RULE 099.41. ARKANSAS WORKERS' COMPENSATION DRUG FORMULARY

TABLE OF CONTENTS

Part I. General Provisions

Pursuant to Ark. Code Ann. 11-9-517 (Repl. 1996) and Commission Rule 099.02 (Effective March 1, 1982) the following rule is hereby established in order to implement a workers' compensation Drug Formulary.

A. Scope.

1. This rule does all the following:

(a) Adopts by reference as part of this rule the Public Employee Claims Division (PECD) Workers' Compensation Drug Formulary, which is maintained and updated by UAMS College of Pharmacy Evidence Based Prescription Program and any amendments to that formulary.

(b) Establishes that all Opioid prescriptions shall have a 90 MED per day limit for five days for the initial prescription with a 90-day maximum duration period.

(c) Establishes the effective date for implementation of Rule 099.41.

(d) Establishes procedures by which all payors shall have on staff a Pharmacist and Physician or Medical Director or shall contract with a PBM, who has a Pharmacist and a Physician or Medical Director on staff or has contracted with a Pharmacist and a Physician or Medical Director.

(e) Establishes a procedure for pharmacists filling workers' compensation prescriptions.

(f) Provides for the certification of all payors, determined to be in compliance with the criteria and standards established by this rule. (See Part II. A for Certification requirements.)

(g) Provides for the implementation of Medical Cost Containment Division (MCCD) review and decision making responsibility. The rule and definitions are not intended to supersede or modify the workers' compensation laws, the administrative rules of the Commission, or court decisions interpreting the laws or the Commission's administrative rules.

(h) Provides for the right to appeal from the MCCD to an Administrative Law Judge.

(i) Provides requirements in order for payors to be held responsible for payment of FDA

approved Opioid medications.

B. Definitions.

As used in this rule:

1. "Administrator" means the Administrator of the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission or his/her designee.
2. "Day" means calendar day.
3. "Dispute" means a disagreement between a payor, pharmacists, provider, or claimant, regarding this rule.
4. "Filling Pharmacist" is a pharmacist filling a prescription for medication.
5. "Medical Director" is a physician that is on staff or is contracted with either a PBM or the payor of the worker's compensation claim.
6. "Outpatient service" means a service provided by the following but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and free-standing surgical outpatient facilities.
7. "Payor" is a self-insured entity, third party administrator or insurance carrier which pays workers' compensation benefits.
8. "Reviewing Pharmacist" is an individual with a Doctorate in pharmacy or a Bachelor's degree in pharmacy contracted with or on staff with a Payor or Pharmacy Benefit Manager.
9. "Pharmacy Benefit Manager" (PBM) is a third-party administrator (TPA) of prescription drug programs.
10. "Provider" means a facility, health care organization, or a practitioner.
11. "MED" means Morphine Equivalent Dose Per Day.

Part II. Process for Requiring all Payors to contract with a Pharmacist and Physician or Medical Director or PBM who has contracted with a Pharmacist and Physician or Medical Director.

All payors shall have on staff or shall contract with a Pharmacist and Physician or Medical Director or PBM who has contracted with a Pharmacist and Physician or Medical Director or has a Pharmacist and Physician or Medical Director on staff. Certification requires the Payor to furnish the current name, license number, and address of their Pharmacist, PBM, and Physician or Medical Director to the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission and update this information when changes occur.

Part III. Opioid Medications

A. For workers' compensation injuries or illnesses with an incident date on or after September 1, 2017 payors will not be held financially responsible for payment for FDA approved Opioid medications in excess of 90 MED per day.

B. Prior to prescribing Opioid medications, physicians should check the Prescription Drug Monitoring Program (PDMP) database for the current controlled substances that the injured employee is taking in order to make informed decisions as to what medications to prescribe.

C. A Payor shall not be required to pay for more than five (5) days of medication for the first prescription of an Opioid medication. A Payor shall not be required to pay for

continuing an Opioid medication beyond the first five (5) day prescription unless all of the following requirements are met:

1. The medication is prescribed by an authorized treating physician; and
2. The medication is reasonable, necessary and related to the workers' compensation injury or illness; and
3. The provider prescribing the medication examines the injured employee in a follow-up visit and certifies that the medication taken so far is proving to be effective in treating the injured employee's injury or illness; and
4. The provider prescribing the medication certifies that continuing the Opioid medication therapy is medically necessary.
5. A Payor shall not be required to pay for continuing an Opioid medication beyond 90 days without certification of medical necessity by the authorized treating physician prescribing the medication.

Part IV. Process for Filling Workers' Compensation Prescriptions

A. Pharmacists filling a workers' compensation prescription must verify that the prescribed drug(s) are listed on the approved drug formulary.

B. If the prescribed drug(s) is not on the approved drug formulary, the pharmacist must contact the Payor for approval of the prescribed drug(s) and must consult with the Prescribing Physician before switching the medication to a formulary medication(s).

