DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
MARCH 1, 2006 MINUTES

Wednesday, March 1, 2006
1:00 P.M. – 4:00 P.M.
1 W. Wilson Street, Room B141 (moved to B139)
Madison, WI 53701

DUR Board Members Present:	Robert M. Breslow, R., Ph. Daniel Erickson, M.D. Rocky LaDien, R.Ph. Mike Boushon, R.Ph. Robert Factor, M.D. Lee Vermeulen, R.Ph., M.S.
APS Healtcare/EDS:	Mike Mergener, R. Ph. Ph.D. Allan Mailloux, Pharm. D. Karen Paulson (Scribe) Margaret Asquith, Pharm.D. Scott Hawley
DHCF:	Dr. Richard Carr Lynn Radmer Rita Hallett Roma Rowlands Ted Collins Carrie Gray Marilyn Howe Pamela Appleby
GUESTS:	Rebecca Stewart, Ortho-McNeil Cher Beilfuss, Allergan Jennifer Stoffel, Ortho-McNeil

Minutes

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

I. Approval of Agenda

The agenda was approved as published.

II. Approval of Minutes – December 7, 2005 Meeting

The minutes were approved with one amendment. Page 2 of the minutes reflected a reduction of 118 prescriptions. The number should have been 818.

III. Introduction of New Members

Dr. Carr introduced the three new DUR Board Members.

- 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.

IV. Retrospective DUR

Anti-epileptic intervention final report.

Dr. Mergener presented the final report on the 2005 anti-epileptic intervention (see attachment 1).

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

- With an adjustment for a reduction in the price of gabapentin cost savings as a result of the intervention were calculated to be $752,232.
- In the future, if another anti-epileptic intervention is conducted it should look at approved diagnosis on a drug by drug basis rather than developing a group of approved diagnosis for all drugs in the class.
- Based on the prescriber feedback, the intervention was successful in changing prescribing patterns to match approved indications and diagnosis. It also appears to have caused prescribers to review the entire regimen of medications a patient was taking and remove medications from a patient's regimen that were no longer needed.

Anti-emetic utilization final report.

Dr. Mergener presented the final report on the analysis performed on anti-emetic drugs to determine if the DHCF should adopt a quantity limits policy for the drug class (see attachment 2).

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

- At the last DUR Board meeting it was shown that most anti-emetic drugs are prescribed for approved indications. Based on the analysis, staff did not recommend diagnosis restrictions be placed on the anti-emetic drug class.
- Based on the analysis conducted since the last DUR Board meeting, staff did not recommend quantity limits be placed on the anti-emetic drug class. The DUR passed a motion to not recommend quantity limits be placed on the anti-emetic drug class.

V. Prospective DUR (Follow-up)

Criteria modifications

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

- Modify the alert to separate the long-acting and the short-acting opiates so that short-acting and long-acting opiates will no longer consider each other when triggering the alert.
- Modify diuretics duplication. Change so thiazides do not duplicate with metolazone or loop diuretics but only with other thiazides.

Both modifications have been approved by DHCF staff and implementation should occur before the June DUR Board meeting. Once implemented, a final letter will go out to participants of the intervention to let them know what actions were taken as a result of the intervention.

Early refill (alert intervention) follow-up

At the December 2005 DUR Board meeting, Dr. 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. Because one of the new DUR Board members, Rocky LaDien, represents chain-stores, the Board agreed to ask Rocky to address why chain-stores would have such a low override percentage as compared to the average. It was suspected that demographics of the stores were relevant to the low override percentages.

Rocky reported that the problem did not appear to be one related to demographics. He received a list of the Walgreens stores that had low override percentages. In most cases the pharmacist had not been trained to ask the 'right' questions to the patient to determine if the early refill override should or should not be overridden. In most cases, the patient was told it was too early for a refill and the patient simply returned at a later date.

VI. Break (2:00 p.m.)

VII. DUR criteria

Retrospective DUR criteria

Dr. Mergener provided the DUR Board members a hand-out that categorized the DUR criteria that are currently available (see attachment 3). Dr. Mergener led a discussion for each category and provided a recommendation to the DUR Board for how to proceed with each. Following are the categories and approved recommendations.

Pregnancy contraindication – Analyze the drugs on the list and activate any drug with an FDA category of D or X.

Renal and hepatic toxicity – Do not activate drugs requiring dosage adjustments. Review drugs causing hepatic and renal toxicity to be sent to members for a decision at the next DUR Board meeting.

