

Assessment of Public Comment

The 45-day public comment period with respect to Proposed Rule I.D. No. WCB361200003 commenced on September 5, 2012, and expired on October 22, 2012. The Chair and the Workers' Compensation Board (Board) accepted formal written public comments on the proposed rule through October 26, 2012.

The Chair and Board received six written comments. The Board received written comments from Injured Workers' Pharmacy (a home delivery pharmacy), Stone River Pharmacy and Progressive Medical (a pharmacy processor and a pharmacy benefits manager or "PBM"), CompPharma (a consortium of nine PBMs), Express Scripts (a PBM), MyMatrixx (a PBM and member of CompPharma), and PMSI (a pharmacy and DME service provider). These comments were reviewed and assessed. Many of the commenters made similar comments. Accordingly, this assessment will summarize and respond to the comments by subject.

Definition of "Average Wholesale Price (AWP)" (12 NYCRR 440.1[a]):

Several commenters suggested that the Board select only one authorized publisher of AWP rather than permitting use of either Red Book published by Thomson Reuters or Medi-Span Master Drug Database published by Wolters Kluwar Health. The commenters suggested that permitting more than one AWP source would create confusion. In the alternative, the commenters suggested that the Board eliminate the last sentence of the paragraph defining AWP at 12 NYCRR 440.1(a). This sentence requires insurance carriers or employers to pay the lesser of any difference in the AWP published by Red Book or Medi-Span.

When the Chair initially adopted 12 NYCRR Parts 440 and 442 as emergency regulations, the regulation required AWP be calculated using Red Book. However, in June of 2011, the Board added Medi-Span as an additional source for determining AWP. This change to the emergency regulation was made for several reasons. The Board had been advised that Red Book does not publish an AWP for all drugs that may be prescribed to workers' compensation claimants. In addition, Red Book by Thomson Reuters has discontinued its print and CD

publications, and at least one user of the Pharmacy Fee Schedule has contended that it can no longer afford a subscription to Red Book. Finally, Medi-Span also publishes AWP. Thus, the Board selected two sources for AWP to provide payers with a choice. Insurance carriers and self-insured employers may elect to use one source over another or may use both sources.

Based on the fact that an insurer or self-insured employer may not have access to both RedBook and Medi-Span, the Board has accepted the commenters suggestion to remove this sentence in 12 NYCRR 440.1(a): “In the event of a difference in the average wholesale price of a prescription drug in the two publications, or other pricing index adopted by the Chair or the Chair’s designee, the lowest published average wholesale price on the day the prescription drug is dispensed shall prevail.” Removal of this sentence will still permit an insurance carrier or self-insured employer to select the lowest published AWP, but will not create confusion and bill disputes when an insurance carrier or self-insured employer uses a single source for determining AWP.

Notification of the Board of any material changes to its list of designated pharmacies (12 NYCRR 440.3[1]):

In the emergency regulation originally adopted in 2007, insurance carriers and employers are required to provide the Board with notice of any material changes to their list of designated pharmacies on a monthly basis. This requirement was carried over into the published proposal in 12 NYCRR 440.3(1). One commenter suggested, and the Board’s Health Management Bureau agrees, that monthly updates are burdensome and do not enhance efficient operation of pharmacy networks. The Board has accepted the suggested change that notification of material changes must occur quarterly. It is noted that the notice requirements contained in 12 NYCRR 440.4 to the injured worker are unchanged: an up-to-date list of designated pharmacies must be published by employers and available to the injured worker by a phone call and available on a website.

An insurance carrier’s obligation when a case is controverted is not clear.

One commenter suggested that 12 NYCRR 440.3(d) setting forth the insurance carrier and self-insured employer’s obligations when a case is controverted requires clarification. The commenter did not have any

specific suggestions as to what portion is unclear or how to improve the subdivision's clarity. Following internal review, the Board maintains that this subdivision is sufficiently clear and has not made any change.

Claimant's rights when a case is apportioned

One commenter suggested that 12 NYCRR 440.3(f) is confusing and should be removed. However, under the Workers' Compensation Law when a claim is apportioned, more than one insurance carrier may be liable for payment of the claimant's benefits including pharmacy benefits. Accordingly, it is necessary to establish a rule as to how a claimant may select a pharmacy network in these cases. Each liable insurance carrier or self-insured employer will supply the claimant with pharmacy network information and the claimant may select a pharmacy from among these networks. If an insurance carrier or self-insured employer does not notify the claimant that he or she must use a network, the claimant may obtain pharmaceuticals from an out-of-network pharmacy and submit the bill to the liable insurance carrier or self-insured employer that did not provide notification of the requirement to use a network.

The Fee Schedule is too low

One commenter suggested that the proposed fee schedule is too low and that it should be set at AWP plus a \$5 dispensing fee for generic drugs and \$4 dispensing fee for brand name drugs. The Board has not accepted this suggestion as the fee schedule is an important cost-savings component of the 2007 reform of the workers' compensation system. The fee schedule has remained unchanged since its introduction in 2007, and appears to be functioning well for all parties.

Board's right to audit

Two commenters expressed concern that the regulation does not require that the Board keep confidential the results of an audit of the agreements between a carrier and its network as performed by the Chair pursuant to subdivision (b) of section 440.5. The language of the regulation as currently drafted reflects a change from the original draft that would have required production of these agreements to the Board. After due consideration,

the Board determined that it did not need to routinely collect this information, but rather could conduct audits when necessary. As New York State Law does not permit the Board to guarantee that any information it collects while performing its statutory or regulatory duties remain confidential, the regulation may not be modified. The Chair's right to audit is designed to be a minimally intrusive means for the Board to conduct its regulatory function.

