Physician Dispensing in Workers' Compensation White Paper

Summary of Issues and State Practices in Physician Dispensing

State of Arizona, Industrial Commission of Arizona

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BACKGROUND

Physician dispensing refers to the practice in which clinicians dispense medications directly to patients out of their offices. Most states allow this practice to occur to facilitate patients receiving needed medications immediately at the point of care. As part of this service, physicians earn revenue from prescribing medications in-house. The practice is an exempted form of physician self-referral, which is banned under the Ethics and Patient Referrals Act of 1989, also known as the *Stark Law*. The original statute banned self-referrals for designated services when a patient was covered by Medicare or another government payer. Self-referral occurs when physicians refer patients to healthcare entities for services from which they or an immediate family member benefit financially. This includes: clinical and laboratory services, physical and occupational therapy services, medical imaging services, home health services, as well as the provision of medical equipment and supplies. The law was intended to eliminate any financial motivation for physicians to provide patients with unnecessary care and services that could raise overall healthcare costs. Since its original version in 1989, Stark Law has been amended twice in 1995 and 2007. The Law has numerous exceptions, one of which is the provision of in-office ancillary services whereby physicians are allowed to provide certain services on-site, including medications dispensing.

Physician dispensing has become a major contributor to increasing prescription drug costs, often accounting for over 60-300% of the increase in prices paid for commonly prescribed medications compared to retail pharmacies in Workers' Compensation.[1] Patients who are not paying for medications out of pocket are often shielded from the higher drug costs in the physician dispensing environment, leaving employers to bear the full brunt of the price differential. This trend has led to increasing regulation of physician dispensing in those states where the practice is allowed.

In addition to cost concerns, evidence of detrimental public health impacts relating to physician dispensing is starting to emerge. Physician dispensing bypasses established prescription monitoring systems that track the use of potentially addictive drugs such as opioids. As such, the practice undermines public health efforts to respond to the ongoing opioids epidemic in the United States. This report further delineates the various public health implications surrounding physician dispensing and outlines regulatory responses by states to curtail physicians' ability to dispense opioids.

PHYSICIAN DISPENSING IN WORKERS' COMPENSATION

Financial Incentives vs. Medical Necessities

Studies by the Workers Compensation Research Institute (WCRI) have shown that between the period of 2007 to 2011, there was a rapid growth in physician-dispensed pharmaceuticals for injured workers under states' Workers' Compensation plans.[2] WCRI found that the share of overall prescribed medications was largely accounted for by physician dispensing, and the prices for dispensed medications were drastically above that of pharmacies. In 13 of the 20 states studied, a minimum of 1 in 6 prescriptions was dispensed at a physician's office. In California, Florida, Illinois, Georgia, Maryland, and Arizona, physician dispensing accounted for at least 1 in 3 prescriptions in Workers' Compensation in between 2010 and 2011. Across the board, pricing analyses reveal a misalignment between the total share of prescription dispensed and the total prescription spending since prices of physician-dispensed medications were much higher than pharmacy-dispensed prescriptions. WCRI reported that this is particularly prominent in Illinois, Georgia, Maryland, and Louisiana.

[1] Wang, Dongchun. "Physician Dispensing in Workers' Compensation." WCRI. July 2012. Accessed July 11, 2018. https://www.wcrinet.org/reports/physician-dispensing-in-workers-compensation.
[2] Ibid.

Recent pricing regulations aimed at physician dispensing have been shown to alter prescribing patterns in workers' compensation, thus revealing that the practice of physician dispensing may be prone to influence by monetary returns rather than medical necessity and convenience alone. Although the statistical significance of this change in pattern is unclear, WCRI has found that among states where physician dispensing was common (Florida, Georgia, Illinois, and Maryland), there was a higher percentage of injured workers being prescribed medications that were rarely dispensed in other study states where physician dispensing was not as prevalent. Furthermore, drugs commonly dispensed under workers' compensation, such as hydrocodone-acetaminophen and cyclobenzaprine were found to be some of the most common drugs to have been produced under higher-priced, new strengths and formulations that are able to bypass numerous pricing regulations.[3]

Recent pricing regulations aimed at physician dispensing have been shown to alter prescribing patterns in workers' compensation.

