States put the brakes on physician drug dispensing

Yet reforms see mixed results as doctors adjust prescribing patterns

States have pursued several different approaches to restrict costly physician dispensing of medications, particularly opioids, often with mixed results.

Twenty states changed rules governing reimbursement for physician-dispensed drugs as of last August, according to the Workers Compensation Research Institute in Boston.

These efforts usually are driven by a desire to combat the opioid epidemic or to crack down on the rising costs of physician-dispensed drugs inside and outside the workers comp system, although they often run into resistance from physicians concerned their patients will be unable to access needed medications or those with financial incentives to prescribe certain medications, experts said.

“Broadly categorizing, I would say there's been good compliance,” said Frank Radack, vice president and manager of commercial insurance and claims managed care at Liberty Mutual Insurance Co. in Boston.

Florida banned physicians from dispensing Schedule II and Schedule III opioids such as Vicodin in July 2011, leading to a 12% decrease in the percentage of injured workers receiving strong Schedule II and III opioids from their doctors, according to a WCRI study published in December 2014.

Prior to the reforms, 3.9% of injured workers received strong opioids dispensed by physicians during the first six months after their injuries. After the ban, only 0.5% of patients with new injuries received physician-dispensed strong opioids, according to the study.

“The reform has been very successful in what it set out to do,” said Donald Lipsy, Tucson, Arizona-based manager of regulatory, communications and compliance at First Script, the pharmacy benefit management program offered by Coventry Workers' Comp Services.

However, a Journal of the American Medical Association study last August found that Florida's policies were associated with just a 1.4% decrease in opioid prescriptions and a 2.5% decrease in opioid volume.

“They went through all this effort, they passed this major legislation, or so they thought, and really when you think about the problem of opioids, that's in my opinion a really minimal impact,” said Dr. Teresa Bartlett, senior vice president of medical quality at Sedgwick Claims Management Services Inc. in Troy, Michigan.

WCRI expected that Florida physicians would continue prescribing these medications after the ban and that they would be filled at pharmacies, leading to an increase in pharmacy claims of strong opioids, said Vennela Thumula, Boston-based author of the WCRI study. But the percentage of patients receiving strong opioids through pharmacies was 12.5% post-reform versus 12.2% prereform, according to WCRI's study.

Instead, physicians dispensed medications that they could fill, including nonsteroidal anti-inflammatory drugs and weaker Schedule IV opioids such as Tramadol, she said. The percentage of post-reform

patients receiving physician-dispensed NSAIDs increased from 24.1% to 25.8% and weaker opioids increased from 9.1% to 10.1%, according to the study.

It is possible physicians were dispensing other medications they could prescribe so they could still receive financial incentives, Ms. Thumula said.

“All these findings do suggest that the strong opioids that physicians dispensed prior to the ban may not have been necessary,” she said.

It is unclear whether other states will follow Florida's lead, but Tennessee implemented a similar statewide ban in October 2013.

“Do I think more states will pass legislation?” Dr. Bartlett said. “I do ... not necessarily at a workers comp level, but at a state level in an effort to really decrease opioid use altogether. It's such an alarming trend that I feel our country has to do something bigger.”

Indiana, Nevada, North Carolina and Pennsylvania limit workers comp physician dispensing to a short timeframe, according to WCRI research. In North Carolina, Schedule II and Schedule III drugs are limited to an initial five-day supply.

The majority of physician-dispensing reforms to date have focused on price, with 14 states adopting reforms focused on cost reduction only, according to WCRI. The states generally targeted higher prices paid to physicians for drugs they dispense — mostly repackaged drugs — compared with filling them at a pharmacy, WCRI said in a January 2015 study.

Price-focused reforms often limit reimbursements to an amount similar to the average wholesale price assigned by the drug manufacturer, but regulated parties sometimes found ways to maintain their revenue by prescribing newly introduced dosages of existing medications.

“The prevalence of these high-priced, new-strength products is increasing the overall prices paid for these drugs, which brings into question in the long run if the price-focused reforms are going to be effective in controlling the costs of physician-dispensed drugs,” Ms. Thumula said.