

# RETHINKING YOUR APPROACH TO PRESCRIPTION “REFILLS”

Treating every prescription as a new prescription encourages appropriate care, decreases practice costs and reduces medicolegal risks.

It happens every day. Patients seeking prescriptions contact your office, occupy your staff with telephone triage, interrupt your schedule, ask you to referee conflicts with their insurers and pharmacies, and expect you to acquiesce as they jump the queue of patients who are actually paying to see you. Curiously, many doctors respond to this by rolling out elaborate prescription refill programs utilizing complex phone menus, web portals and dedicated staff time, which often end up stimulating rather than quelling the clamor for appointment-free prescriptions. No matter how slick and sophisticated (read: expensive and cumbersome) they are, prescription refill programs ultimately founder because they foster unrealistic patient expectations and follow this formula: Physician interruptions + Staff work + Malpractice risk = No reimbursement.

A common justification for refill programs is patient convenience, but these programs do not provide what patients really need: expanded opportunities to meet with their doctors. Instead, these programs apply clerical actions in place of the clinical reviews that are essential for safe prescribing. This delays full medical assessments,

bypasses opportunities to provide preventive care and jeopardizes patient safety. In addition, doctors robo-signing batches of prescriptions discounts the doctor-patient relationship and trivializes the medical profession.

## New vs. refill

The critical perceptual error of refill programs lies in their name. “Refill” programs don’t actually supply refills – that is, a repeat dispensing of medications per the directions of a valid prescription. Only pharmacists do that. Instead, these programs produce *new* prescriptions, something most thoughtful physicians wouldn’t handle over the phone. The distinctions between refills and new prescriptions have far-reaching but under-appreciated repercussions.

New prescriptions include far more than simply starting an established patient on a new medication or writing a prescription for a patient who is new to your practice. They also involve a range of nuanced legal and clinical actions that are often incorrectly described as refills and inappropriately handled like minor clerical chores. Here are three examples:

- A new prescription is required *to change a medication dosage, form or administration route*. State laws empower pharmacists to varying degrees. For example, in some states, if a child won’t swallow a prescribed pill, you can count on being called to substitute a liquid. Sometimes, you can preempt this with your instructions (e.g., “May substitute with equivalent pill, tablet, capsule or liquid”). Other times (i.e., when adjusting medication doses), you should not. (See “Prescribing warfarin changes,” page 18.)
- A new prescription is also required *for commercially*

*directed medication substitutions.* Preferred drugs and tiered formularies fluctuate because of dynamic pricing and discount brokering between payers and drug distributors. If you don't have a system that alerts you of formulary restrictions as you prescribe, you will likely receive calls from pharmacies requesting new prescriptions for alternative medications. Prescribing drugs by generic names will avert some of these calls. Pharmacists can then swap among covered brands. Adding the diagnosis or diagnostic code to prescriptions provides an additional safety check and is often sufficient "prior authorization." However, the bottom line is that these are clinical decisions, not clerical decisions.

• A new prescription is also necessary *to repeat or extend an acute prescription.* The results of patients with persistent or worsening infectious diseases receiving "refill" antibiotics without repeat clinical evaluations fill medicolegal casebooks. Relying on relayed telephone reports, a physician cannot distinguish between a viral illness unaffected by an

antibiotic and a resistant bacterial infection on the brink of causing serious harm. Red flag these treatment failures for quick clinical assessment rather than authorizing "refills."

In some practices, office staff actually create new prescriptions on their own using front-desk protocols; however, protocols come with risks. Illnesses are unpredictable, and patients are often wiler than check-off sheets. In most cases, the conditions that refill protocols target could be quickly managed – and dependably reimbursed – via an office visit. At least half of family medicine's top 10 medicolegal misadventures relate to the care and communication gaps that telephone prescribing

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#### QUICK TIPS

- Provide sufficient drug quantities and refills to last beyond the next appointment.
- "Top-up" all prescriptions at every patient visit.
- Use EHR software to prompt sufficient refills and coverage verifications during the prescribing moment.
- Preload prescriptions with instructions to allow substitute dosage forms.
- Add diagnoses or diagnostic codes to prescriptions.
- Use generic rather than brand names.
- If patients run out of medication before their next planned visit, investigate whether appointment-scheduling strategies are insufficient or drugs are being diverted.
- Don't automatically write a new prescription when a patient changes pharmacies. Pharmacists may transfer a prescription's remaining refills between pharmacies.
- Resist the temptation to placate patients with unnecessary prescriptions.

widens.<sup>1</sup> Why shun opportunities to get paid while filling these gaps? Besides catching a noxious condition posing as a minor nuisance, seeing these patients offers opportunities for further care integration and prevention counseling – sweet spots of family medicine.

#### Before phoning it in

Your practice can reclaim prescribing as a clinical event by following these steps.

**1. Stop providing new prescriptions without a doctor's visit for the highly diverted drug classes: opioids, sedative-hypnotics, stimulants and antibiotics.** As patients learn your prescription policies, you can expand the list of drug classes you refuse to "refill" over the phone and ultimately eliminate visit-free prescribing. (You'll want to maintain separate plans for disasters and pandemics.)