Physician Dispensing as a Bureaucracy Bypass

Proponents of physician dispensing in workers' compensation argue that the ability to obtain medications at the point-of-care avoids delays in access to medications given the convoluted and bureaucratic systems that injured workers must navigate to fill prescriptions through pharmacies. However, further research is needed to capture the extent of delays due to administrative and bureaucratic issues that prohibit injured workers from promptly being able to obtain prescribed medications. Likewise, the impacts of such delays on health outcomes is poorly documented within the literature. Without concrete data, the extent of the benefits in which physician dispensing provide to injured workers in comparison to the tradeoffs in higher costs and potential safety issues are unclear.

Physician Dispensing and Medication Initiation and Adherence

Most prescriptions in workers' compensation are for pain medications, and patient compliance in filling prescriptions is of less concern.

Another claim in support of physician dispensing in workers' compensation include the idea that convenience in obtaining medications during the office visit encourages timely medication initiation and adherence. Numerous peer-reviewed articles on this topic reveal that there are wide variations in initiation and adherence metrics dependent upon the types of medications and the conditions in which the prescriptions were for. With medication initiation, studies have found that the most number of prescriptions that often remain unfilled are for skin conditions, and the highest proportion of prescriptions that get filled are pain medications for conditions such as headaches and migraines. With regards to medication adherence, research on the subject is often focused on maintenance medications for chronic diseases such as cardiovascular disease or diabetes, rather than chronic pain.[4]

[3] Wang, Dongchun. "Physician Dispensing in Workers' Compensation." WCRI. July 2012. Accessed July 11, 2018. https://www.wcrinet.org/reports/physician-dispensing-in-workers-compensation.

[4] Rolnick, Sharon J., Pamala A. Pawloski, Brita D. Hedblom, and Stephen E. Asche. "Sharon J Rolnick." Clinical Medicine & Research. April 11, 2013. Accessed July 11, 2018. http://www.clinmedres.org/content/early/2013/04/12/cmr.2013.1113.abstract. See also: Michael A. Fischer, Margaret R. Stedman, Joyce Lii, Christine Vogeli, William H. Shrank, M. Alan Brookhart, and Joel S. Weissman. "Primary Medication Non-Adherence: Analysis of 195,930 Electronic Prescriptions." Journal of General Internal Medicine. February 04, 2010. Accessed July 11, 2018. https://link.springer.com/article/10.1007/s11606-010-1253-9.

However, it is important to note that most prescriptions in workers' compensation are for pain medications, and patient compliance in filling prescriptions is of less concern here than in other sectors of the health care field. Furthermore, the concept of adherence in the literature is loosely defined and is highly dependent upon the criteria specific to a given research study. Adherence reflects a multitude of practices, from over-use, under-use, discontinued-use, or other forms of mis-use altogether. Therefore, a catch-all statement regarding the advantages of physician dispensing for medication adherence does not yield meaningful insights on the relationship between physician dispensing, appropriate medication use, and the achievement of desired health outcomes.

Proponents	Opponents
• Physician dispensing ensures medication initiation, adherence, and compliance. • Point-of-care access to medications reduces geographic barriers in remote areas. • Ability to obtain medications at the point-of-care increases patient satisfaction. • Reduction in overhead costs, reduced need to communicate with pharmacies. • Reduced likelihood of communication errors due to decreased need to relay information to pharmacies. • Vital source of extra revenue.	• Overpriced medications when dispensed by physicians rather than pharmacies drive prescription costs. • Increased likelihood that over the counter medications will be prescribed at a higher cost under physician dispensing. [5] • Physician dispensing circumvents public health surveillance systems that rely on centralization of prescription data. • Physician dispensing undermines mechanisms designed to identify drug safety issues, narcotics abuse or diversion, and duplicate therapies. [6]

PHYSICIAN DISPENSING DRIVES COSTS

Repackaging

While the practice of physician dispensing is not new, the recent emergence of repackaging is. Over the last two decades, the drugs repackaging industry has grown to become a major contributor to the growing costs of prescription drug treatments, particularly within the Workers' Compensation industry. According to a WCRI study published in 2012, over 50% of Workers' Compensation prescription drug costs in states such as Illinois and Florida were attributable to physician-dispensed repackaged drugs, and the increases have been growing well over 10% year over year.[7]

