DUR UTILIZATION AND REVIEW (DUR) BOARD MEETING
December 7, 2005 MINUTES

Wednesday, December 7, 2005
1:00 P.M. – 4:00 P.M.
1 W. Wilson Street, Room B155 (first basement level)
Madison, WI 53701

DUR Board Members Present:	Mark Buhler, R.Ph. Robert M. Breslow, R., Ph. Daniel Erickson, M.D. Pamela Ploetz, R., Ph. Nancy Ness, M.D. Nancy Ranum, M.S., RN Ward Brown, M.D.
Innovative Resource Group:	Mike Mergener, R. Ph. Ph.D. Allan Mailloux, Pharm. D. Karen Paulson (Scribe) Margaret Asquith, Pharm.D.
DHCF:	Dr. Richard Carr –DHCF Rita Hallett – DHCF Roma Rowlands - DHCF Ted Collins – DHCF Carrie Gray-DHCF
GUESTS:	Jagdish J. Shastri – Lilly Scott Hawley – EDS Dean Groth - Pfizer Mike Boushon – Wisconsin Veterans Home, Pharmacist Kimberly Smithers - BHCSD

Minutes

Dr. Richard Carr called the meeting to order at 1:00 P.M.

I. Approval of Agenda

Agenda was approved as published.

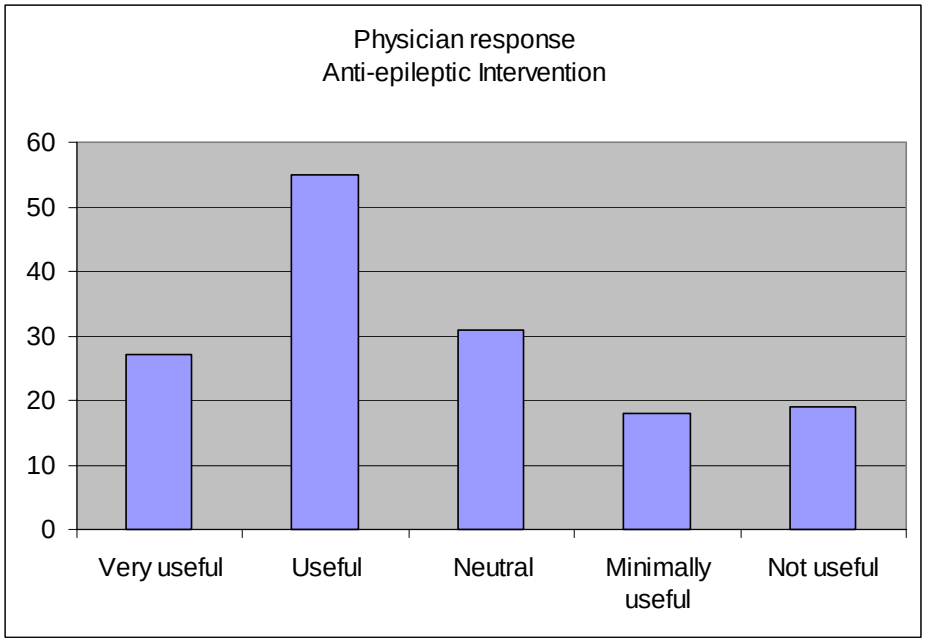
II. Approval of Minutes – September 7, 2005 Meeting

Minutes were approved as published.

III. Retrospective DUR

Anti-epileptic intervention update.

Prescribers were asked to participate in a survey as a means of collecting feedback on the usefulness of conducting the 2005 anti-epileptic intervention. In total, 488 prescribers were sent surveys and of those, 188 (38.5%) responded. Following are the preliminary results of the survey:



Doctors that participated stated they reviewed the information that was provided and had the following responses (% of respondents):

33% will review the treatment regimens for my patients.
50% have already explored other options before prescribing these drugs.
2.7% changed how I am prescribing anti-epileptic drugs for non-approved indications.
37.8% did not modify the drug therapy because I believe treatment is appropriate.
5.3% have discussed an action with the patient.
0.5% referred the patient for additional evaluation.