One commenter stated that the Board may not interfere with its contracts even when such contracts are inconsistent with the fee schedule. As Workers' Compensation Law section 13(o) states that the pharmaceutical fee schedule "establishes the maximum allowable fees for prescription medicines provided pursuant to this chapter," the Board may audit contracts to ensure that they do not reimburse in excess of the fee schedule.

The Board should not permit carriers to require use of networks

One commenter suggested that the Board should allow injured workers to select their own pharmacy and not require use of a network. As Workers' Compensation Law section 13(i)(5) expressly authorizes carriers and employers to enter into contracts with pharmacy networks, the Board has made no change to the regulations based on this comment. Pharmacy networks are an important cost savings component of the 2007 workers' compensation reform.

Carriers should not be able to deny payment to a pharmacy when a prescription does not conform to the Medical Treatment Guidelines

One commenter stated that it is unfair to permit a carrier to deny payment to a pharmacy when the prescription was not consistent with the Medical Treatment Guidelines as the pharmacist filling the prescription is not providing the claimant with medical treatment. Compliance with the Medical Treatment Guidelines (MTG) is an integral component of the 2007 workers' compensation reform. The MTG are designed to ensure that the claimant receives medically necessary care using an evidence based medical standard and in accordance with protocols recognized within the medical community. The MTG are published on the Board's website. A

pharmacist who is concerned that a prescription does not conform to the standards of the MTG may confirm with the prescribing physician that the prescription is appropriate under the MTGs. Allowing carriers and employers to object to improperly prescribed medications is a key method to ensure compliance with the MTGs.

Carrier is responsible for requesting further information when a bill is disputed

One commenter suggested that subdivision (b) be amended to explicitly state that the insurance carrier or self-insured employer is responsible for sending any notices about billing or requesting further information regarding the bill from the pharmacy, PBM, pharmacy processing agent or third-party biller. The Board has made this suggested change to eliminate any ambiguity as to who is responsible for this notification.

Carriers should pay bills from out-of-network pharmacies when the pharmacy has not received notice

One commenter objected to the language in subdivision (d) of section 440.8 that permits a carrier to deny payment to an out-of-network pharmacy for a prescription dispensed more than ninety days after notice to a claimant for a controlled substance and more than sixty after notice to a claimant for a non-controlled substance. The commenter states that it is unfair to deny payment to the pharmacy when it has not received notice of a network requirement. While it is true that the pharmacy may not have received notice in this situation, the cost savings associated with use of pharmacy networks is an important piece of the 2007 workers' compensation reform. Under the current emergency regulation, a carrier is not required to give out-of-network pharmacies any notice. In the permanent regulation, a carrier must pay a bill from an out-of-network pharmacy within the first sixty days or ninety days following notice to the claimant and until the out-of-network pharmacy has received notice. It is believed that this additional "transition period" will prevent most cases of unreimbursed pharmacy bills. Furthermore, most insurance carriers and self-insured employers are likely to notify any out-of-network pharmacy that it will not pay for prescriptions following the ninety or sixty day transition period.

The Durable Medical Equipment Fee Schedule should permit reimbursement for shipping fees

One commenter states that the fee schedule for durable medical equipment should permit separate billing for shipping, handling and delivery and that permitting the supplier to bill separately for shipping would result in a more accurate and lower price for the equipment. By not permitting a separate charge for shipping, the commenter suggests, the Board encourages suppliers to build the shipping charges into every piece of durable medical equipment. The Board has not accepted this comment due to the difficulty in regulating shipping charges and the risk of ensuing bill disputes. Furthermore, the Board is not aware of inflated costs for durable medical equipment since adoption of the emergency regulation in 2007.

The Board should permit Durable Medical Equipment Networks

One commenter suggested that many disputes regarding the purchase of durable medical equipment could be avoided if the Board permitted carriers and employers to enter into contracts with durable medical equipment networks. The Board does not have statutory authority to permit a carrier to require that a claimant use a particular durable medical equipment supplier. Workers' Compensation Law section 13-j states that a carrier may not participate in the care of an injured worker except as set forth in that provision, such as requiring a claimant to use a diagnostic testing network or a pharmacy network. Accordingly, the Board may not create by regulation the ability of a carrier to require use of a durable medical equipment network.

CHANGES TO THE REGULATION:

The Regulation that is being adopted contains the following insubstantial changes from the proposed rule published in the September 5, 2012 State Register:

- In section 440.2(a), the reference to "Thompson Media" has been changed to "Thompson Reuters" the successor publisher of RedBook

- In section 440.2(a), the sentence “In the event of a difference in the average wholesale price of a prescription drug in the two publications, or other pricing index adopted by the Chair or the Chair’s designee, the lowest published average wholesale price on the day the prescription drug is dispensed shall prevail” has been removed.
- In section 440.3(a)(1), the reference to “monthly” has been changed to “quarterly” in two places.
- In section 440.5(c), the sentence “If the NDC is not supplied with the bill for the prescription drug or medicine, the self-insured employer or insurance carrier may identify the NDC of the underlying drug product to calculate reimbursement” has been added.
- In section 440.8(b)(2), “by the self-insured employer or insurance carrier” has been added to the last sentence of the subparagraph.