Summary of All Comments Received by the Arkansas Workers’ Compensation Commission Regarding Proposed Rule 099.41

1. Eddie Walker, Attorney At Law

Adopting the drug formulary is a good idea, but he believes that such a rule should be given a trial period so that any needed adjustments can be made prior to the actual adoption of the rule. Therefore he suggests that the proposed rule be specifically identified as an interim rule that is initially being considered on a trial basis and that a permanent rule will not be adopted until the effects of the interim rule are evaluated.

Secondly he has grave concerns about the 10 day appeal time. He does not believe that an injured worker that does not already have an attorney will be able to obtain one quickly enough to comply with such a short time frame. Especially since they will be looking for an attorney willing to represent them for free. Even if the attorney is to be paid, he does not know many attorneys who would be willing to agree to handle an appeal on such short notice.

He states that the Public Employee’s Claims Division stated they have had very few appeals as support that the program is good and he suggests that they may have had few appeals because the injured worker could not find an attorney to represent them or didn’t believe they could get a doctor to explain why the recommended treatment/prescription is appropriate. He says his experience has been that most physicians don’t like being second guessed by insurance companies, nurses, or pharmacists.

He says it appears the conditions to which the appealing party have to certify are unnecessarily onerous and place additional requirements on the treating physician which is likely to run more doctors out of the ranks of those who are willing to treat workers’ compensation injuries.

Also he says that since the implementation of a drug formulary will save Respondents a considerable amount of money, some provision for an attorney’s fee for an attorney who successfully represents an injured worker would be appropriate and suggests a flat fee of $500.00.

He proposes that attorneys are already donating a significant amount of time helping injured workers when respondents refuse to authorize medical treatment and now, they will be expected to donate even more time representing injured workers regarding disputes relative to prescription medications even though those prescriptions are coming from authorized treating physicians. He says this clearly creates an unfair situation for injured workers.

AGENCY RESPONSE - The Commission discussed the possibility of a trial period for this Rule but did not see any benefit, in view of the fact that the Public Employee Claims Division of the Arkansas Insurance Department has been using this drug formulary since November of 2015. The Commission also discussed the process and timeframe for appeals of denied medications and decided not to make any changes to the proposed rule. A short appeal time will allow the injured worker to obtain a resolution of the issue quickly. The Commission believes that any provision for an attorney’s fee will have to be addressed by the Legislature.
2. Jason M. Hatfield, P.A., Attorney At Law

He has concerns about the proposed rule. He says from the claimant’s perspective delay equals denial and this is one more way to force litigation on injured workers. He says the workers’ compensation rules in our state do not provide attorney’s fees for disputed medical expenses and injured workers will have a difficult time finding an attorney to represent them in disputes between the carrier and doctor.

Also he says this rule will run more doctors away from handling pain management related issues in workers’ compensation claims and result in few, if any, qualified doctors interested in fighting the red tape battles on behalf of their patients.

He says the question of whether medical treatment is appropriate, reasonable and necessary is already an issue in every workers’ compensation claim and there is no reason to add additional hurdles over the issue of whether a particular form of medication management is appropriate or not.

He urges the Commission to contact as many pain management professionals as they can in the State of Arkansas to specifically request their opinion and comment on the subject before implementing this rule.

AGENCY RESPONSE – The Commission believes that any provision for an attorney’s fee will have to be addressed by the Legislature. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

3. Steven McNeely, Attorney At Law

His specific concerns with the rule include:

90 MED per day is too low and does not take into account multiple prescriptions which may be required during the first few days or weeks following an injury or surgery.

This MED bright line does not take into account an individual’s body type, body mass or other individual factors.

A 100 mcg/hour Duragesic patch taken once a day would not be allowed under this formula.

He believes a better rule would be whenever an injured worker’s MED reaches 120 mg they be sent to a pain management doctor for an evaluation concerning their prescriptions.

The current rule will accomplish its goal of reducing costs for the carrier and it does not have any benefit to the injured worker.

He foresees more doctors not wanting to accept a work comp patient, which will add additional stress to an already stressful workers’ life and could delay and even prohibit their recovery.

Also he says the UAMS Drug Formulary is only 4 pages long and then moves to a prior authorization process.
AGENCY RESPONSE – The Commission understands Attorney McNeely’s concerns but has chosen to rely on the CDC guidelines.