[5] Wang, Dongchun, Te-Chun Liu, and Vennela Thumula. "The Prevalence and Costs of Physician-Dispensed Drugs." WCRI. September 2013. Accessed July 11, 2018. https://www.wcrinet.org/reports/the-prevalence-and-costs-of-physician-dispensed-drugs.
[6] Bao, Yuhua, Yijun Pan, Aryn Taylor, Sharmini Radakrishnan, Feijun Luo, Harold Alan Pincus, and Bruce R. Schackman. "Prescription Drug Monitoring Programs Are Associated With Sustained Reductions In Opioid Prescribing By Physicians." Health Affairs 35, no. 6 (June 1, 2016): 1045-051. doi:10.1377/hlthaff.2015.1673.

[7] Wang, Dongchun. "Physician Dispensing in Workers' Compensation." WCRI. July 2012. Accessed July 11, 2018. https://www.wcrinet.org/reports/physician-dispensing-in-workers-compensation.
[8] Ibid
[9]"Coventry Solutions: 2017 Drug Trend Series Part 2 Assessing Managed vs. Unmanaged Utilization." Coventry. June 2018. Accessed July 11, 2018. https://coventrywcs.com/content/dam/pdf_assets/drug_trends/2017-report/DrugTrendsSeries-Part2-Managed-Unmanaged-Views-20180626.pdf.

Repackaging is a practice by which a procured drug product is taken from its original container and placed in a different container and given a new label, without manipulating or otherwise altering the drug itself. Repackaging can be done for a variety of reasons: for convenience, reducing medication errors, or redistributing bulk medication into individualized tubes or packages. Until recent state pricing reforms, repackaging was a common method employed by physicians to obtain higher reimbursement rates for drugs that are prescribed in-office under a new National Drug Code (NDC) that has higher reimbursement rates than pharmacies. This was due to lack of regulations requiring that repackaged drugs be reimbursed according to the average wholesale price (AWP) of the original drug used in the repackaging process.

Studies have shown that medications prescribed under physician dispensing are often more expensive when compared to the pricing of the same drug at a pharmacy due to repackaging.[8] The difference in pricing has been gradually increasing in tandem with growth in the practice of physician dispensing and repackaging overall.

Case Study:
A recent report published by Coventry notes that high-dollar, private-label topical analgesics marketed directly to physicians' offices are contributing to a significant rise in unmanaged topical utilization per claim, making it the highest ranking in overall cost. This rise remains unchecked since physician dispensing evades the traditional cost-containment scrutiny that pharmacy benefits managers provide.[9]

Unmanaged Prescriptions

Unmanaged prescriptions are medications prescribed outside of traditional and mail order pharmacies, or outside of traditionally negotiated networks. Most of the unmanaged prescriptions filled are the first and only prescriptions for injured workers. The fact that there is a disproportionate amount of unmanaged prescription within workers compensation highlights the financial vulnerability that workers' compensation systems bear when it comes to physician dispensing. Additionally, physician dispensing is a significant cost contributor specifically for the following reasons:

- Physician dispensing bypasses the traditional cost and utilization controls applied by networks that make up pharmacy benefits managers before prescriptions are dispensed.
- Physician dispensing as a practice does not employ rigorous formulary enforcement, thus decreasing generic efficiency which can be a significant driver of cost.
- Physician dispensing does not allow for the necessary data-sharing systems in which pharmacy benefits managers have in place to be used to track data associated with various injured worker populations. This can have wide ranging implications in utilization cost as well as health outcomes (which can ultimately lead to greater costs).

According to the WCRI and the NCCI, physician dispensing accounts for numerous significant price discrepancies for commonly prescribed medications. A few examples of this, using data from 2010-2011, include:

Hydrocodone-Acetaminophen (Vicodin ®): among states that physician dispensing accounted for more than 20% of all prescriptions, pre-reform data by the WCRI indicates that the average price per pill paid for Vicodin in physician dispensing was 100-300% higher than the price per pill paid for the same drug

dispensed by pharmacies. When pricing reforms occurred in numerous states, the figure ranges from 19% in California to 67% in Georgia.

