributed to situations where physicians can dispense medications with little to no additional clinical benefit at a marked-up rate. Data available to myMatrixx from Evernorth indicates that the cost of physician-dispensed private label products may be, on average, as much as five times higher than a comparable product from a retail pharmacy.**

Physician dispensing typically relies on paper billing and can essentially be categorized as unmanaged pharmacy. For payers and plan managers, this creates a unique challenge for intervention due to the need to retroactively address this practice and the inability to intervene directly at the point of prescription. Under most state laws, medically necessary treatment as recommended by a physician must be covered. This can mean that even with clinical intervention on the part of the payer or PBM, physicians with the ability and incentive to dispense pharmaceuticals to injured workers will continue to do so.

Beyond raising drug spending for employers and plan administrators, physician dispensing can also have a negative effect on state and municipal budgets. In states without regulations or restrictions on this practice, state and city budgets are becoming increasingly stressed by unreasonably high reimbursement rates for drugs dispensed by physician's offices.

An additional concern around physician dispensing beyond cost is safety. Clinical pharmacists play an essential role in reviewing drug therapy, including dosages and interactions with other prescribed drugs. In many situations, a prescribing physician may not have full visibility into a patient's regimen of prescription drugs, increasing the risk of issues, including excessively high doses or dangerous drug interactions.

2. Compounding in workers' compensation

Compounding is defined as the combining, mixing or altering of drug ingredients to form a new substance that can be marketed outside the traditional mechanisms of FDA approval. Valid reasons for compounding include a patient having allergies or intolerances to an ingredient or requiring a liquid version of a drug due to an inability to swallow pills.

Unfortunately, compounding can also be a source of exorbitant and unnecessarily marked-up costs for payers across the health care and workers' compensation systems. Although representing a small portion of total prescriptions in workers' compensation, it is yet another disproportionate cost driver.

Thanks to a dedicated focus on this practice, compounding is an area where myMatrixx has responded successfully:

According to a recent myMatrixx Drug Trend Report, compounding represented approximately .02% of prescriptions, with a year-over-year decline in spending of

42.3%***

Private label topicals

Private label topicals, or dermatologicals, is one category where physician dispensing and compounding overlap. Topical drugs, which are applied to the skin, are widely available over the counter or commonly dispensed affordably through retail pharmacies. Often, private label topicals dispensed by physician's offices are egregiously priced and offer little to no therapeutic advantage for injured patients over traditional therapies.

For example, as mentioned previously, a private label topical can be identical to what is available through retail pharmacies. Diclofenac 1.5% solution is the most prescribed topical from physician's offices in states without any physician-dispensing restrictions and costs up to 750% more than the exact same product dispensed from a retail pharmacy, which equates to a $1,300 markup. This same drug isn't in the top 10 topicals dispensed from retail pharmacies, which suggests its only reason for being dispensed from physician's offices is financial, not medical.

State laws and physician dispensing

Currently, 23 states in the U.S. have laws or restrictions on the practice of physician dispensing. Of those 23, 13 are either monopolistic states that require employers to buy workers' compensation insurance from a state-operated insurance fund or states with legislatively mandated, enforceable formularies.

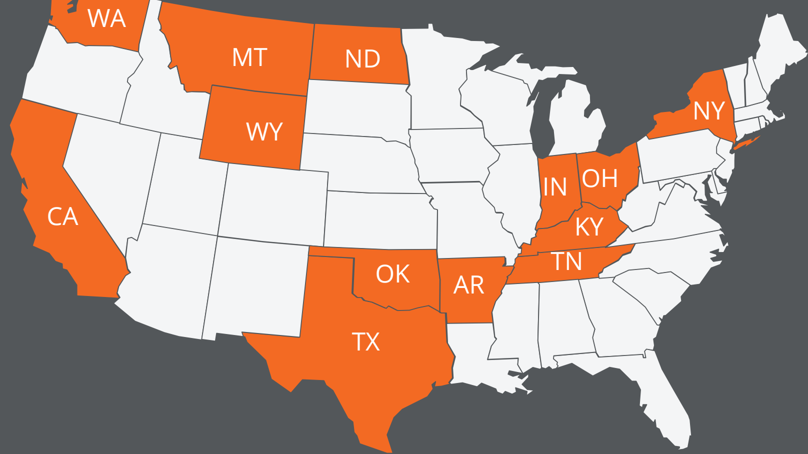
3. States with physician dispensing limitations (not including opioids)

States with some form of limitations on physician dispensing (not necessarily related to workers' compensation) include Arizona, Kansas, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island and Utah.

Examples of these limitations include the following:

- They must be dispensed within seven days from date of injury, and the prescription is limited to no more than a one-time, 10-day supply.
- They should be used only when necessary for immediate and proper treatment until the patient can get a prescription filled by pharmacy.
- Legend drugs dispensed by physicians will not be reimbursed except in emergency situations.