4. Greg Giles, Attorney At Law

Mr. Giles addressed his concerns from the claimant’s perspective. He said delay equals denial and this is simply one more way to force litigation on an injured worker with very little chance of representation since the workers’ compensation rules in Arkansas do not provide attorney’s fees for disputed medical expenses. This will result in injured workers being forced to be unrepresented in this dispute between the carrier and doctor.

He suspects this rule will simply run more doctors away from handling pain management related issues in workers’ compensation claims and the net result will be few if any, qualified doctors interested in fighting the red tape battles on behalf of their patients.

Also, he says the question of whether medical treatment is appropriate, reasonable, and necessary is already an issue that comes into play in every workers’ compensation claim and there is no reason to add additional red tape to the process over the issue of whether a particular form of medication management is appropriate or not. A “Drug Formulary” should not be necessary to try and establish some boundaries over what is appropriate medical care. He says the Arkansas Democratic Gazette says this issue is already being addressed in other ways. He includes an article in the Gazette originally printed in the Washington Post.

He urges the Commission to contact as many pain management professionals as they can in Arkansas to specifically request their opinion and comment on the subject before adopting this rule which limits pain management.

AGENCY RESPONSE – The Commission believes that any provision for an attorney’s fee will have to be addressed by the Legislature. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

5. Steven A. Bennett, Associate General Counsel, American Insurance Association

AIA supports adoption of a workers’ compensation drug formulary, but recommends that the Commission adopt the Official Disability Guidelines (ODG) drug formulary produced by the Work Loss Data Institute. It is important to adopt a nationally-recognized, evidence-based formulary that has been adopted in other states (Texas, Oklahoma, Tennessee, New Mexico, North Dakota, and Ohio) and has a proven track record.

They recommend ODG based upon the following:

- The ODG Formulary is based upon evidence-based medical treatment guidelines, applying the most complete and thorough medical knowledge;
- The ODG Formulary is updated monthly so it is current and up-to-date;
- The ODG Formulary has a proven track record of success and Texas is given as an example;
• The ODG Formulary covers the broadest range of potential prescriptions and treatments (covers all 10,000 ICD9 codes, 65,000 ICD10 codes and 11,000 CPT codes);
• The ODG Formulary has already been successfully integrated by most payers and prescription benefit managers, thereby reducing or eliminating implementation delays and costs;

AIA also offers the following recommended changes to the proposed rule:

Legacy Claims: It is critical that the formulary and the proposed rule apply to all workers’ compensation injuries including legacy claims. They suggest a delay of six to nine months before applying the formulary to existing claims which will allow time to wean the workers off dangerous, addictive drugs.

Compound Medications: The proposed rule should include strong restrictions on the use of all compound medications. The proposed rule should require pre-authorization for any compound drug and require medical certification of the patient’s inability to tolerate treatment by other non-compound, medications.

Opioid Restrictions: The proposed rule allows initial prescriptions beyond five days and prescriptions for continuing opioid medications beyond 90 days if the treating physician certifies a “medical necessity” for the prescription. This exclusion based merely on a treating doctor’s certificate of “medical necessity” may destroy the effectiveness of the proposed restrictions. Departure from the opioid restrictions should be allowed only upon prior authorization and medical certification that more conservative, non-opioid medications were attempted with the injured worker but were ineffective.

AGEDNY RESPONSE – The Commission desires patient-centered care. Other states have adopted formularies and have seen good results in reducing opiates and costs. We are more comfortable with UAMS than an out-of-state company with no input by the Commission. UAMS is able to address our concerns and to react quickly. We believe that UAMS is a better fit than ODG. The Public Employee Claims Division has chosen to utilize the UAMS drug formulary and has seen a 20-25% overall reduction in opiates.

Compound medications are subject to fee schedule reimbursement according to the pharmacy schedule in Rule 099.30. Language will be added to the proposed rule to require pre-authorization from the payor for compound medications and to require medical certification of the patient’s inability to tolerate treatment by other non-compound medications.

