DUR UTILIZATION AND REVIEW (DUR) BOARD MEETING
December 6, 2006 MINUTES

Wednesday, December 6, 2006
1:00 P.M. – 4:00 P.M.
1 West Wilson Street, Room B139

Madison, WI 53703

DUR Board Members Present:	Daniel Erickson, M.D. Franklin LaDien, RPh Robert Breslow, RPh Robert Factor, MD Nancy Ranum, MS RN Mike Boushon, RPh
Innovative Resource Group:	Dr. Richard Carr Mike Mergener, RPh, PhD Allan Mailloux, PharmD Karen Paulson (Scribe) Scott Hawley, EDS
DHCF:	Jim Vavra – DHFS Marilyn Howe, RN - DHFS Carrie Gray - DHFS Rita Hallett, RN– DHFS Kevin Hayden - DHFS Kimberly Smithers – DHFS Lynn Radmer, RPh – DHFS
Guests:	Jagdish Shastri, - Eli Lilly Amy Kennedy – UW SOP Sarah Caldwell – UW SOP Amanda Borleske – UW SOP Dean Groth – Pfizer Kylie Smith – Pharmacy Student Jill Purdue – Walgreen Company Julie Zatizabal - Serono

Minutes

Jim Vavra called the meeting to order at 1:00 P.M.

I. Approval of Agenda

Agenda change: Agenda items #6 & #7 were switched. Agenda was approved as amended.

II. Approval of Minutes – September 7, 2006 Meeting

Minutes were approved as distributed.

III. Data Availability for DUR Analysis – Presentation by Rita Hallett

In response to the request by the Board at the previous meeting, Rita Hallett gave a presentation about the information available in the data warehouse. This information is available for data analysis. Attachment 1 is a copy of the slides.

The data warehouse currently stores 2 terabytes of data which comprises 80 universes.

Generally, claims data is used to find out who provided the service, what service was provided, how much of the service was provided.

As part of the discussion, Mike Boushon asked about what data was available for Medicaid managed care. This data is submitted by the Managed Care Organizations as encounter data and contains many of the same data elements, however there is a significant claims lag. There is some additional time needed to scrub the data and enter it into the data warehouse. The utility of this data is mostly for comparison purposes.

It was pointed out that some of the quality projects for Dr. Carr, we use encounter data for disease management for asthma, diabetes, and lead testing.

Bob Breslow asked how the new national provider identifier (NPI) might be incorporated into claims processing. Kim responded that there is currently work being done to develop a way to include the NPI with the claim. Currently, pharmacies are Medicaid providers but pharmacists are not. Bob raised the issue that this method of reimbursement may preclude the payment of certain cognitive services not directly related to a product.

IV. Retrospective DUR – Results in criteria review and implementation.

Mike discussed the spreadsheet that was sent to the Board on the number of criteria exceptions from the November 2006 DUR cycle. The spreadsheet is enclosed with the minutes as Attachment 2. These criteria were recommended by the Board. The cycle was run in test mode. The cycle ran as if it were a live cycle and the reviewers made decisions whether or not to send letters. The letters for the criteria that were not yet approved were not sent. The test mode allows a review of the letters to make sure that the criteria are setting appropriately and the information appearing in the letters is correct.

The results of the November retrospective DUR cycle are summarized in the Attachment 2. For three of the criteria, only the top ten cases for each were chosen due to the volume of cases returned. For purposes of the reviews, reviewers only selected the highest risk cases. Risk score is built on a number of factors including the number of prescribers and pharmacies visited, patient age, or different diseases states that lowered the risk.

Attachment 2 contains the number of cases selected for review, the number of cases that were selected for potential intervention and a column labeled “Yield” which is the number of cases selected for intervention divided by the number of cases reviewed.

Specific criteria were discussed in more depth to answer questions by the Board.

The Board unanimously approved a motion to implement all of the new criteria and to report back at the next meeting with a table similar to the one presented.

Rocky LaDien suggested that we revisit the criteria list from time to time to see if we need to modify it. It was noted that currently the prescriptions for SeniorCare are included in the monthly DUR cycle. This could change if Wisconsin's request to continue SeniorCare is not approved by CMS.

V. Break

VI. Miscellaneous-Summary of cost savings initiatives

Quantity limits

The quantity limits initiative was implemented with the state is proceeding slowly. The first quantity limits have been applied to the triptans. The limits are 18 tablets (of any tablet); eight syringes or 6 nasal sprays per month. Utilization shows about a 10% drop in the average quantities and a similar 10% drop in savings. Although there are a considerable number of patients on triptans, the number exceeding this limit is relatively small.