**2. Dismantle any enabling device.** This includes telephone and web site prompts that direct patients away

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In most cases, the conditions that refill protocols target could be quickly managed – and dependably reimbursed – via an office visit.

■ The first step to reclaiming prescribing as a clinical event is stop providing new prescriptions without a doctor's visit for the highly diverted drug classes.

■ Do away with telephone or web site prompts that encourage patients to seek refills without a clinical assessment.

■ Prescribe sufficient medication to last the patient just beyond his or her next scheduled appointment.

from clinical assessments. Replace them with descriptions of pharmacy laws and your practice's commitment to abide by them. Not all patients will accept this. After all, some have invested considerable effort in grooming your practice to prescribe for them solely on their terms. Don't be alarmed if they choose to leave your practice. Your practice has nothing to gain from these one-sided relationships.

**3. Consistently write prescriptions so that patients have enough medication supply to last just beyond their next scheduled appointment.** This is the simplest way to avoid off-visit prescribing. Fortunately, prescribing laws allow prescriptions to cover stan-

dard assessment intervals plus a few months' leeway. Depending on the state, non-controlled drugs can be prescribed for 12 to 24 months. (Note: Download a list of state laws regarding the maximum length of prescriptions at <http://www.aafp.org/fpm/2011/1100/fpm20111100p16-rt1.pdf>.)

**4. Reconcile all medications and provide new prescriptions for chronic medications at each visit.** Alert patients to the need to "top up" their prescriptions. Post signs in exam rooms stating: "Ask NOW if you will need any medication before your next visit." Some electronic health record systems (EHRs) can also be programmed to calculate when a patient will run out of medication and prompt the physician to produce a new prescription during clinical assessments.

**5. Prescribe medications only when there is reliable evidence of their effectiveness for the patient's condition.** What doctor hasn't felt the impulse to write a prescription as a short-term escape from a treatment dilemma? Resist this temptation, and you won't entangle patients in pseudo treatment failures, side effects and "refill" requests. Prescribe because of medical necessity, not to placate. If you

## CONTROLLED SUBSTANCES

Rates of diversion and overdose from prescription medications are alarming, with some states reporting more deaths from prescribed controlled substances than from motor vehicle accidents.<sup>2</sup> The continuing scourge of prescription drug abuse is an iatrogenic consequence of overprescribing schedule II drugs. Nationwide improvements are needed to restore saner, safer use and control of these drugs. The following legal basics offer guidance.

### Legal basics:

- Regardless of how long you've known a patient or how stable his or her dose, a new prescription is *always* required for schedule II medications.
- Write controlled substance prescriptions for no more than a 30-day supply of medication.
- Prohibit refills.
- Do not post-date prescriptions.

Despite specific and clear federal laws<sup>3</sup>, confusion persists regarding how to provide patients with more than 30 days of schedule II medications. For stable conditions in reliable patients, you may prolong the time between clinical assessments by providing up to three sequential 30-day prescriptions during an appointment. All the prescriptions must share the date they were written. The second and third prescriptions must include the statement, "DO NOT FILL BEFORE \_\_\_\_\_" (30 or 60 days from the date of the original prescription).<sup>3</sup> Use this appointment-based "going-forward" strategy to provide sufficient medication coverage up to 90 days, and you can avoid legally dubious "refill" routings, eliminate the need for patients to appear at your office every 30 days to pick up a new prescription and end telephone demands for interval prescriptions.

are compelled to trade prescriptions against symptoms of medication-resistant conditions, prescribe alternative treatments such as exercise. These prescriptions never require prior authorization or result in demands for refills.

There are no safe clerical shortcuts through

the prescribing moment. This unique clinical event involves a doctor integrating a range of patient and community data, applying professional judgment and directly sharing advice about medication tolerance, adherence and interactions. Respect these steps, and you will

safeguard patient safety, fortify your medicolegal defenses and ensure practice viability. **FPM**

### PRESCRIBING WARFARIN CHANGES

As part of their "refill" programs, some practices allow staff members to adjust drug doses based on lab results. Trying this with warfarin prescriptions is a recipe for disaster. Warfarin's therapeutic ranges are condition-specific; patient responses to the drug vary widely and quickly; and the consequences of over- and under-anticoagulation can be catastrophic. Adjust warfarin only with intense clinical oversight that addresses both the dangers of the anticoagulant and the condition requiring warfarin. (For help with warfarin adjustment, check out this calculator at <http://www.soap-note.org/cardiovascular/coumadin-calculator/> or download FPM's outpatient anticoagulation flow sheet, which includes a dosage adjustment algorithm, at <http://www.aafp.org/fpm/2005/0500/fpm20050500p77-rt1.pdf>.)

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

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■ Review patients' medications at each visit, and write new prescriptions if they are running low.

■ Be careful not to prescribe medication as a short-term escape from a treatment dilemma.