The Commission will make the following change to the proposed rule regarding an Opioid medication beyond 90 days:

PART III. Opioid Medications

5. A Payor shall not be required to pay for continuing an Opioid medication beyond 90 days without written certification of medical necessity which shall include the following:

1. Follow-up visits
2. Documentation of improved function under the medication

3. Periodic drug screening

4. A detailed plan for future weaning off the Opioid medication

5. A summary of conservative care rendered to the worker that focused on increased function and return to work

6. Mandatory and documented review of the PDMP prior to issuing every prescription for a Schedule II or III narcotic or benzodiazepine

7. A statement on why prior or alternative conservative measures were ineffective or contraindicated (including non-opioid pain medications)

8. A summary of findings of the data received from an automated Prescription Drug Monitoring Program (PDMP)

The Commission has excluded legacy claims from the proposed rule. At this point there has not been enough feedback and study to include these claims. The Commission may undertake an interim study on legacy claims.

6. Chris Merideth, Manager, Government & Industry Affairs, Farmers Insurance

Farmers supports policies to control opioid abuse and cost abuse (physician dispensing/repackaged/compound drugs), including opioid dosing limitations, strengthening prescription drug monitoring programs, implementing closed formularies, banning or severely limiting physician dispensing, and requiring pre-authorization for dispensing compounds. Farmers also supports policies on medical treatment that are in accordance with sound treatment guidelines embodying principles of evidence-based medicine.

**AGENCY RESPONSE** – The Commission will add language to the proposed rule to require pre-authorization by the payor for compound medications and to require medical certification of the patient’s inability to tolerate treatment by other non-compound medications.

7. Sandy Shtab, AVP Advocacy & Compliance, Healthe Systems

They offered the following comments in support of the drug formulary rulemaking process.

Adopting a lower Med threshold and requiring physicians to demonstrate medical necessity if the prescriber recommends greater than 50 MED for more than 5 days. This would allow patients with acute injuries or post-operative care to access needed opioids while holding prescribing physicians accountable for addressing ongoing medical necessity when prescribing higher doses for more than a short duration.
They recommend additional language which specifies “All compounded medications are subject to preauthorization and a medical necessity review.”

They oppose the reconsideration process to the reviewing pharmacist. They propose the same utilization review as in Rule 30 be applied to reconsiderations of payor decisions and would then be performed by a certified UR agent rather than a pharmacist. They state that a licensed physician is better qualified to examine all the medical records of the patient to arrive at an appropriate, medically supported finding.

They propose the effective date of the Rule be at least six months after the date of the rule adoption, January 1, 2018 instead of September 1, 2017.

**AGENCY RESPONSE** – The Commission discussed the MED limit and decided to stay with the CDC guideline of a 90 MED per day limit. As noted in response to previous comments, the Commission will add language to the proposed rule regarding compound medications. The Commission discussed the process for disputes. We modeled this process after the Public Employee Claims Division and will leave the dispute process as it is. The Commission will delay the effective date of the proposed rule to all claims with a date of injury on or after January 1, 2018.

8. **Kevin C. Tribout, Executive Director, Government Affairs, Optum Workers’ Comp and Auto No-Fault**

Optum is supportive of the proposed drug formulary but offers comments and suggestions to better aid the Commission during the rule-making process. They believe their suggested language will assist the Commission in developing a sound and effective drug formulary rule. Optum has extensive experience in working with several other states in the development of their drug formularies.

He suggests the following changes to these parts of the proposed Rule.

Part I. General Provisions

A. Scope.

(a) He suggested that language be added that the formulary shall be reviewed at least quarterly or more frequently if needed to allow provision for all appropriate medications and that updates shall not take effect for a minimum of thirty days.

(b) He suggested this part be changed to say that all initial prescriptions for opioids shall be limited to a 5-day supply. All subsequent opioid prescriptions shall be limited to a 90-day maximum supply and shall not exceed a 90 MED dosage limitation per day.

He suggested adding a definition for “initial prescription” and “drug formulary”.

Part III. Opioid Medications
A. He proposed language be added that suggests an implementation date change to January 1, 2018 to allow all stakeholders more time to prepare and address the impact of formulary changes.

B. He suggested the language be changed from should to shall regarding checking the Prescription Drug Monitoring Program database and saying “the prescribing of opioid therapies” rather than what medications to prescribe.

C. Changing the rule language from first to initial prescription of an Opioid medication.

5. Add written to the physician certification of medical necessity for continuing an Opioid medication beyond 90 days.

Part IV. Process for Filling Workers’ Compensation Prescriptions

He says that physicians are the key to initiation of formulary conformity and the proposed rule places the initiative on prescribers. The blue represents the language of the proposed rule and the red is their suggested language.