DHCF completed a pre/post intervention comparison of the number of prescriptions and the amount paid for the claims in the entire class of drugs and also specifically for gabapentin. The comparison shows a reduction of 818 prescriptions and the amount paid reduced by $213,000. Following are the results provided at the meeting:

	3 Months Pre-intervention	3 months Post-intervention	Change
# RXs	29222	28404	-818
Amt Paid	$5,211,305.82	$4,997,479.71	-$213,826.11
# Gaba RXs	8653	7758	-895
Amt Paid	$899,369.97	$580,212.49	-$319,157

During the discussion of this agenda item the following items were noted:

- The Board discussed ways to determine the overall value of conducting the intervention. Mike will look at a group of individuals not included in the intervention to see what pre and post impact they had as a control group. There was discussion about a match group on this topic. Mike agreed to re-run the data with a comparison to a match group to determine the impact of the intervention. This will be completed for the March DUR Board meeting.
- Mike agreed to complete a comparison of market share switch between drugs in the classes during the pre and post timeframe.
- The pre and post comparison will consist of a post comparison of five months that will end with December 2005 claims.
- A final report will be provided at the March DUR Board meeting.

Anti-emetic utilization data results and recommendation.

The Wisconsin Medicaid Prior Authorization (PA) Advisory Committee asked the DUR staff to consider adding a PA or quantity limit policy to the anti-emetic drug class. To determine if this is recommended, staff analyzed the utilization within the 5HT inhibitor class. Between July 1, 2004 and June 30, 2005 there were 2360 recipients that took drugs in that class. In total, there were 6700 prescriptions that totaled $4.3 million. A diagnosis profile was developed for all 2360 recipients and analyzed to determine the diagnosis that indicate the proper use of anti-emetic drugs and those that did not. Of the 2360 recipients 35 did not have a diagnosis that was determined to be appropriate. That inappropriate utilization represents 98 claims totaling $74,000. One of the identified patients accounted for more than $54,000 of the total.

Nausea and vomiting were included as appropriate diagnosis in the analysis. The Board discussed whether or not nausea and vomiting should be included as appropriate diagnosis for using anti-emetic drugs. If nausea and vomiting are combined with another diagnosis, then the use of an anti-emetic could be appropriate. Staff stated that it will be difficult to ensure that combinations of diagnosis represent appropriate and inappropriate use because of the way diagnoses are reported to Medicaid.

Staff clarified that the PA Advisory Committee asked the DUR staff to look at the possibility of implementing quantity limits in the class and not just the appropriateness of the drug use. Staff will conduct analysis to determine if the appropriate quantities of the drugs are being used, regardless of the diagnosis. The goal is to ensure the drugs are not being over-prescribed and therefore being wasted. Staff will prepare analysis based on the notes from the meeting and present for the final time at the March DUR Board meeting. At the meeting the DUR Board will make a recommendation to proceed with either the PA or quantity limit policy within the anti-emetic drug class.

IV. Prospective DUR (Follow-up)

Addresses of low ER override pharmacies.

Mike Mergener presented a list of pharmacy names and their addresses that represent the pharmacies that have low override percentages of the ER (early refill) DUR alert. The DUR Board requested this list at the September meeting to determine if there were certain geographic regions or types of pharmacies that had low override percentages. The average ER alert override percentage is 30%. Most of the pharmacies on the list are significantly below the average. The list was mostly comprised of pharmacies from one specific chain-store, but not necessarily one geographic area.

One of the new DUR Board members, Rocky LaDien, represents chain-stores. At the March DUR Board meeting, Rocky will be asked to address why chain-stores would have such a low override percentage as compared to the average. If the stores have a company policy to deny prescriptions whenever the override is sent, the DHCF may have to work with the stores so they properly provide medications based on the individual needs and not simply the presence or absence of the alert. Mike Mergener will discuss the issue with Mr. LaDien prior to the next meeting.

