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Formulary wave challenges comp payers

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Workers compensation payers welcome the expanding trend of states adopting prescription drug formularies for their comp systems, but are challenged by sometimes stark differences among the states in the makeup of the formularies and enforcement of their provisions.

Many workers compensation payers have had drug formularies in place for several years, but state-required formularies add legal muscle to what medications can be prescribed or denied to injured workers.

With 12 states already having a legislation-mandated formulary and three where one is pending or in development, the trend is keeping pharmacy benefits managers and other stakeholders busy understanding the intricacies of the formularies.

“The state initiatives are helpful, but PBMs are having to build to those specs, which is putting a burden on them,” said Dr. Paul Peak, Memphis, Tennessee-based assistant vice president of clinical pharmacy at Sedgwick Claims Management Services Inc.

Adding to the task of understanding individual state nuances, as many as 30 states have some version of treatment guidelines for their comp systems and various states have laws that put restrictions on opioid prescribing for all doctors, according to Craig Prince, a Thornton, Pennsylvania-based pharmacist working for Coventry Workers Comp.

Pennsylvania, for example, doesn’t have a workers comp formulary in place but now limits opioid prescribing to seven days on the first fill. Only 11 states have no drug regulations affecting workers comp, while every other state has some regulation or set of guidelines that PBMs and others have to understand and manage, according to a tally by Mr. Prince.

Simplifying the process for introducing regulations, most of the 12 states whose legislators voted to create a formulary have adopted an Official Disability Guidelines drug list developed by an outside firm with Austin, Texas-based MCG Health LLC — which says its drug list combines evidence-based medicine with claims data analytics to create its list of appropriate drugs — being the most common across the states, according to experts.

Meanwhile, some states adopted guidelines published by the American College of Occupational and Environmental Medicine while some states have combined ACOEM and ODG guidelines.

California — dubbed by experts as the most robust and comprehensive of the state formularies — created its formulary based on ACOEM guidelines with enhancements such as the medical treatment utilization schedule, which instead of just a yes-or-no drug list uses injury guidelines to match ailments with appropriate drugs. That formulary is now in its second year.

While states using the ODG guidelines use the term “nonpreferred” for drugs deemed ineffective or not appropriate, California labels those drugs as “nonexempt” if they are not listed as a proven treatment for an injury. All opioids are listed as nonexempt, subjecting doctors and injured workers to an oversight process for all such pain medications outside of the first emergency fill.

Adding to the challenge for payers, and the PBMs that oversee the drug programs, are the different ways states enforce their formularies, and how injured workers and their providers can override the system for drugs that are not approved by turning to medical reviews.

For example, California itself oversees the utilization review process while other states such as Indiana, which launched its ODG-developed formulary on Jan. 1, give payers the option to override the drug restrictions, and appeals go to an independent medical review if necessary.

Linda Hamilton, Indianapolis-based chairwoman of the Indiana Workers’ Compensation Board, attributed the state’s approach to a manpower issue because the office that regulates workers comp for the state has 26 staff members.

“Other states that have done this have a lot more details than Indiana; Indiana keeps things simple,” she said. “We can’t afford to be super-detailed and high on regulations (because) we are a very small agency.” Meanwhile, Arkansas sends exemptions to a pharmacist for approval outside of the formulary, said Mr. Prince.

Different professionals have different perspectives on introducing and managing a state-mandated formulary, said Silvia Sacalis, a Tampa, Florida-based licensed pharmacist and vice president of clinical services for Healthesystems LLC, adding that she’s a proponent of state formularies.

“Each one has the right intentions. It’s just a matter of how detailed and descriptive the (formularies) are.”

For states deciding on formularies and enforcement, “it has to do with what kind of administrative burden they want to put on themselves,” said Dr. Peak. “There might be a more comprehensive process, (and) it depends on what level of comfort that state has in taking that on,” he said.

Simple drug lists likely would not work because it’s what payers previously had in place for years, Dr. Peak said. “If you don’t have a way to enforce it or do it the right way, then the formulary doesn’t mean that much,” he said.