A. Prescribers, before writing Pharmacists filling a workers’ compensation prescription must shall check to see if verify that the prescribed drug(s) are listed as covered on the approved drug formulary.

B. If the prescribed drug(s) is not listed as covered on the approved drug formulary, the prescriber shall notify the injured worker that the prescribed medication may require prior authorization.

C. If the prescriber desires to utilize a drug which is not listed as covered on the drug formulary, the prescriber shall attempt to seek authorization for the medication prior to prescribing.

D. Unless indicated by the physician, before dispensing any medication not listed as covered on the drug formulary, the pharmacy shall attempt to verify pharmacist must contact the Payor for approval of the prescribed drug(s) and must consult with the Prescribing Physician before switching the prescription to a drug listed as covered on the drug formulary. the medication to a formulary medication(s).

E. The filling dispensing pharmacist, in seeking reimbursement for dispensed opioids, shall must abide by the rule requirements for maximum opioid duration and dosage levels. 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)

F. Approval through a prior authorization process is required for all topical analgesics or compounds.

G. Where an employer or insurer contracts with a pharmacy benefit manager or pharmacy network for the provision of drugs for treatment of injured workers, drugs available to the injured worker must be consistent with the drug formulary and contractual terms of the agreement.

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, 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 prescription may be dispensed as authorized. 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.

AGENCY RESPONSE – The Commission discussed the comments received from Mr. Tribout and decided to make changes to the proposed rule. Language will be added to state that the formulary will be reviewed and updated as needed. Language will be changed regarding initial and subsequent opioid prescriptions. A definition will be added for “initial prescription”. The implementation date will be delayed until January 1, 2018. The language will be changed from “should” to “shall” regarding checking the Prescription Drug Monitoring Program database.

9. Nathan Culp, Director, Public Employee Claims Division of the Arkansas Insurance Department

Public Employee Claims administers about 3,600 claims a year and we implemented the program that is being proposed in November 2015. It would go into effect for new claims and would not affect people who are currently taking opioids for their workers’ compensation claim. Our program has a reconsideration process in place. We have received three reconsideration requests from physicians since implementation. On one of the three reconsideration requests a change of physician was obtained. The Public Employee Claims Division does support the Rule and also the Arkansas Self-Insured Association is in support.

AGENCY RESPONSE – The Commission appreciates the comments made by Mr. Culp during the public hearing.

10. Jill Johnson, Risk Management Resources (TPA)

Risk Management Resources handles claims for self-insured employers and five large groups. She has been doing this 30 years and has seen the effects of opioid addiction and the epidemic, and we try to get people to doctors that will help them get off of opioids and have received thank you’s from claimants and their families. Risk Management Resources supports the formulary.

She suggests that the notification requirement to the Commission of the PBM be added to the Form O which is a form that employers fill out listing their TPA and who’s responsible for getting bills and who their contact is and etc.

Under resolving disputes in Part 5 the proposed rule says, “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.” She doesn’t understand why if they deny it they would be the ones that would pursue that. She doesn’t know that the payor is the one that should make that appeal or make that reconsideration request.

**AGENCY RESPONSE** – The Commission discussed and decided not to modify the Form O. The notification is not burdensome and may be accomplished by sending an e-mail notification to the Medical Cost Containment Administrator, Ms. Pat Hannah.

**11. Trey Gillespie, PCI, Property Casualty Insurers**

Property Casualty Insurers Association of America (PCI) is a trade association representing over 1000 property and casualty insurance companies and write 34% of the private workers compensation insurance market.

PCI accepts and supports that a request for reconsideration should be reviewed by a Physician or Medical Director and that the payor must have a Physician or Medical Director on staff or has contracted with another entity that has such a contractual relationship.

PCI accepts and supports that Payors and PBMs should be allowed to have a reviewing pharmacist review the request for approval of the prescribed drugs not on the approved drug formulary.

PCI opposes the mandatory requirement that the Payor have on staff or contract with a reviewing pharmacist to review requests for approval of prescribed drugs not on the approved drug formulary. This may create an unnecessary expense and regulatory burden if the ultimate payor decision rests with the review by the Physician/Medical Director.

The Payor should be allowed to have a reviewing pharmacist be part of the process but should not be required to contract with a reviewing pharmacist or have one on staff.