Elderly specific – Review drugs in the three subsets to be sent to members for a decision at the next DUR Board meeting. Do not activate Beers' list criterion.

Controlled substance overuse – Keep current criteria. Do not activate individual drug criteria.

Migraine treatments – Activate criteria to evaluate results, but do not take action. A separate initiative by the State is currently looking at quantity limits for triptans.

New therapeutic duplication – Do an in-depth review of the category that will be sent to members for the next DUR Board meeting.

Dose consolidation/splitting – Activate the appropriate alerts in conjunction with the State's comprehensive program.

Maximum dose – Do an in-depth review of the category that will be sent to members for the next DUR Board meeting.

Disease contraindications – There are eight criteria in this group and only two with a category 1 severity level. The Board recommended activating the two criteria with a category 1 severity level, which are cyclic antidepressants in patients with Wolff-Parkinson-White syndrome and patients with narrow angle glaucoma.

Drug/drug interactions – Do an in-depth review of the category that will be sent to members for the next DUR Board meeting.

Drugs as disease markers – Do an in-depth review of the category that will be sent to members for the next DUR Board meeting.

Late refill – Review list to see if any categories should be sued in prospective system. Do not activate late refill alerts in retrospective system.

Miscellaneous criteria – Finish review of these criteria and develop recommendations for decisions at the next DUR Board meeting.

During the discussion of this agenda item the following item was noted:

- The vendor that provides the retrospective DUR system is Health Information Designs (HID). HID develops the criteria available in the system at the request of one of their clients. Once it is developed for one of their clients, the criteria is made available to all of their clients.

VIII. Pharmacy Cost Savings Initiatives

Tablet splitting and dose consolidation

In the past the DUR Board has approved the idea of implementing tablet splitting and dose consolidation policies for Medicaid, BadgerCare, and SeniorCare. Work has started to implement the policies and this agenda item is an update to communicate to the Board the State's intent.

Dr. Mergener provided a handout and verbally summarized a draft proposal for implementing tablet splitting and dose consolidation policies for Wisconsin Medicaid, BadgerCare, and SeniorCare. Dr. Factor will provide a list of drugs included on the VA Hospital pill splitting program to possible include with the State's new policy.

The Board suggested that the State consider including atypical antipsychotic drugs on the list of drugs to be included in the policy.

The Board approved the list of drugs included in the draft policy.

Drug regimen review

The Board was presented two articles related to drug regimen review. The articles were:

1. The Asheville Project: Short-Term Outcomes of a Community Pharmacy Diabetes Care Program.

2. Evaluation of the Iowa Medicaid Pharmaceutical Care Management Program

The articles were presented to the Board as examples of what other States are doing for drug regimen review programs.

As a cost savings initiative, the State of Wisconsin is considering the creation of a pilot project for pharmacists to do some drug regimen reviews. The pharmacists would get paid for doing the reviews. By creating the program the State hopes to improve a variety of health parameters for patients taking a large number of prescriptions and also provide financial benefit back to the State.

The State would like the DUR Board to offer a recommendation for how to identify recipients that could be targeted for conducting drug regimen reviews.

Other States have based their criteria on the number of prescriptions a patient is taking at a given point in time. Is it possible for the DUR Board to recommend a specific number of prescriptions that could be the starting point for conducting the reviews?

After discussion the subject the Board agreed that picking a specific number is not the best approach. Additional time is needed to determine the best approach. The following items should be considered when making the determination:

- number of prescriptions
- overall drug cost of the patient
- diagnosis of the patient

IX. Adjournment

The meeting was adjourned at 4:00 P.M.

X. Miscellaneous Agenda Item

Requiring Diagnosis on all Prescriptions

At the December DUR Board Meeting the 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. DHCF staff agreed to discuss if the diagnosis should be required and if so, how that might be accomplished.

Dr. Carr provided the DUR Board members a handout (Attachment 4) that outlines the issue and the reason why DHCF does not currently require the diagnosis code to be submitted on all drug claims. Dr. Carr summarized that with the advent of better technology (ePrescribing) there may be a way for DHCF to require the diagnosis code in the future, but not today.

Dr. Mergener added that requiring diagnosis codes on pharmacy claims ought to come from other professional organizations such as PSW or the State Medical Society in a unified fashion for all healthcare plans.