- **Meloxicam (Mobic ®)**: in several states where physician dispensing was common, the average price per pill paid to physicians was between $4 and $8, which was approximately 40% to 220% higher than the average price per pill paid to pharmacies. Furthermore, there is a lack of medical evidence suggesting that Meloxicam is more effective than ibuprofen, which is cheaper in comparison. The higher cost of meloxicam when dispensed by physician is suspected to be the reason why states with high growth of physician dispensing such as Illinois sees a large proportion of its total prescription of meloxicam coming from physician offices. For Illinois, 80% of all meloxicam prescriptions were dispensed by physicians during the study period.

- **Ibuprofen (Motrin ®)**: the price discrepancy for physician dispensed ibuprofen ranges from a 40% increase in Indiana to a 215% increase in Pennsylvania.

The large premiums for physician dispensed drugs seen between 2010 and 2013 propelled some of the reforms outlined in this report. The strongest evidence that physician dispensing drives avoidable prescription costs lies in analysis of drugs that are largely only prescribed when physician dispensed and far more rarely prescribed when not dispensed by a physician. This further supports the hypothesis that the practice of physician dispensing may be prone to influencing prescribing patterns based on profitability more than clinical indications.

Case Study:
Among states where physician dispensing was common prior to reforms (Florida, Georgia, Illinois, and Maryland), 8-11% of injured workers were prescribed either omeprazole or ranitidine HCL (Zantac ®) or both. The average prices per pill under physician dispensing in these four states are much higher than that paid to pharmacies, often nearly twice as high. The two medications are rarely prescribed in states where physician dispensing is less common.[10]

PUBLIC HEALTH IMPACTS OF PHYSICIAN DISPENSING

Recent transformation in healthcare information technology systems and infrastructures brought on by Meaningful Use initiatives have accelerated the adoption of electronic health records and prescriptions systems. The transformation has unlocked information from paper records, allowing for more robust data transfer to support coordinated service delivery and public health surveillance. Despite such efforts, however, multiple medication prescription systems lack the needed interoperability to communicate with one another, thus undermining the potential benefits that come with the digitalization.

From an infrastructure point of view, physician dispensing prohibits rigorous public health surveillance and monitoring of medication usage as well as drug-drug interactions due to the fact that data within each individual physician offices are often kept in their respective silos. The transfer of data during billing processes provide little

[10] Wang, Dongchun. "Physician Dispensing in Workers' Compensation." WCRI. July 2012. Accessed July 11, 2018. https://www.wcrinet.org/reports/physician-dispensing-in-workers-compensation.

benefits to patients since medications would have already been prescribed, and each office have no access nor visibility into the interactions a patient may have with other providers. Pharmacies, however, do have the ability to provide medication oversight and utilization reviews given their one-to-many relationships with multiple providers who may be serving the same patient at the same time. This visibility into patients' entire continuum of care puts pharmacies in a unique position to monitor for possible drug interactions and detect any potential medication abuses. Additionally, due to higher patient volumes compared to physician offices, pharmacies are better able to track and provide population-level data on medication prescription patterns and use, which are critical for health policy planning and public health surveillance.

Physician Dispensing and Opioid Use

The opioid epidemic in the United States has called into question an array of common prescribing practices and highlighted the need for more robust surveillance of opioid use and abuse. The Centers for Disease Control estimates that nearly half of all annual opioid overdose deaths involve a prescribed opioid.[11] Recent changes in clinical guidelines have resulted in further discouragement of opioid prescription and stricter prescription guidance. The extent to which the new guidelines are being followed, however, is unclear.

The Centers for Disease Control estimates that nearly half of all annual opioid overdose deaths involve a prescribed opioid.

Under the Controlled Substance Act of 1970, the manufacture, distribution, possession and use of opioids are regulated under various classifications depending on medical uses and potential for abuse. Of the five substance schedules, V being the lowest threat for abuse and I being illegal with high abuse potential and no medicinal properties, opioids largely fall under schedules II and III. Prescription for schedule II drugs require a signature of the practitioner and are not eligible for refills, while prescriptions for schedule III medications may be refilled up to five times in six months.