PCI supports the proposed 5-day limitation on the first prescription of an Opioid and requirements for continuing an Opioid medication beyond the first 5-day prescription. However it appears there are fewer requirements imposed for continuing an Opioid beyond 90 days than for the 5-90 day period. They recommend: In order for an Opioid medication to be continued beyond 90 days, there should be at least the following minimum requirements: (1) follow-up visits, (2) documentation of improved function under the medication, (3) periodic drug screening, (4) detailed plan for future weaning off the Opioid medication, (5) screening for drug abuse disorder, and (6) mandatory and documented review of the PDMP prior to issuing every prescription for a Schedule II or III narcotic or benzodiazepine. Arkansas should follow the “CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016.”

The Rule should apply to Legacy claims and compounded drugs. The current Rule only applies to FDA approved drugs. They suggest that the language be changed to say: *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 drugs that are prescribed and dispensed for outpatient use. For workers’ compensation claims with a date of injury prior to September 1, 2017 this Rule is effective March 1, 2018.*
AGENCY RESPONSE – The Commission discussed and decided not to make any changes to the requirement for the Payor to have a reviewing pharmacist contracted or on staff. As noted in response to previous comments, the Commission is adding additional requirements to the rule for Opioid medications which are continued beyond 90 days. The Commission is also adding language to address compounded drugs. The Commission has excluded legacy claims from the proposed rule but may undertake an interim study of this issue.

12. Denny Altes, Arkansas State Drug Director

Thanks the Commission for striving to abide by the CDC guidelines and hopes this will cut down on the opioids hitting the street and save the lives of our kids. He appreciates all that is being done in the fight against illegal use of drugs and their destruction.

AGENCY RESPONSE – The Commission appreciates the comments submitted by Mr. Altes.

13. David Wroten, Executive Vice-President, Arkansas Medical Society

The Arkansas Medical Society represents over 4,500 physicians from all over Arkansas. AMS respectfully requests that the Commission review and adopt an approach that follows this year’s Act 820 for maximum consistency so physicians do not have one set of rules for their Workers’ Compensation patients and another for all their other patients.

Regarding the 90 MED per day. At the very minimum there should be a mechanism which is not overly burdensome to obtain approval for a larger dosage if warranted by the patient’s injury. This mechanism should be managed similarly to how a “prior authorization” is handled by payers/carriers and/or their contracted agents and should not involve the AWCC.

He suggests that we replace the language in Part III. Opioid Medications B. with the following:

*Prior to prescribing Schedule II or II opioid medications, prescribers shall check the Prescription Drug monitoring Program database according to the provisions of Act 820 of 2017(or Arkansas Code 20-7-604 (d).*

In regards to Part III. Opioid Medications C. The AMS has serious concerns with this language and suggests a complete rewrite. What is intended by “five (5) days of medication? Is there an assumption this would be five days of medication up to 90 MED on each of those five days? Does this unwittingly encourage physicians to prescribe five days of 90 MED per day with each prescription?

AMS opposes limiting this to five days. Gives an example of a patient undergoing outpatient surgery on Monday and receives five days of medication (whatever that may be) and they run out on Friday night or over the weekend. Their pain may not be managed for up to 2 or 3 days or they may present to a hospital ER. What about patients who are admitted to the hospital with major
trauma and need pain medications for several days? Even IV pain medication is “prescribed.” Proposes a change to 7-10 days for the initial prescription.

Also rather than requiring all five conditions be met for a payor to be required to pay for continuing an Opioid medication beyond the first five day prescription they suggest something like this language “the prior authorization request as mentioned in our response to Part II, A. above for any prescription above the recommended 7-10 day threshold.”

If the Commission decides to stay with the current proposed five requirements listed under C the following questions need to be answered.

1. What is meant by “authorized” treating physician? AMS suggests removing “authorized.”
2. Who determines if the medication is “reasonable, necessary, and related to the workers’ compensation injury or illness”? Is this the treating physician, insurer, employer or the AWCC?
3. It is expected that there will be follow-up visits, but how does the physician “certify” the medication is effective and to whom? Suggests it should say the treating physician “determines and notes in the medical record” rather than certifies. Also, states that opioid medications are to treat the pain associated with injury or illness and do not treat the actual injury or illness. AMS suggests this language, “effective in treating the pain associated with the injured employee’s injury or illness.”
4. Same comment as #3.
5. How does a physician certify medical necessity and to whom. “Authorized” is not clear and if the physician treating the patient under AWCC rules is authorized. AMS suggests deleting “authorized” and leaving it as “treating physician.”

