Workers' Comp

Keeping Injectable Spend in Check with Smarter Utilization Review

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4 MIN READ

When injectables become common, inconsistency becomes costly. WCRI's January 2026 study shows that injectables were used in about four in 10 lost-time claims, and injectable payments per claim varied dramatically across states.

This article breaks down why injectables deserve focused utilization review (UR) attention and what a strong UR approach looks like when you set clear clinical expectations for injectables, so approvals stay appropriate, consistent and defensible.

UR's growing role in injectable oversight

The increased frequency of injectables brings increased financial impact and a strong need for consistent clinical guardrails. WCRI reported wide variation in injectable payments per claim, ranging from $362 in California to $2,404 in Louisiana, noting differences may be driven by treatment mix, fee schedules or utilization controls.

The combination of high utilization, high cost, and high variation is where UR brings clear value: not as a blunt cost-cutting tool, but as a structured way to confirm the right injectable is used appropriately for every injured employee.

Why injectables are a UR priority category

1) The market is shifting toward higher-cost therapies

Clinically administered injections still dominate spending (WCRI cites 85% of injectable payments in early 2024), but self-administered injectables are taking a growing share—15% of injectable payments in early 2024, up from 7% in 2018. These drugs show up in relatively few claims yet can materially move total spend due to high unit costs.

2) Many injectables should follow stepwise, evidence-based sequencing

WCRI flags pain management injections (notably nerve blocks and epidural steroid injections) as both important and costly and notes these injections are "usually indicated only after oral medications, physical therapy, and an

adequate time for healing has been allowed." That is practically a blueprint for UR: verify conservative care was attempted, confirm indications, and ensure the plan is consistent with evidence-based pathways.

3) Newer injectables raise reasonableness questions, not just reimbursement questions

WCRI raises step-therapy concerns for multiple emerging, high-growth categories. For example, it notes hyaluronic acid injections are "approximately 18 times more costly than cortisone products," and suggests payers/regulators consider whether utilization protocols are adequate to ensure compliance with graduated step therapy.

Similarly, WCRI notes PRP injections may produce unpredictable outcomes because indications have not been established with evidence-based certainty.

Where UR adds the most value (and how)

UR's best contribution is not simply to approve or deny, it's clinical risk management, consistency and clarity. Here are the highest impact UR leverage points, aligned with WCRI's findings:

Validate medical necessity through step-therapy documentation

Because many local injections are delivered months after injury and reflect escalating care, UR ensures that escalation is warranted and not premature.

WCRI explicitly points to unanswered questions about whether injections are being used as step therapy after conservative options fail and calls out the role of review/authorization processes in ensuring appropriate use.

Apply evidence-based frequency and sequencing controls

Even when an injection is indicated, repeat procedures can become the cost and variation driver. UR sets guardrails around:

- Number of injections per episode/time window
- Required functional improvement to justify repeat injections
- Appropriate progression

This is especially relevant for high-cost pain management pathways where additional procedures are often needed.

Manage appropriateness risks in high-cost biologics

WCRI highlights that self-administered biologics, such as migraine treatments, have become major cost drivers within self-administered injectables. They also note uncertainty about whether they're being used first-line or after less costly options fail, and that uncertainty about the diagnosis could contribute to off-label use.

UR can add value by requiring:

- Documentation showing how a diagnosis was determined and why similar conditions were ruled out (e.g., chronic migraine vs. post-traumatic headache)
- Prior preventive therapy trials and why they failed or weren't appropriate
- Treatment duration and reassessment schedule

Clarify "compensability adjacency" for comorbid-related injectables (e.g., GLP-1s)

WCRI notes GLP-1 receptor agonists remain relatively uncommon in workers' comp but are appearing more frequently. In some situations, they are used with the rationale that short-term use could improve recovery or enable necessary treatment. However, guidance on duration, goals and stopping rules remains limited.

UR can operationalize this by asking:

- What compensable treatment is being enabled (surgery clearance, functional participation in rehab, etc.)?
- What is the target (e.g., weight/BMI milestone, A1c goal, surgical readiness)?
- What is the timeline and discontinuation plan?

The bottom line: Strong UR helps keep injectable care clinically appropriate while reducing unwarranted variation and cost volatility

With a well-designed UR program, you can protect patients by avoiding unnecessary invasiveness, protect outcomes by ensuring stepwise care, and protect budgets by preventing high-cost therapies from becoming the default before lower-risk options are tried. When UR is aligned to clear clinical criteria, measurable goals, and time-limited trials, it helps ensure injectables are not just *approved*—but truly reasonable and necessary in each claim.



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