C. The filling pharmacist must abide by the rule requirements for prescribed Opioids for the Payor to be required to pay for the medication(s). (90 MED per day for five (5) days and a 90 day duration)

Part V. Process for Resolving Disputes Between Provider and Reviewing Pharmacist or PBM

When the Payor denies the medication and the injured employee, filling pharmacist, or prescribing physician insists on the medication that has been denied, a reconsideration may be made to the reviewing pharmacist on staff or contracted with the Payor or the Payor's PBM by submitting a Reconsideration Form. The Payor should promptly send a Reconsideration Form to the prescribing physician to complete and submit together with any supporting documentation to the reviewing Pharmacist. The reviewing Pharmacist shall have three (3) business days to consult with the Physician or Medical Director, if necessary, and to respond to the reconsideration request. If the reviewing Pharmacist does not respond within three (3) business days, the filling pharmacist may fill the prescription. If the reviewing Pharmacist denies the reconsideration request, an appeal may be made within 10 business days to the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission.

Part VI. Hearings

A. Administrative Review Procedure

An appeal may be made to the Administrator of the Medical Cost Containment Division by mail, fax, or email.

Administrator of the Medical Cost Containment Division

P.O. Box 950
Little Rock, AR 72203-0950
501-682-1790 fax
501-682-2747 fax
Phannah@awcc.state.ar.us

1. Appeals will be reviewed by the Medical Cost Containment Division and a determination will be issued within three (3) business days of receipt of the appeal and supporting documentation.
2. An appeal may be rejected if it does not contain the following information:
    (a) Injured employee name;
    (b) Date of birth of injured employee;
    (c) Social Security Number of injured employee;
    (d) Arkansas Workers' Compensation File Number;
    (e) Date of Injury;
    (f) Prescribing doctor's name;
    (g) Prescribing doctor's DEA number;
    (h) Name of drug and dosage;
    (i) Requestor's name (pharmacy or prescribing doctor);
    (j) Requestor's contact information;
    (k) A statement that the approval request for a prescribed drug(s) has been denied by the insurance carrier, accompanied by the denial letter if available;
    (l) A statement that the prior approval denial poses an unreasonable risk of a medical emergency and justification from a medical perspective such as withdrawal potential or other significant side effects or complications.
    (m) A statement that the potential medical emergency has been documented in the prior approval process.
    (n) A statement that the insurance carrier has been notified that a request for an expedited determination is being submitted to the Arkansas Workers' Compensation Commission; and
    (o) The signature of the requestor and the following certification by the requestor for paragraphs (g) to (o) of the above subsection, "I hereby certify under penalty of law that the previously listed conditions have been met."
3. An appeal determination shall be processed and approved or denied by the Administrator in accordance with this section. At the discretion of the Administrator, an incomplete appeal may be considered in accordance with this section.
4. A determination by the Administrator becomes final under the appeal process and shall be effective retroactively to the date of the original prescription.
5. Any party feeling aggrieved by the Order of the Administrator has the right to appeal the final decision of the Administrator to an Administrative Law Judge of the Arkansas Workers' Compensation Commission for an expedited hearing. The appeal must be made within 10 business days. The Administrative Law Judge shall have **two weeks from receipt of the appeal** to conduct an expedited hearing and render a decision.
The Notice of Appeal shall contain the following:
(a) A copy of the Administrator's Order appealed from;
(b) Copies of all materials submitted to the Administrator in the appeal proceedings.

Part VII. Rule Review

The Arkansas Workers' Compensation Commission encourages participation in the development of and changes to this Rule by all groups, associations, and the public. Any such group, association or other party desiring input or changes made to this Rule and associated schedules must make their recommendations, in writing to the Medical Cost Containment Administrator. After yearly analysis, the Commission may incorporate such recommended changes into this Rule.

Part VIII. Effective Date of Rule

This Rule is adopted for all prescriptions for workers' compensation claims with a date of injury on or after **September 1, 2017,** and applies to all FDA approved drugs that are prescribed and dispensed for outpatient use.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Workers' Compensation Commission

DIVISION Medical Cost Containment

PERSON COMPLETING THIS STATEMENT Barbara Webb

TELEPHONE 501-682-2510 **FAX** 501-682-2786 **EMAIL:** bwebb@awcc.state.ar.us

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Workers' Compensation Drug Formulary

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;
   NA

   (b) The reason for adoption of the more costly rule;
   NA

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;
   NA

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.
   NA

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ Unknown	$ Unknown

All entities involved in any workers' compensation claim filed after August 1, 2017. This would include pharmacists, dispensing physicians, treating physicians, claimants, carriers, and self-insured employers. It will affect reimbursement and the claims processing for all FDA approved prescription drugs.

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ Unknown	$ Unknown

We do not know how it will affect county and municipal governments but we do have information regarding state employees. Public Employee Claims implemented a drug formulary similar to this one a year ago and they have shown a cost savings with few requests for review of claims processed.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.