Within the realm of workers' compensation, physician-dispensed opioids are of particular concern due to the nature of chief complaints in which workers often report. According to a study conducted by the National Council on Compensation Insurance (NCCI) conducted in 2016, opioids such as Oxycontin and Oxycodone-Acetaminophen (Percocet), were among the most widely prescribed drugs in workers compensation in 2014.[7] During that same year, data from the WCRI indicated that physician-dispensed drugs and controlled substances both grew faster than any other prescription drugs.[8]

Recent regulations and reforms by states have increasingly targeted the practice of physician-dispensing of opioids. While longitudinal data on the effectiveness of such reforms are lacking due to the relative immaturity of the regulations, states have seen a change in prescribing patterns overall which points to the fact that pre-reform prescription of opioids may not be due to medical necessity alone.

Florida's decision to prohibit physician dispensing of Schedule II and III substances altogether in 2011 represent the most restrictive policies on this matter. Studies conducted after Florida's ban have shown that the number of prescriptions for controlled substances declined in tandem with the abolishment of opioids dispensing. This further

[11] "Opioid Overdose." Centers for Disease Control and Prevention. October 23, 2017. Accessed July 11, 2018. https://www.cdc.gov/drugoverdose/index.html.
[7] Lipton, Barry, and David Colon. "Workers' Compensation and Prescription Drugs: 2016 Update." National Council on Compensation Insurance (NCCI). September 2016. Accessed July 11, 2018. https://www.azica.gov/sites/default/files/media/NCCI ResearchBrief WC Prescription Drugs 2016.pdf.
[8] Thumula, Vennela. "The Impact of Physician Dispensing on Opioid Use." WCRI. December 2014. Accessed July 11, 2018. https://www.wcrinet.org/reports/the-impact-of-physician-dispensing-on-opioid-use.

supports the notion that prescriptions written for controlled substances as part of physician dispensing prior to the ban may have been motivated by the higher reimbursement prices rather than true clinical justifications.

Drug Monitoring Programs and Physician Dispensing

One of the most effective and sustainable ways of curbing opioids abuse is the enforcement of drug monitoring programs, which are statewide databases that gather information from pharmacies on dispensed prescriptions of controlled substances. The database is used by prescribers, pharmacists, law enforcement agencies and medical licensure boards. All states except Missouri have either implemented or recently upgraded their prescription drug monitoring programs or enacted legislations to do so. The practice of physician-dispensing, however, undercuts the ability of drug monitoring programs' to efficiently and effectively carry out their function in a number of ways:

- Physician dispensing reinforces the fragmented nature of medication prescription without coordination among providers. This encourages the practice of "doctor shopping" whereby opioids abusers visit multiple providers to obtain prescriptions. The issue of doctor shopping cannot be addressed without systematic implementation of prescription databases that every physician office utilizes to verify the medication records of every patient. In light of the widespread lack of interoperability in healthcare in general, this approach is currently not feasible for every single physician dispensing practice to employ today.
- Physician dispensing provides instant access to opioids, thus circumventing many of the surveillance and review mechanisms that drug monitory programs put in place, rendering them useless as tools to actively combat opioids abuse.
- Without the need to prescribe medications outside of the office, there is little to no incentive for providers to send data into a centralized resource such as drug monitoring programs. Prohibiting physicians from dispensing opioids would mean that a centralized source such as pharmacies will receive prescription information, which allows for tracking in real-time for utilization review and surveillance purposes.

Opioids Prescription and Duration of Temporary Disability

In addition to concerns regarding abuses related to physician-dispensed opioids, the practice may also have implications on the duration of temporary disability benefits among workers. The WCRI recently published a report in 2018 which contains a finding that extensive opioid prescriptions lead to longer duration of temporary disability benefits. In fact, when compared to no opioid prescriptions, the WCRI found that the duration of temporary disability benefits triples when the supply of opioids prescribed exceeds the first three months of injury. Little evidence exists of this effect for when a small number of opioid prescription over a short period of time was prescribed. The study accounted for variation in severity of conditions and other behaviors affecting disability duration through usage of estimation of local opioid prescribing patterns to yield variations among workers included in the study.[9] Allowing physicians to dispense opioids without utilization reviews may further contribute to this effect since the practice has been shown to encourage opioids prescription with little to no oversight.