**AGENCY RESPONSE** – The Commission discussed the comments received from Mr. Wroten. As noted in response to previous comments, the language will be changed from “should” to “shall” regarding checking the Prescription Drug Monitoring Program database. The current meaning and application of the terms “authorized treating physician” and “reasonable, necessary, and related to the workers’ compensation injury or illness” will not be changed by this rule.

**14. M. Carl Covey, M.D.; Medical Director, Pain Treatment Center of America**

Commends the AWCC’s attempt to address the opioid epidemic which is a clear public health disaster.

He states it is clear the AWCC is drawing the “90 MED” in the proposed formulary from the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain. The result will be a tragedy of suffering and injury to many chronic pain patients and he predicts will result in legislative action and litigation as unintended consequences.

He says he has spoken to many physicians, other medical providers, and other stakeholders who have not read the CDC Guidelines but have simply plucked out the unsupported 90 MME/day number.
He says the first sentence of the CDC Guidelines refutes the AWCC proposal: “This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain….”.

He also says the following regarding the CDC Guideline:

It was not intended for all Specialties, especially Pain Management physicians whose patients require medically necessary doses of opiates exceeding the 90 MED per day proposed;

It mentions considering referral to a Pain Management Specialist no less than six times;

Experts agreed that lower dosages of opioids reduce the risk for overdoes but that a single dosage threshold for safe opioid use could not be identified;

In the list of Grading Clinical Evidence for the document there were 33 study groupings, 18 had serious limitations, 6 had very serious limitations, 7 had insufficient evidence, and only 2 had no limitation but those 2 were for Myocardial Infarction and Motor Vehicle Crash Injuries; and

The CDC was very humble in its closing statement stating, “Yet, given that chronic pain is recognized as a significant public health problem…a guideline for prescribing is warranted with the evidence that is currently available.”

He suggests that the AWCC consider setting the opioid ceiling for Primary Care Physicians/providers as defined in the CDC Guideline for Primary Care of 90 MME/day (if a defined number is necessary) but with the caveat quoted from the same CDC Guideline, “for example, before increasing the long-term opioid therapy dosage to >120 MME/day, clinicians in Washington state must obtain consultation from a pain specialist who agrees that this is indicated and appropriate.” To do otherwise according to him will cause unjustified pain and suffering and reduce or eliminate access to medical care for the most desperate and vulnerable patient population.

AGENCY RESPONSE – The Commission discussed and decided not to alter the 90 MED limitation. Other pain management doctors support a limit of 90 MED per day.

15. Carlos Roman, MD

He strongly supports the AWCC’s drug formulary Rule 099.41 of limiting prescriptions to CDC recommended 90 MED’s per day and it should be applied to any prescribing physician primary care or pain management specialist. This limitation is appropriate and well founded and is still a tremendous amount of narcotics. These levels of narcotics for chronic non cancer pain are more than generous for proper pain management and will lead to better patient care, lower levels of physical opioid dependency, improved safety, less opioid induced hyperalgesia, better pain control due to lower opioid tolerance, decreased risk of overdose deaths, and help decrease the epidemic of prescription drugs diverted into our communities.

He says the opioid drug epidemic is a direct effect of a well marketed and focused effort by large pharmaceuticals to sell products and they have effectively hijacked the educational process for
many physicians. The CDC guidelines represent an undeniable trend in decreasing opioid use for chronic pain.

He says that prior to 2009 the mantra of “pain management” physicians was titrate to effect regardless of dose. In 2009 this argument was addressed by the American Pain Society-American Academy of Pain Management which recommended a maximum of 200 MeQ and in 2016 the CDC guidelines recommended a max of 90 MeQ. He says this trend will continue and he cites an article by Robert Barth, PhD that says prescription narcotics at a high dose prevents a return to work by injured patients.

**AGENCY RESPONSE** – The Commission agrees that the current CDC guidelines should be the standard, which is the basis of this rule. The Commission appreciates the comments made by Dr. Roman.


Supports Dr. Covey’s analysis of the proposed opiate prescribing guidelines and formulary.