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

- Currently diagnosis codes on pharmacy claims and medical claims are used for conducting DUR analysis. When the diagnosis code is available it is very useful in conducting the analysis.
- Whenever possible the DHCF encourages pharmacies to include the diagnosis codes on drug claims, but has never taken the step to require the diagnosis codes on drug claims.
- Often, patients do not want doctors to write their diagnosis down on the prescription because of privacy concerns.

- When a doctor writes down a diagnosis on a prescription, the pharmacist must convert the diagnosis from a term, such as, ‘hypertension’, into a specific ICD-9 code to bill on the claim. Because there are thousands of ICD-9 codes for different type of hypertension, accurately picking the current code is problematic for the pharmacy.
- Once better IT procedures and ePrescribing standards are accepted, reporting diagnosis codes may be possible, however before that occurs it is unlikely the DHCF will be able to require physicians to report diagnosis on ALL prescriptions.

Attachment 1

Analysis of anti-epileptic drugs

GOALS:

- To analyze the use of these agents for non-FDA approved indications
- To develop potential targets for a letter intervention

METHODS:

All claims for the newer anti-epileptic drugs (gabapentin, lamotrigine, felbamate, tiagibine, oxcarbazapine, topirimate, and levetiracetam) were extracted for June 2004 through May 2005. Type and specialty were extracted for all providers and associated with the provider number attributed to the prescription. Data were aggregated by provider for preliminary analysis.

A query was run to gather any diagnosis for post-herpetic neuralgia, diabetic neuropathy, or any seizure disorder since 2003 for all patients included in the initial abstract. If any diagnosis was found for these conditions, all prescriptions for the anti-epileptic were eliminated from the original extract. A similar aggregation was produced from the remaining claims.

PRELIMINARY RESULTS:

A summary of the findings includes:

- Almost $40 million was paid for these drugs in the most recent 12 months analyzed. One third of the payments was for gabapentin.
- No approved diagnosis could be found for almost 60% of the prescriptions. Almost 80% of gabapentin RXs had no approved diagnosis on file
- Three drugs, levetiracetam (Keppra), felbamate (Felbatol), and tiagabine (Gabitril) had most of their use for approved indications
- The top 500 prescribers (less than 10%) account for almost 60 percent of the total expenditures for drugs with no diagnosis. Prescriber numbers identifying institutions, e.g., Froedtert Hospital were excluded from the intervention.
- Over 50% of the expenditures in the top 500 were for prescriptions written by psychiatrists

The analysis suggests that there are a considerable number of prescriptions written for these drugs with little evidence to support their use. The DUR Board recoomended that we send an educational intervention to the psychiatrists, family practitioners, general practitioners, and the unspecified specialty types to inform them of the Medicaid expenditures for antiepileptic drugs, and asking them to review their use of these drugs. Based on Board input, the intervention was sent to all specialty types ranked in the top 500 by total amount paid for the prescriptions attributed to the prescriber. (Some of the top 500 prescribers were attributed to institutions and the default DEA number. As a result 495 intervention packets were prepared. In addition, seven prescriber addresses were not valid, leaving 488 prescribers who received an intervention packet.

The materials included in the intervention were a cover letter, a summary of the appropriate use of antiepileptic drugs, a list of patients and their antiepileptic drugs (including the amount paid) attributed to the prescriber, a response form, and a return envelope.

Anti-epileptic drugs	**6/2004 to 5/2005**	
All claims		
Description	Amount Paid	% total costs
GABAPENTIN	$12,824,937.08	32.3%
LAMOTRIGINE	$9,332,176.94	23.5%
TOPIRAMATE	$8,194,263.08	20.6%
LEVETIRACETAM	$3,620,885.49	9.1%
OXCARBAZEPINE	$2,995,423.40	7.5%
ZONISAMIDE	$1,426,056.73	3.6%
TIAGABINE	$697,710.41	1.8%
FELBAMATE	$597,978.37	1.5%
Total	$39,689,431.50	

6/2004 to 5/2005		
No diagnosis		
Description	Amount Paid	% claims with no diagnosis
GABAPENTIN	$10,120,079.42	78.9%
TOPIRAMATE	$4,923,287.74	52.8%
LAMOTRIGINE	$4,226,915.60	51.6%
OXCARBAZEPINE	$1,793,039.37	49.5%
LEVETIRACETAM	$834,471.05	27.9%
TIAGABINE	$478,171.62	33.5%
ZONISAMIDE	$458,028.42	65.6%
FELBAMATE	$87,505.01	14.6%
Total	$22,921,498.23	57.8%