Extensive opioid prescriptions lead to longer duration of temporary disability benefits. Physician dispensing has been shown to encourage opioids prescription with little to no oversight.

Considering recent reforms, research that specifically addresses the causes and effects of physician dispensing and opioids use are slowly coming to light, and the increasing

[9] Savych, Bogdan, David Neumark, and Randall Lea. "The Impact of Opioid Prescriptions on Duration of Temporary Disability." WCRI, March 2018. doi:10.3386/w24528.

availability of longitudinal data will allow for stronger causal analysis. It is important to note, however, that opioid use and physician dispensing is a conversation that extends beyond reimbursement prices alone, but also includes aspects such as duration of use, potential for abuse, and other public health implications overall.

REGULATORY APPROACHES TO PHYSICIAN DISPENSING

Recent reforms by states have sought to either prohibit the practice of physician dispensing entirely or target various components pertaining to the practice. Several mechanisms are employed, and they are as follows:

Pricing reforms and regulations

- Parity in fee schedules between pharmacies and physician dispensaries, often determined by the average wholesale price (AWP).
- Given that repackaged drugs are frequently given a new National Drug Code (NDC) and therefore can be billed outside of existing fee-schedules, certain states have required that repackaged medication be billed under the original manufacturer's NDC, which prevents the inflation of prices of the same drugs under different fee schedules.
- States prohibit doctors from collecting dispensing fees, which is commonly found as part of the fee schedule for drugs dispensed at pharmacies.

Licensing and reporting requirements

- Through the use of Medical Boards and Boards of Pharmacies, many states require that physicians obtain a license and pay the associated administrative fee to dispense out of their offices.
- States have also required that physician dispensaries report the purchase price of drugs dispensed to keep track of pricing markups that may be substantially higher in physician dispensing compared to pharmacies.
- The Drug Enforcement Agency (DEA) also has registration and licensing requirements for dispensing physicians who prescribe controlled substances on-site.

Regulations of supply and dosages

- Certain states have placed prohibitions or restrictions on physician dispensing for medications that are prone to abuse such as controlled substances.
- In instances in which medications are allowed to be dispensed by the physician, restrictions on dosage and length of supply have been implemented by numerous states with the intent to provide immediate medication initiation but will only allow the prescribed supply to last until the patient can get to a pharmacy (e.g. 48-hour or 72-hour supply).
- Another form of restriction in supply is where states prohibit physicians from dispensing medications in general unless it is in an emergency, or if the patient lives in a rural area where it is not practical to have medication dispensed from a pharmacy.

Restrictions on credentials of those allowed to dispense medications

- Certain states require that only licensed Medical Doctors (MDs) are able to dispense medications, while others allow Physician Assistants (PAs) and Nurse Practitioners (NPs) to do so.
- For states where mid-level practitioners are able to dispense medications, there is a wide variation in the categories of medications the practitioners are allowed to expense, with the most restrictive group being controlled substances.

Among states that allow physician dispensing, regulations are increasingly extending beyond pricing controls to include restrictions on the types and dosages of drugs that physicians can describe. As the clinical authority for

mid-level health professional grows due to increasing task-shifting away from medical doctors to PAs and NPs, regulations pertaining to physician dispensing is slowly expanding to incorporate such trend as well.

REGULATION BREAKDOWNS BY STATE

State	Prohibition	Regulation						
		Pricing			Licensing	Supply	Credentials	
	Strict prohibition or limitation	Base on AWP of original manufacturers' NDC or pharmacy	Require explicit original NDC on bills for repackaged medications	Prohibit dispensing fee for physician dispensed medications	Require dispensing physicians to secure permit or license	Explicit restrictions on supply or drug types	PAs	NPs
AL			X	X	X			
AK		X	X				X	X
AZ		X	X		X		X	X
AR				X	X			
CA		X	X				X	X
CO			X			X	X	
CT		X						
DE			X	X		X		
FL			X		X	X	X	X
GA		X	X				X	X
HI		X	X					
ID			X	X			X	X
IL		X	X				X	X
IN			X			X	X	X
IA					X		X	X
KS			X					
KY			X	X		X		X
LA	X				X	X		X
ME							X	X
MD					X		X	X
MA	X				X	X		
MI		X	X		X		X	X
MN	X				X		X	X
MS			X	X			X	X
MO					X		X	X
MT	X						X	X
NE					X			X
NV			X		X	X	X	X
NH							X	X