The Board expressed concerns about how someone who exceeds the limit but needs the medication would be able to get the drug. The procedure for the emergency dispensing was explained to the Board. This allows the dispensing of up to 14 days of an emergency supply but the pharmacist must initiate this and bill on paper. It is an additional administrative burden for the pharmacist. The State has been including information to pharmacists about this procedure.

The issue of whether the denial of the medication may cause an increase in emergency room visits or other medications such as narcotics was raised. At this time, it is too early to evaluate whether this is occurring but it will be followed.

Dose consolidation and tablet splitting

The retrospective system alerts prescribers of these opportunities. Alerts for prospective DUR have also been activated. An evaluation of the effectiveness of this initiative has not been performed yet. Some analysis may be available at our next board. Through the pharmaceutical care program, pharmacies get paid for the time it takes to split the tablets.

100 day supply

The 100 day supply alert was activated a little over a month ago. This alert notifies pharmacists that the drug may be dispensed in up to a 100 day supply. The current list of medications for which a 100 day supply is allowed is a relatively small list. The state intends to expand the list to other drugs.

There is an additional fee paid to the pharmacist when the prescriber is contacted to switch the patient to a 100 day supply.

Some members of the Board expressed that this policy might be a disincentive for pharmacists. Others thought that it was still an appropriate cost savings effort and that pharmacists should and will participate.

VI. Miscellaneous-Atypical Antipsychotic Intervention

Mike Mergener discussed a handout on the atypical antipsychotic intervention. The handout is included with the minutes as Attachment 3 and provided information on the numbers and percentages of atypical antipsychotics used as monotherapy in low doses for the Medicaid population (it did not include SeniorCare).

Summary of the important points include:

- There were 10,818 patients on monotherapy with an atypical antipsychotic.
- Of these, 5333 are on low dose monotherapy.
- The drug most commonly used as low dose monotherapy was Seroquel followed by Risperdal.
- Most of the therapy in the very young patients was with Risperdal presumably for its indication to treat autism.
- Most of the prescribers of low dose monotherapy were psychiatrists (83%).
- A fair number of the responses referred to the fact that low dose therapy may be appropriate, particularly in the pediatric population.
- Prescribers were appreciative of the cost information provided.

Bob Breslow suggested that we might want to divide the responses from those seeing primarily older patients from those seeing children to see if there is a difference in responses. Mike Boushon suggested that we could also look at the actual doses.

VI. Miscellaneous-other DUR programs

Three articles were sent to the Board prior to the meeting. They described the CMS evaluation of state Medicaid DUR programs and present some suggestions for change. There are many ideas for the Board to consider. Mike Mergener also prepared a spreadsheet comparing other state Medicaid programs of similar size to Wisconsin. This information is compiled from a survey presented at the American Drug Utilization Review Society's annual meeting.

VII. Annual DUR Projects for 2007

The Board had previously been solicited to provide ideas DUR projects for the coming year. Topics included: 1) identifying patients with cardiovascular disease and seeing if they were on appropriate preventive medications, 2) a general expansion of the disease management efforts, 3) evaluate the effect of the PDL on utilization, and 4) developing an intervention on the anti-cholinergic drugs.

Other topics raised include an intervention to identify patients who may overuse triptans and might be better treated with prophylactic medications, how the state may encourage pharmacists to participate in pharmaceutical care, whether interventions could be designed to look at health care outcomes rather than just utilization of services, to use some of the already developed guidelines, e.g., HEDIS, in the development of our interventions.

The discussion did not reach any consensus so Mike Mergener will send out an e-mail to the Board to ask them to rank the ideas so he can begin to develop the project for the next Board meeting. Based on

previous interventions, it would probably be reasonable to expect we could complete 2 of the additional major interventions per year.

VIII. Recipient Lock-in Annual Report

Allan Mailloux presented a summary of the Recipient Lock-in activities for the past year. A copy of the summaries is included with the minutes as Attachment 4.

Important points from the summary include:

- There are fewer reviews conducted because of the migration of recipients to Medicare Part D and SSI managed care.
- Enrollment in the lock-in program is down from its historic high but is not down proportionate to the drop in enrollment.
- Requests for hearings is down considerably.
- The type of intervention, e.g., lock-in, prescriber letter, patient letter is relatively stable.
- Previous cost savings analyses show significant savings.

The next DUR meeting will be on March 7, 2007.

Meeting adjourned at: 3:45 p.m.