Anti-epileptic drugs	**6/2004 to 5/2005**	
Top 500 prescribers	**No diagnosis**	
Specialty	Amount paid	Count
PSYCHIATRY	$6,958,926.22	215
NEUROLOGY	$1,895,900.83	69
FAMILY PRACTICE	$1,226,323.54	63
INTERNAL MEDICINE	$1,092,991.39	52
NONE SPECIFIED	$981,348.04	45
ANESTHESIOLOGY	$391,355.65	16
PHYSICAL MEDICINE/REHAB	$269,556.07	14
PEDIATRICS	$201,375.35	7
GENERAL PRACTICE	$149,693.17	5
GERIATRICS	$87,845.33	3
PATHOLOGY	$52,013.16	1
EMERGENCY MEDICINE	$29,500.65	2
RADIOLOGY	$13,337.81	1
URGENT CARE	$12,934.07	1
CARDIOVASCULAR DISEASE	$10,360.86	1
	$13,373,462.14	495

RESULTS

Prescriber response

(N=188) Response rate =38.5%

I have reviewed the information provided and found it:
33 very useful. **Average = 3.38**
68 useful.
35 neutral.
22 minimally useful.
22 not useful.

I have reviewed the information provided and: **% 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

Pre/post evaluation

In order to compare the results of the intervention, the cumulative costs for the prescriber/patient combination sent in the intervention were extracted from the paid pharmacy claims. Since Medicaid Part D began on December 2005, there was only 5 months of comparison data available post intervention. Therefore, the 5 months post comparison data was compared with the 5 months of data preceding the intervention.

The pre-post comparison for the intervention is summarized in the following table:

Drug	Decrease in Rxs	Decrease in spend
LAMOTRIGINE	1068	$91,458.71
FELBAMATE	1	-$2,593.73
GABAPENTIN	2643	$600,606.86
TOPIRAMATE	1518	$244,490.85
OXCARBAZEPINE	720	$83,991.11
TIAGABINE	473	$32,545.22
LEVETIRACETAM	228	$20,383.51
ZONISAMIDE	217	$21,251.04
PREGABITRIL	-216	-$28,545.14
Total	**6652**	**$1,063,588.43**
Adjusted for gabapentin price decrease		$752,232.41

Because the cost of gabapentin has been dropping, an additional calculation was performed to adjust for cost savings due to price decrease. With the adjustment, cost savings was calculated to be $752,232.

A similar cost analysis was performed for cohort of prescriber/patient pairings that did not receive an intervention letter. The pharmacy claims data were extracted for this cohort for the same time periods used for the intervention comparisons. The summary of these results is shown.

Drug	Increase in Rxs	Increase in spend
FELBAMATE	7	$1,655.70
GABAPENTIN	1274	-$389,174.20
LAMOTRIGINE	967	$258,702.09

LEVETIRACETAM	395	$92,520.58
OXCARBAZEPINE	396	$83,635.96
TIAGABINE	-48	$13,003.79
TOPIRAMATE	740	$218,380.36
ZONISAMIDE	171	$23,767.55
PREGABALIN	292	$39,339.70
Total	4240	$341,831.53
Adjusted for GBP		$825,351.09

DISCUSSION

Overall, less expenditures occurred in the intervention group post-intervention when compared to a similar time frame in the pre-intervention period. The opposite is true in the control group. This is despite the introduction of a new drug (pregabalin) in the anti-epileptic drug category in the post-intervention period.

While it is difficult to control for outside influences on the use of these drugs, the intervention seems to have contributed to the overall decrease in expenditures. Interventions of this type might be considered for other drug classes where clinical prescribing protocols have been developed.

Attachment 2

Analysis of anti-emetic drugs

Objectives:

- To analyze the utilization
- To assess whether a need exists for quantity limits

Methods:

All drug claims for the 5-HT antagonist anti-emetics (ondansetron, granisetron, dolastron, alesetron) and aprepitant were extracted for July 2004 through June 2005. Diagnosis information from medical claims from 1/1/2004 through 11/30/2005 was also extracted for any patient receiving any contained in the drug extract.

Preliminary results:

A table of the aggregated data is attached.