NJ	X					X		X
NM		X		X		X	X	X
NY			X			X	X	X
NC			X		X	X	X	X
ND							X	X
OH			X	X	X			
OK			X	X	X			
OR	X				X	X		X
PA			X			X	X	
RI		X					X	X
SC		X	X		X		X	X
SD					X		X	X
TN	X	X	X	X		X	X	X
TX	X					X		
UT	X					X		
VT							X	X
VA	X				X			
WA		X					X	X
WV					X	X	X	X
WI				X				
WY					X		X	X

* Data regarding pricing, licensing, and supply is valid as of 2017, data regarding credentials is valid as of 2013.
This summary is intended as a guide for research purposes only and does not constitute a legal opinion. It represents best knowledge at time of data collection.

States with the strictest physician dispensing regulations include, but are not limited to: Louisiana, Massachusetts, Minnesota, Montana, New Jersey, Texas, Utah, and Virginia. Among these, Utah only allows physicians to dispense certain drugs at an employer-sponsored clinic, and Texas will only allow dispensing to meet patients' immediate needs or in rural areas. Massachusetts only permits dispensing of drug samples. Montana and New Jersey prohibit physician dispensing with exceptions for very limited circumstances such as pharmacy availability, and Louisiana and Virginia have strict licensure requirements.

Regulations of supply duration, particularly for controlled substances, are also commonly found with states such as Indiana, Kentucky, Louisiana, North Carolina, New Jersey, New Mexico, Nevada, New York, and Oregon only allow 2 to 15-day supply. Florida prohibits physicians from dispensing Schedule II and III controlled substances in all instances.

Among states that allow some level of dispensing by mid-level health professionals (PAs and NPs), regulations range from extremely limited authorization specific to certain drug classes and situations to broader authorizations. Several examples of restrictions pertaining to dispensing for PAs and NPs include, but are not limited to:

- Licenses that are tied to the practitioner and therefore each dispensing PAs or NPs must obtain such license.
- Supervising MD needed, unless specific authorizations have been made by the Medical Board or Board of Pharmacy.

- Mid-level clinicians only be allowed to dispense medications in instances where pharmacy services are not reasonably available or when such practice is in the best interest of patients—profits cannot be made.
- Specific supply duration and dosages only.

LESSONS LEARNED FROM OTHER STATES

Comparisons pre- and post-reforms

In response to rising prescription drug prices in physician dispensing, 21 states have passed regulations pertaining to physician dispensing between 2007 and 2014. California, Arizona, Georgia, South Carolina, Tennessee, and Pennsylvania have implemented reforms aimed at price reduction by requiring the same fee schedule to be used between pharmacies and physician dispensaries. Other states allow for reimbursement at higher AWPs but limit or prohibit the collection of dispensing fees. Given the years that have passed since these reforms were implemented, empirical evidence regarding their effects on pre- and post-reform costs are slowly emerging.

California

In 2007, California implemented a reform which required that fee schedules for physician dispensed drugs be based on the original manufacturers' NDC, the rule that was already in place for pharmacies. Arizona, Georgia, South Carolina, and Tennessee soon adopted California's policy in the following years. Several conclusions from research conducted on the effect of California's reform shows that:

- Price reduction did not result in lower prescription, as cited as a concern of the reform. This indicates that patients' access to medications at physician offices was not interrupted, as clinicians were equally inclined to prescribe under the adjusted fee schedule.
- Less repackaged drugs were dispensed, and cheaper, non-repackaged drugs were dispensed instead when physicians are paid the same prices as pharmacies.
- There was a decrease in the frequencies of prescriptions for drugs associated with higher than usual reimbursement prices under physician dispensing when parity between physician dispensing and pharmacies' fee schedules was achieved.
- In instances where some physicians stop dispensing in response to large price reduction, pharmacies were able to dispense the same prescriptions at a lower price compared to the price under physician dispensing.[10]