Criteria modifications.

During the September DUR Board meeting it was decided to implement the following changes to the TD alert in the prospective DUR system.

- Separate the long acting and the short acting opiates. Long acting drug should be extended release morphine and oxycodone, fentanyl transdermal, and methadone.
- Modify diuretics duplication. Change so thiazides do not duplicate with metolazone or loop diuretics but only with other thiazides.

The DHCF has started the process for implementing the changes. At this time an implementation date is not available.

Letter to participating pharmacies.

Mike Mergener provided DUR Board members a draft letter that will be sent to pharmacies that participated in the ER and TD alert intervention. The letter thanks providers for participating and also states the actions DHCF is taking based on the results of the intervention. The letter will be sent to pharmacists once the system has been modified as stated in the previous agenda item. The DUR Board endorsed the letter and approved it for distribution once system changes have been implemented.

V. Break (2:20 p.m.)

VI. Recipient Lock-in Update

The following items were discussed from the previous DUR Board meeting:

- What impact will the implementation of Medicare Part D have on the recipient lock-in program? Staff found that approximately one-third of the current recipient lock-in participants are dual-eligible with Medicare and will therefore not be in the program after the implementation of Medicare Part D. At this time, the Medicare Part D program is not ready to accept the reporting of who is included in the Wisconsin Medicaid lock-in program. However, that information, if requested, can be reported to the appropriate entity. The number of cases in the lock-in program will decrease. In anticipation for the decreased

workload, staff has already been given additional responsibilities to account for decrease in work.

- The DUR Board requested an overview of the emergency room lock-in project. Staff provided the DUR Board members with a hand-out that summarized current ER utilization (see attachment 1). On average Medicaid pays for two ER visits per recipient per year. The commercial average is one ER visit per individual every seven years. The project was started as a cost savings initiative with a goal of saving the state budget $1.6 million through the reduction of inappropriate emergency room use. This is done through the use of recipient and provider letter interventions, a web-based data-tool for emergency rooms that allows recipient history to be accessed, a lock-in program for those recipients identified as intentionally abusing emergency room services, and case management for selected individuals to address complex medical needs.

  The team is first focusing on recipients that have six or more ER visits in a year. In total, there are 5000 recipients that meet those criteria. The team plans to send the first intervention letters out in January. Depending on the establishment of a primary care provider, letters will be sent to recipients, physicians, Community Service Programs, and Targeted Case Managers. In total, there will be approximately 5000 letters sent to recipients and 8000 to providers.

The DUR Board members asked questions and discussed specific details related to the update provided. No specific follow-up actions or decisions were noted.

VII. DUR criteria

Prospective DUR modifications: High Dose, Low Dose

When the new MMIS system is implemented in January of 2007 there will be some new prospective DUR alerts available that are not available today. DHCF would like the recommendation of the DUR Board to include or not include the new alerts in the development of the new system. Mike Mergener presented the handout title, 'Prospective DUR High/Low Dose Alerts' (attachment 2). The handout explained the criteria for setting the alerts. Mike Mergener pointed out that the DUR Board only had to decide if the new alerts should be included at this point and time. At future meetings the DUR Board will determine how the new alerts should be configured.

The DUR Board members discussed the usefulness of the alerts. In general the following items were noted:

- New alerts should be implemented to increase the safety of taking prescriptions and not to save on pharmacy costs. Although, it is possible to both increase safety and also save on cost at the same time.
- It is likely that if the new alerts are implemented they would be intended to increase safety but they would also likely catch data entry errors on the claims (decimal point in wrong place)
- To be most useful, the alert would have to be paired with a diagnosis. However the alert is not built to work with a diagnosis, nor is the diagnosis required on the claim. The alert is built using minimum and maximum dose levels for all indications, not for specific indications.
- The high dose alert would be useful from a safety standpoint if someone's prescription were incorrectly interpreted as being the wrong drug or quantity.
- The low dose alert does not appear to have value from a safety standpoint

The DUR Board recommends the DHCF implement the High Dose alert in the new MMIS system. The DUR Board does not recommend the DHCF implement the Low Dose alert in the new MMIS system. In addition, the DUR Board recommends the High Dose alert be put at the end of the DUR alert hierarchy.