			RXs	Amt Pd
# of recips receiving anti-emetic drug	2360		6775	$4,353,253.23
# of recips with appropriate diagnosis	2325		6676	$4,278,577.99
# of recips with inappropriate diagnosis (including N and V)	35		99	$74,675.24
# of recipients with pregnancy diagnosis	604			
# with hyperemesis diagnosis	268			

1. Selected all claims for 5-HT antagonist anti-emetic from 7/1/04 through 6/30/05
2. Identified unique recipients (N=2360)
3. Extracted all diagnoses associated with identified patients' medical claims
4. Selected diagnoses associated with nausea/vomiting.
5. Queried for acceptable diagnoses by patient
6. Did not find an approved diagnosis for 35 patients

The DUR Board recommended removing patients if nausea and vomiting were the only diagnosis available. This resulted in one additional patient without an acceptable diagnosis.

The issue was further refined to review claims to decide if quantity limits might be appropriate for this drug class.

Additional results

Claims were re-extracted and aggregated by total number of units dispensed for analysis.
Recipients were selected if the annual quantity dispensed exceeded 200. The recipients were rank ordered by quantity.

Some of the large quantities dispensed were the result of oral liquid dosage forms that are dispensed by milliliters which tends to inflate the quantity. A query was run on the top 15 ranked patients by quantity. Fourteen of these 15 patients have complicated medical conditions most of which seem to have legitimate reasons for the use of anti-emetics. Individualized chart review or some other face-to-face intervention would be necessary to verify this.

Conclusion/Recommendations:

Based on the analysis, we would recommend that no quantity limits be placed on these drugs.

Attachment 3

Retrospective DUR criteria analysis and recommendations

The current retrospective DUR criteria have been developed by Health Information Designs' clinical staff beginning in the early 1990's and continue to be developed as new clinical information becomes available. References supporting the criteria are provided on the printed profiles and prescriber letters.

The currently available DUR criteria have been reviewed and categorized by Mike Mergener to lead the discussion on approval of new retrospective DUR criteria. The criteria have been grouped by Dr. Mergener into the following general categories:

Pregnancy contraindication
Renal and hepatic dosing
Elderly specific
Controlled substance overuse
Migraine treatment
New therapeutic dups
Dose consolidation/splitting
Max Dose
Disease contraindications
Drug/drug interactions
Drugs as disease markers
Late refill

Pregnancy contraindication

The drugs listed in this group include chemotherapeutic agents such as azathioprine and common drugs known to cause problems with fetal development, e.g., statins and ARBs.

All drugs with an FDA category D or X are currently alerted in the prospective DUR system. Although retrospective notification of a drug causing fetal toxicity is not an ideal situation, there appears to be little downside in notifying the prescriber of this situation if it occurs. This should occur relatively rarely.

Recommendation: Analyze the drugs on the list and activate any drug with an FDA category D or X.

Renal and hepatic toxicity

A considerable number of patients reviewed are in SeniorCare. Since these individuals are more likely to have diminished renal or hepatic function, some of these criteria may be clinically relevant. We currently have a specific criterion for acetaminophen toxicity active.

Criteria include drugs which may be reno- or hepatotoxic as well as drugs which may require dosage adjustment in patients with diminished renal or hepatic function. Even though the diminished function is a clinical issue, we do not receive that information for SeniorCare participants.

Recommendation: Do not activate drugs requiring dosage adjustments. Review drugs causing hepatic and renal toxicity to be sent to members for a decision at the next DUR Board meeting.

Elderly specific

Because of the SeniorCare population this could be an important area. Many of the criteria relate to the specific use of benzodiazepines. Another criterion is a general caution on drugs in the Beers' list. A previous analysis on Beers' drugs should minimal use of most of the drugs on this list. There are also 3 specific subset criteria on warnings in the elderly which I have not reviewed.

Recommendation: Review drugs in the 3 subsets to be sent to members for a decision at the next DUR Board meeting. Do not activate Beers' list criterion.

Controlled substance overuse

Our current criteria review these categories as a class. These criteria are more specific, e.g., alprazolam use alone versus benzodiazepines as a category.

Recommendation: Keep current criteria. Do not activate individual drug criteria.

Migraine treatment

Criteria are specific to each triptan. Basic message is for overuse of triptans and a suggestion that if this occurs, a trial of prophylactic medication may be warranted. One criterion is for all triptans.

Recommendation: Put on hold. A separate initiative by the state is currently looking at quantity limits for triptans.

New therapeutic duplication

Therapeutic duplication of specific drugs is also addressed in the prospective system. Some of these drugs are already covered by current retrospective alerts. Some new categories are available and may be useful, e.g., ARBs, atypical antipsychotics,

Recommendation: Do a more in-depth review of the category to be sent to members for a decision at the next DUR Board meeting.