He has had 2 workers’ compensation patients cut off from their Opana medication (low dose) when medication trials demonstrate efficacy to the patient when nothing else could control their pain and physical function. WC carriers have physicians for hire to opine and question the clinical care of injured workers with no accountability other than to improve financial gain to the WC carrier. The WC expert opinion directed patient to a cheaper opiate that had previously been tried and demonstrated inferior and ineffective in the patient’s course of care. Often the drug of choice for WC was methadone with little regard to the risk of this inexpensive opiate.

WC is taking advantage of misinformation and generalization of opiate poisoning and rising death rates at the expense of the injured worker. Raw ER data concerning the opiate death rate is being used rather than data of patients being treated with opiates that are monitored appropriately and followed as part of a comprehensive pain care regimen. WC is manipulating this “raw data” to their financial advantage. He challenges WC to produce data of our patient population under the care of board certified practitioners that support the need for the proposed opiate guidelines.

WC continues to obstruct, obfuscate, and deny chronic pain care as a campaign to deny the injured worker and pushes the patient and his/her family into poverty and into the legal system.

He recommends certification of pain prescribers who treat chronic pain and for WC to be held accountable for failure of duty to the injured workers.

**AGENCY RESPONSE** – The Commission discussed the concerns of Dr. Swicegood but decided not to make any changes to the proposed rule as a result of these comments.

**17. Cathy Luo, MD, Pain Management & Rehabilitation Consultants**
Opposed to the 90 MED limit. This may cause patients more suffering. Some patients have been on chronic opioid treatment for a long time and have a high tolerance to pain meds. It will be difficult to keep all patients under 90 MED per day. Suggests that the Commission contact the Arkansas Pain Boards for recommendations.

**AGENCY RESPONSE** – The Commission discussed the MED limit and decided to stay with the CDC guideline of a 90 MED per day limit. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

**18. Randy Zook, President & CEO, Arkansas State Chamber of Commerce and Associated Industries of Arkansas**

His comments are provided on behalf of over 1,200 member businesses, industries, business associations, local chambers of commerce and local economic developers.

The proposed formulary is a positive step, but ODG would provide the most effective service. It is a superior product because it’s objective, more detailed, based upon medical evidence, widely available and more comprehensive than the proposed formulary developed by UAMS. ODG is the only independent commercially published and updated monthly workers’ compensation drug formulary and guideline with current guideline contact adopted in multiple states that is tied to evidence based treatment guidelines that have been adopted and implemented in any US Jurisdiction by rule or regulation.

The UAMS Formulary is only updated quarterly and its adoption will require multi-state businesses to maintain separate systems. They are also concerned about the future cost of the UAMS Formulary over that of ODG.

Texas adopted the ODG Drug Formulary in 2011 and is the only state that has collected, analyzed and reported data from their use of the ODG Drug Formulary and the ODG Treatment Guidelines, and their experience with ODG is remarkable. 30% reduction in medical costs, opioid costs decreased from 27% of the total pharmacy costs in 2009 to 18% in 2015, 49% savings in premiums, total drug costs in TX work comp system fell by 15%, etc.

Arkansas employers using ODG in other states support adoption of ODG in Arkansas because: ODG is based on medical evidence, objective and usable, updated monthly, provides a file that can be uploaded to process pharmacy bills, provides 46,000 NDC codes for the various versions of medications, provides continuing education resources for physicians, and benefits injured employees.

UAMS’ Formulary has no downloadable file format and no related guidelines. UAMS has no current plans to provide this for their formulary.

Examples of Experience and Successes in Other States

New Mexico—total annual losses or outliers drop 78%, North Dakota—premium reductions of 40%, Ohio—savings of 66% in absence-60% in medical costs-77% in treatment delay-84% provider
approval, Oklahoma-44% cumulative drop in loss-cost rates. Other examples of Industry Success were given for ESIS, Shell Oil, Marathon Oil, Adelaide AHTA, and Rand Corporation.

ODG has a proven methodology. It is owned by MCG Health, the worldwide leader in evidence-based medical guidelines for general health care, and is part of the Hearst Health Network. Its methodology has been ranked among the best and most rigorous in the world for technical quality by Rand Corporation and others. ODG is currently adopted in Texas, Tennessee, Oklahoma and Arizona. The current ODG Drug Formulary includes over 331 prescription medications commonly prescribed for workers’ compensation injuries with reasonable options for short acting opioids and musculoskeletal on the preferred Y-drug list, most PBMs and Payors have already integrated the ODG Treatment Guidelines and/or Drug Formulary into their systems & procedures and this eliminates and minimizes obstacles and costs of implementation. Over two million workers’ compensations prescriptions have been filled under the ODG Formulary compared to zero by other Commercial Work Comp Guidelines Publishers.