Updated retrospective DUR system and criteria.

Mike Mergener provided the DUR Board members a hand-out listing some of the new criteria available in the new retroactive DUR system. The handout provides a listing of some of the criteria the new system offers. The DUR Board will need to make recommendations for either implementing or modifying the criteria. After today's presentation, DUR Board members will receive 'homework' assignments from Mike Mergener to complete previous to the next meeting. The DUR Board recommendations will help DHCF determine the priority of criteria to implement and modify.

Mike summarized how the new retrospective DUR system functions. Mike agreed to provide what claims the new system uses to process alerts against. It is assumed that the system uses both pharmacy and medical claims.

There are approximately 1100 new criteria in the new system and the DUR Board members will need to help DHCF prioritize them. Mike will work with the vendor HID to put together a list of the criteria to review. The list will be send to DUR Board members prior to the next meeting. Members should provide feedback to Mike so the results can be summarized and discussed at the next meeting in March. The goal will be to review criteria for every meeting and complete the review within one year. To help the review, a severity listing has already been associated with each criterion. That listing will be included in the list Mike generates.

VIII. Miscellaneous Agenda Item

Requiring Diagnosis on all Prescriptions

The DUR Board members discussed the benefits of requiring the diagnosis code on all incoming pharmacy claims. Members expressed frustration with the inability to effectively analyze drug utilization because not all claims are associated with a diagnosis. This same topic has been

discussed at a number of previous DUR Board meetings. Following are discussion points that were stated during the conversation:

- If the diagnosis is required on a claim, it must be required of the prescriber and not the pharmacist. Currently, the pharmacy submits the claim and if the claim required a diagnosis, the pharmacist would be required to call the prescriber to get the diagnosis if it was not written on the prescription.
- The DUR Board may be interested in pursuing a law or regulation change that would require prescribers to put the diagnosis code on all prescriptions.
- If the diagnosis code is required, it needs to be written both in plain English so that the patient understands why they are taking the drugs and also the correct ICD code so the claim can be billed correctly. Who is going to be responsible for the additional work?
- Mike Mergener clarified that the system would only be able to accept the ICD code for a diagnosis. Plain text would not be useful in data analysis and is not compliant with the NCPDP standards.
- Many patients do not want the diagnosis documented on their prescriptions because of privacy concerns.

DHCF staff agreed to discuss if the diagnosis should be required and if so, how that might be accomplished. The item will be brought back to the next DUR Board meeting.

New DUR Board members

As the terms of DUR Board members end, the DHCF will be appointing new members. This year the DHCF has chosen to appoint three new members. For that reason this meeting is the final meeting for three of our existing members. Those members are:

- Nancy Ness, M.D.
- Mark Buhler, R.Ph.
- Barry Hess, R.Ph.

The DHCF staff thanked the exiting members for their time, efforts, and accomplishments while serving on the WI Medicaid DUR Board.

The March meeting will be the first meeting for the three newly appointed DUR Board members. The new members are:

- Franklin “Rocky” LaDien, R.Ph. – Rocky is a Walgreens regional manager for southeast Wisconsin.
- Mike Boushon, R.Ph. – Mike currently works for the Wisconsin Veterans’ Home in Waupaca County and previously worked with the DHCF as a pharmacist.
- Robert Factor, M.D. – is a psychiatrist working for the VA Hospital in Madison.

The meeting was adjourned at 3:50 P.M.