

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR 436-009, Oregon Medical Fee and Payment

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Dec. 6, 2016, 8:30 a.m. to 10:30 a.m., Pacific Standard Time Labor & Industries Building, Room F (basement) 350 Winter Street NE, Salem, Oregon Teleconference: 1-213-787-0529 Access code: 9221262#
Facilitator:	Fred Bruyns, Workers' Compensation Division
8:30 to 8:40	Welcome and introductions; meeting objectives
8:40 to 10:25	Discussion of issue
10:25 to 10:30	Summing up – next steps – thank you!

Attached: [Issue document](#)
[Letter of advice from Sedgwick CMS](#)

**Oregon Administrative Rule Revision
Chapter 436, Divisions 009 and 010**

Issue # 417

Rule: OAR 436-009-0090

Issue: Should WCD develop rule language relating to insurers' use of pharmacy benefit managers (PBMs)?

Background:

- A stakeholder asked the division to bring this issue up at the next advisory committee.
- The stakeholder explained that PBMs essentially provide a worker with a pharmacy card which allows access to direct billing of medications at participating dispensaries.
- The stakeholder opined that the programs are generally beneficial for workers since most medications are dispensed without the need for "approvals," however, the problem he sees is with medications classified as "non-formulary," such as narcotics.
- Overall, PBMs seem to have a positive impact on the workers' comp system. It appears easier for workers to receive many prescribed medications without having to pay for them out-of-pocket and then request reimbursement from the insurer. Pharmacies are used to interacting with PBMs in private health.
- The division does not have direct jurisdiction over PBMs; rather, the division regulates insurers, and PBMs are viewed as an extension of the insurer.

Options:

- Add language to OAR 436-009-0090 relating to insurers' use of PBMs.
- No change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Recommendations:

WCD Rulemaking Advisory Committee
OAR 436-009 & OAR 436-010
November 17, 2016

Larry Bishop, Technical Standards & Compliance Consultant
Sedgwick CMS

In the United States, a pharmacy benefit manager (PBM) is a third-party administrator (TPA) of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.

PBMs are now offered by claims administrators to their employer/clients. PBM programs have been available for Sedgwick clients for about ten years.

PBM programs identify “non-formulary” medications. They include medications such as opioids and medications not typically prescribed for the accepted medical condition. At the point of service, non-formulary medications are submitted by the pharmacy through the PBM to the claims administrator for “approval or denial”. This process involves PBMs submitting requests for approval to claims handlers through email. In most cases, the review/approval protocol includes escalations to another examiner if a response is not received within a specified time-frame.

We raised this issue with MRT because of a dispute and an accompanying request for sanctions filed by a worker’s attorney. The dispute involved a “denied” authorization request. In this case, the worker had a PBM card. Following surgery on a Friday, the worker was released from the hospital that evening. An opioid was prescribed, which the worker elected to fill at the hospital pharmacy. The medication triggered the “non-formulary” review and approval process. However, the email requesting approval was received after the office had closed that evening. Escalations occurred during the weekend, again while the office was closed. An approval was finally provided on the next business day following the weekend. However, because there was no approval at the point of service, the hospital made an exception to their general practice and elected to bill the prescription to our office rather than have the worker pay for the medication out-of-pocket.

This particular dispute was resolved through a stipulation. As a result, the matter was not forwarded to the Sanctions Unit. It was felt that the question of the appropriateness of PBM requests for approval of non-formulary medications might be best resolved through discussion and clarification of the rules.

BM programs offer definite advantages for workers, since the majority of medications are automatically approved at the point of service, and the cost of the medication is charged directly to the worker’s claim. Workers are not burdened by paying for medications out-of-pocket and later requesting reimbursement. We definitely feel that the concept is worthy of support. However, the question remains whether administrative rules allow for review and approval of any medications.

I was able to identify two administrative rules addressing approval of prescription medications:

436-009-0090 Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

436-010-0230 Medical Services and Treatment Guidelines

(11) Prescription Medication.

(a) Unless otherwise provided by an MCO contract, **prescription medications do not require prior approval even after the worker is medically stationary.** For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available) according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must pay the total cost of the brand-name drug out-of-pocket and request reimbursement from the insurer. However, if the insurer has previously notified the worker that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug. Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker, up to a maximum of 10 days. Unless otherwise provided by an MCO contract, the worker may choose the dispensing provider.

(b) Providers should review and are encouraged to adhere to the workers' compensation division's opioid guidelines. See <http://www.cbs.state.or.us/wcd/rdrs/mru/ogandcal.html>.

Both rules specify that prescription medications do not require approval.

The question we would like to consider is whether it is, or should be permissible for PBM programs to require approval of any class of medications, as the current rules appear not to allow the practice.

Possible options to consider:

1. Determine that PBMs are not appropriate, based on the two current rules cited.
2. Clarify that PBM programs may no longer require administrative approval for blocked non-formulary medications, i.e. allow all medications to be filled at the point of service.
3. Allow non-formulary blocks to require administrative approval, i.e. allow the programs to operate as they currently do, with a specified time-frame for response to requests for approval.

It is rare for an examiner not to approve opioids prescribed for an accepted condition. The issue is the delay a worker may encounter when a request for approval is made at a time when claims handlers are unavailable to review the request.