Dose consolidation/splitting

The DUR Board has previously endorsed the concept of dose consolidation and tablet splitting where appropriate. A separate state initiative is addressing this issue and developing a comprehensive approach to this issue.

Recommendation: Activate appropriate alerts in conjunction with the State's comprehensive program.

Maximum dose

We currently do not utilize maximum dose in prospective DUR. These criteria try to look at the recommended maximum daily dose. This is dependent on the pharmacist's entry in the days supply and quantity fields. The criteria do offer some check on doses above recommendations and consequently provide an additional quality check.

Recommendation: Do a more in-depth review of the category to be sent to members for a decision at the next DUR Board meeting.

Disease contraindications

We do not receive diagnosis information for SeniorCare recipients. However, some diseases are implied by drug usage.

Recommendation: There are only 8 criteria in this group, only 2 are considered category 1 severity level. They are cyclic antidepressants in patients with Wolff-Parkinson-White syndrome and in patients with narrow angle glaucoma. Ask Board for a vote.

Drug/drug interactions

Some but not all overlap with prospective DUR. Retrospective alerting of a drug/drug interaction is not optimal.

Recommendation: Do a more in-depth review of the category to be sent to members for a decision at the next DUR Board meeting.

Drugs as disease markers

Not much overlap with the prospective DUR system. May provide some additional clinical utility. Have not researched individual drugs used as markers to see if they "look" okay.

Recommendation: Review drug marker disease match of the category. Provide recommendations to be sent to members for a decision at the next DUR Board meeting.

Late refill

Most of these drugs are covered in prospective DUR alerts. Looks at mostly maintenance drugs. These criteria provide unique problems to pharmacists, e. g., alerts set when a maintenance drug is changed, alert may set in retrospective situation when patient changes pharmacies, pharmacist may be unable to alert patient

Recommendation: Review list to see if any categories should be used in prospective system. Do not activate late refill alerts in retrospective system.

Miscellaneous criteria

I was unable to classify all of these easily or they may have fit in more than one group at initial review or I needed to research the clinical relevance.

Recommendation: Finish review of these criteria and develop recommendations for a decision at the next DUR Board meeting.

Attachment 4

DIAGNOSIS CODES

Requiring a diagnosis on all prescriptions has been brought up on several occasions. At first glance the request seems straight forward and simple. It would be easy to accomplish. There are, however, several considerations:

1. Take the simple diagnosis of "**congestive heart failure**". In the 2006 ICD-9-CM there are no less than 19 codes applicable to "congestive heart failure"! The choices vary from Congestive heart failure, unspecified (428.0) to Heart failure, unspecified (428.9)

   Cholelithiasis (574) has ten different diagnosis codes.

   Which code to use when the doctor writes on the prescription "CHF" or "gallstones"?

2. Once the code is established, who is responsible for recording the code so that it enters pharmacy paid claims data as useful information? The pharmacist probably doesn't have the time. The pharmacy clerk probably won't have the necessary knowledge base.

Simply asking for a diagnosis code may provide no useful information. If a diagnosis of **"peritonitis**" is sufficient (567.9) it becomes meaningless when data is being reviewed for an association between antibiotic use and "**bacterial peritonitis**" (567.29).

The patient's desire for privacy may preclude entering the correct clinical diagnosis on the prescription. In many cases patients do not wish to have a mental health diagnosis entered into their record when using tranquilizers/antidepressants. In a similar fashion, using an STD diagnosis may provide more information to family members than the patient wishes to disclose.

Which diagnosis to record may be problematic. If an ACE is prescribed and the patient is recently post MI and has hypertension is the correct diagnosis **Acute myocardial infarction** or **hypertension.** (There are TWO FULL PAGES of diagnosis codes for hypertension in the 2006 ICD-9-CM!) In this scenario the patient may very well have diabetes mellitus (type 1 or type 2? – there is ONE FULL PAGE of diagnosis codes for diabetes mellitus!)

Agreed.
A diagnosis code would be very useful and would make the pharmacy paid claims data an even more valuable database. The development of the EMR with hyperlinks may help solve the problem.

The advent of Medicare Part D, and the desire on the part of CMS to link performance with payment for physicians, may represent the first major push to mandate coded diagnoses as a part of routine prescription writing.

Diagnosis codes on prescriptions may come with improved IT – electronic prescription writing with automatic ICD-9-DM diagnosis code download using appropriate applications with diagnosis code hyperlink.