Florida

A provision of Senate Bill 662 in the State of Florida became effective on July 1, 2013 and requires that all repackaged medications dispensed at physician offices be reimbursed at 112.5% of the AWP as determined by the original manufacturer's NDC, plus an $8 dispensing fee. Florida also has explicit prohibition on physician dispensing of Schedule II and III controlled substances that have been in place since 2011. The reform had little impact on whether or not physician dispensing was practiced but did cause a decline in the number of prescriptions dispensed by physicians in the state. Other findings post-reform show that:

- Several common drugs prescribed under physician dispensing saw a 19-41% decline in pricing even though prices paid to pharmacies remained relatively constant or increased.

[10] Wang, Dongchun, Te-Chun Liu, and Vennela Thumula. "Are Physician Dispensing Reforms Sustainable?." WCRI. January 2015. Accessed July 11, 2018. https://www.wcrinet.org/reports/are-physician-dispensing-reforms-sustainable.

- New strength products at higher prices were introduced into the state, and physicians were prescribing them at greater frequencies, leading to a sharp increase in prescription costs of two of the most common physician-dispensed drugs. The average price per pill paid for the new dosages more than double the prices of that with existing strengths.
- The reduction in prices of existing medications were not able to offset the higher prices of newer dosages for the same medications that were introduced to the market.
    - 4 of the top 10 most frequently dispensed drug which made up 16% of the total physician dispensed prescriptions saw a 19-41% decline in price. This, however, was offset by a 63-66% increase in prices of 2 medications that made up 24% of the total physician dispensed prescriptions.
- The 112.5% of AWP allowance, plus an $8 dispensing fee of the reform may have contributed to pricing increase since several medications were priced closer to the AWP pre-reform.
- The AWP for certain generic prices did undergo an increase in recent years.[11]

DISCUSSION

Despite numerous reforms by states, cost remains a major issue since the share of cost associated with physician-dispensed medications still reflect elevated pricing compared to medications dispensed by pharmacies. Cost-focused regulations by states in general are shown to only be effective for a short period of time immediately following implementation. The lack of rigor in reform efforts have left loopholes that allow interest groups to take advantage of, rendering many of the pricing control mechanisms obsolete.

The justification for physician dispensing is strongest in scenarios where timely and adequate access to medications are issues that need to be addressed. This is particularly true for patients in remote areas where distance to the closest pharmacies remain a barrier to proper healthcare. With the exception of rural providers, the argument that physician dispensing provides timely access and initiation to medications remain problematic due to the lack of evidence which shows physician-dispensed medications provide better health outcomes compared to pharmacy-dispensed drugs.

With regards to workers' compensation groups specifically, assertions that the benefits of physician dispensing in medication initiation and adherence may not apply due to the nature of the claims being that of injuries requiring pain medications. It is evident that the practice of physician dispensing can reinforce the existing system of fragmented and uncoordinated care which fuel the growth in opioids use and epidemic. Drug monitoring programs have been shown to sustainably curb access to opioids, but such program relies upon centralization entities such as insurance and pharmacies to pool information into an interoperable system. At present day, most physician offices do not possess the capability to interoperate data the same way these entities do.

The fiscal and public health implications of physician dispensing warrant thorough analyses and weighing of potential benefits of convenience with the need for surveillance and review. The high percentage of opioids prescription in workers' compensation programs introduces a unique set of considerations beyond cost alone. Lessons learned from states that have implemented reforms earlier on such as Florida, California, and Illinois should be incorporated to inform further regulatory efforts in comprehensively addressing both the cost-implications of physician dispensing as well as the public health impact in the in workers' compensation groups.

[11] Wang, Dongchun, Te-Chun Liu, and Vennela Thumula. "Early Impact of Florida Reforms on Physician Dispensing." WCRI. July 2016. Accessed July 11, 2018. https://www.wcrinet.org/reports/early-impact-of-florida-reforms-on-physician-dispensing.

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