States with enforceable formularies (mandated or monopolistic)



In states that do not have any restrictions in place regarding formulary, covered drug list, enforcement or physician dispensing limitations, payers and plan managers are paying, on average, over **400% more** for any medication and **500% more** for topicals specifically.

ARKANSAS

State-mandated formulary; physician dispensing supply limits

CALIFORNIA

State-mandated formulary; physician dispensing supply limits

INDIANA

State-mandated formulary; physician dispensing supply limits; reimbursement for medications dispensed during the first seven days, including the date of injury

KENTUCKY

State-mandated formulary

MONTANA

State-mandated formulary; dispensing limits not specific to workers' compensation

NEW YORK

State-mandated formulary; physician dispensing supply limits

NORTH DAKOTA

Monopolistic state; physician dispensing supply limits

OHIO

Monopolistic state; physician dispensing reimbursement protocols

OKLAHOMA

State-mandated formulary; physician dispensing reimbursement protocols

TENNESSEE

State-mandated formulary

TEXAS

State-mandated formulary; physician dispensing supply limits (Physician dispensing is permitted only to meet a patient's immediate needs unless in "rural" area [not specific to workers' compensation)

WASHINGTON

Monopolistic state; physician dispensing supply limits (State fund does not pay formedication dispensed in a physician's office.)

WYOMING

Monopolistic state (If a pharmaceutical intended for outpatient use is dispensed through the office of a medical care provider, reimbursement will be calculated equivalent to the reimbursement provided to a retail pharmacy.)

4. Legislative action on physician dispensing and private label topicals

The most effective avenue for limiting costs associated with physician dispensing and private label topicals moving forward is likely to be through legislative action. As discussed, states with some form of restriction on dispensing at point of care see significantly lower drug spending compared to those that do not. Strategies can include advocating for state-mandated formularies; limiting physician supplies; putting price caps on specific medications, such as topicals; and limiting physician dispensing to the first 14 days from the date of injury.

Payers and plan managers can and should be in regular communication with regulators and legislators in their state or states regarding the proper role and scope of physician dispensing, particularly as it applies to workers' compensation. For example, in November 2022, the Florida Division of Workers' Compensation (DWC) and Department of Financial Services sponsored a workshop with dispensing physicians, pharmacists, carriers and payers to discuss concerns from both sides on the practice of physician dispensers in the state. Representatives from myMatrixx were present to help clarify the administration of physician dispensing and establish reasonable procedures for the prior authorization process in Florida's workers' compensation program. Unfortunately, the State of Florida made only minor changes to their laws, which went into effect in July 2023, and the outcome of these changes remains to be seen.

5. How myMatrixx can help

For stakeholders encountering physician dispensing and compounding in their workers' compensation drug portfolio, intervening with the provider, even retroactively, can be an effective course of action. A PBM can reach out to the provider with alternative, lower-cost medications, especially in states that require prior authorization. In certain cases, clients can reject the prior authorization request and include a request for a preferred medication.

In addition to advocating on behalf of payers and plan sponsors for effective policy and legislation to responsibly limit the practices of physician dispensing and compounding, myMatrixx also provides clients with clinical resources to control costs and promote safety for injured workers. Clients have successfully used the myMatrixx One Drug Review clinical intervention program to focus on a drug in an injured worker's treatment plan, such as a physician-dispensed medication or private label topical. During this process, a clinical pharmacist performs an assessment to determine if a more cost-effective alternative is available and consults with the prescriber to implement the change in therapy.

In the area of dermatologicals, myMatrixx provides claims professionals and nurse case managers with a Preferred Topical Medication Reference Guide. The non-preferred topicals list is based on the most prescribed and costly topical medications, providing the reviewer with the non-preferred topical, the preferred alternative and its therapeutic indications.

Conclusion

Physician dispensing has grown to become a revenue driver for many practices, potentially contributing to significant cost overruns for workers' compensation plan managers and payers. In today's environment, stakeholders need and deserve careful clinical and formulary oversight to develop a response that will control spending while delivering safe and effective drug therapy to injured patients. The myMatrixx clinical team will continue to stay vigilant and provide updates on the progress of efforts to improve both the legislative and pharmacy benefit management landscape for physician dispensing and compounding.

Sources

* Kanter, G.P., Parikh, R.B, Fisch, M.J., Debono, D., et al. "Trends in Medically Integrated Dispensing Among Oncology Practices." JCO Oncology Practice 18, no. 10 (October 01, 2022). e1672-e1682. https://ascopubs.org/doi/10.1200/OP.22.0013

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*** myMatrixx. 2019 Drug Trend Report. https://www.mymatrixx.com/2019-drug-trend-report