**AGENCY RESPONSE** – In 2015, the Arkansas Workers’ Compensation Commission determined that adoption of ODG Medical Guidelines was not in the best interest of the citizens of Arkansas. Due to an increasing amount of opioid and narcotic prescriptions in the workers compensation arena, the Commission reviewed and studied several drug formularies, including the UAMS Drug Formulary. The Commission has determined that the UAMS formulary is the best formulary for use in Arkansas. The UAMS Drug Formulary was developed by the College of Pharmacy at UAMS and is an evidenced-based formulary based on actual claims experience in Arkansas by Arkansas medical personnel. There are no user fees associated with this formulary and it can be readily available on our website. Because it is local, it will be more responsive to any updates or changes needed.

It has demonstrated its effectiveness since the voluntary adoption of the formulary by the Public Employee Claims Division of the State of Arkansas in both reducing the prescription of opioids and in overall costs without compromise of care to the injured workers.

**19. Janice Van Allen, Senior Director, Walmart Risk Management**

Walmart supports the adoption of an Arkansas Workers’ Compensation Drug Formulary. However they support and ask that consideration be given to adopting the ODG Drug Formulary. It has the following benefits that make it easier for physicians and payors to administer: ODG is updated monthly so new drugs are included sooner than other formularies, ODG is usable, ODG is a continuing education resource for physicians, ODG is based on medical evidence, ODG has been proven to work in several states (TX, OK, TN, NM, ND, and OH), Texas’ results after adoption demonstrate several successes, Walmart’s results show that claims where narcotics were prescribed on 6 month old claims, associates missed 33 less days from work on average and a 75% reduction in the number of MEDs.

If the Commission adopts Proposed Rule 099.41 and the UAMS Formulary the following comments are for their consideration:
The formulary should be published and available in a downloadable format.

They say our language in A1 (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 is written inconsistently throughout the proposed rule and needs to be clarified for intent.

The requirement to ensure this rule is followed is ineffective. Allowing treating physicians to simply state that the request for additional days and MEDs is “reasonable and necessary” will be no more effective than the current requirement. Physicians should provide the following to demonstrate why treatment requests are “reasonable and necessary”: a summary of conservative care rendered to the worker that focused on increased function and return to work; a statement on why prior or alternative conservative measure were ineffective or contraindicated (including non-opioid pain medications); a statement that the treating physician has considered the results obtained from appropriate industry accepted screening tools to detect factors that may significantly increase the risk of abuse or adverse outcomes including a history of alcohol or other substance abuse; a summary of findings of the data received from an automated Prescription Drug Monitoring Program (PDMP); and a treatment plan which includes all the following: overall treatment goals and functional progress, periodic urine drug screens, a conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies, or both and consideration of weaning the injured worker from opioid use.

The rule should include existing claims but allow a weaning period. Their proposed language gave a six month weaning period.

They agree clinicians need to be involved in the identification and review of drug misuse but don’t necessarily agree it has to involve a PBM. They say the language regarding payors to 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 is referenced differently throughout the proposed rule and needs to be clarified for intent.

They ask who will be responsible for administering the provision A1(f) requiring for the certification of all payors determined to be in compliance with the criteria and standards established by this rule.

In regards to A1 (g)-Provides for the implementation of Medical Cost Containment Division review and decision making responsibility. They ask how will the additional staff for this division be funded and will the appointed individuals have medical/pharmaceutical knowledge/education?

**AGENCY RESPONSE** - As noted above in response to other comments received, the Commission has carefully considered the comments in support of ODG but has ultimately decided to adopt the UAMS College of Pharmacy Evidence-Based Prescription Program. The drug formulary has been published to the Commission’s website and is readily available. As noted in response to other comments, the Commission has added requirements to the proposed rule regarding Opioid medications beyond 90 days. The proposed rule does not include legacy claims, but the Commission may undertake an interim study of that subject. The Medical Cost
Containment Division of the Commission will be responsible for certifying payors, and we do not anticipate a need to add additional staff for this purpose.