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Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID

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DRUG USE REVIEW (DUR) BOARD

Suncoast Hotel
9090 Alta Drive
Las Vegas, NV 89145

Approved Meeting Minutes
October 18, 2007

Committee Members Present:
David England, Pharm.D., Chairman
Keith Macdonald, R.Ph.
Paul Oesterman, Pharm.D.
Marjorie Uhalde, M.D. (called-in)
Steven Parker, M.D. (called-in)
Steven Rubin, M.D. (called-in)

Others Present:
Debbie Meyers-DHCFP, Mary Griffith-DHCFP, Gabriel Lither-DAG (called-in), Sabrina Raetz-DAG (called-in), Jeff Monaghan-FHSC, Dave Wuest-FHSC, Shirley Hunting-FHSC, Jeannette Belz-NV Psychiatric Assn., Craig Boody-Lilly, Kirk Huffaker-Schering Plough, Chris Lepore-J&J, Laura Litzenberger-OMJSA, Lisa Wilson-OMJP/J&J, Ed DePaz-Shire, Lee Boyle-Shire, Pam Cassidy-Cephalon, Heather Cash-GSK, John Stockton-Genentech, Lisa Durette-Spring Mountain Treatment Center, Joe Schwab-Novartis, Wilbert Townsend-Southern Nevada Health District, Doug Powell-Forest.

I. Call to Order and Roll Call

Chairman David England was delayed and joined the meeting at 1:28 p.m. In the chairman's absence, Keith Macdonald asked Sabrina Raetz, DAG, if it is appropriate to call the meeting to order, conduct roll call and address non-voting items. Ms. Ratez stated it is appropriate. Mr. Macdonald called the meeting to order and conducted roll call at 1:16 p.m.

Mr. Monaghan informed the Board that due to another commitment, Dr. Rubin has requested to be excused from the meeting at 2:00 p.m.

Jeff Monaghan introduced Dave Wuest. Dave has joined First Health in the role of clinical pharmacist replacing Dawn Daly. He most recently was manager of Arlington Clinical Pharmacy, and has experience in home infusion, retail and hospital settings. His knowledge and expertise will be a welcome addition to our DUR efforts.

II. Discussion and Approval of August 2, 2007 Minutes.

Debbie Meyers stated that action items will not be addressed until the chairman is in attendance.

Discussion and approval of the August 2, 2007, minutes was conducted following Agenda Item IV.

III. Status Update by DHCFP on Average Manufacturer Price (AMP), Physician-Administered Drugs, and the National Provider Identifier (NPI) initiative.

Debbie Meyers provided an update on the regulation contained in the Deficit Reduction Act of 2005 (DRA) for outpatient physician-administered drugs. Physicians currently bill using the Healthcare Common Procedure Coding System (HCPCS) codes and HCPCS units. Effective January 1, 2008, physicians will be required to submit the National Drug Code (NDC) on physician-administered drug claims utilizing the NDC billing units. This will enable the collection of rebates on rebateable outpatient physician-administered drugs.

Ms. Meyers reported that DHCFP has met with the hospital association and concern was expressed by the association that hospital providers will not be able to meet the January 1, 2008, deadline due to the requirement for system enhancements, etc., to convert to NDC billing. Ms. Meyers stated that DHCFP will submit a request to the Centers for Medicare and Medicaid Services (CMS) for a six month extension, however, will continue to move forward with the January 1st effective date until a response is received from CMS. If an extension is granted by CMS, the appropriate bodies will be notified and notification will be posted on the First Health website.

IV. Status Update by DHCFP on the use of Tamper-Resistant Prescription Pads for Non-electronic Medicaid Prescriptions

Ms. Meyers reported that President Bush has signed the "Extenders Law" delaying the October 1, 2007, implementation date to April 1, 2008, for the requirement that all written prescriptions for fee-for-service Medicaid recipients be written on tamper-resistant prescription pads. Per CMS guidance, to be considered tamper-resistant on April 1, 2008, a prescription must contain at least one of the following three characteristics:

1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and/or
3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Effective October 1, 2008, a prescription pad must contain all of the foregoing three characteristics to be considered tamper-resistant.

Further notifications will be posted to the First Health website as updates from CMS are released.

David Wuest stated that FHSC conducted a pharmacy provider forum this week and there was feedback from pharmacies that use a scan system, the newer tamper-resistant prescriptions were blackened out when scanned. He stated that in talking with many physicians, most prescribers are currently meeting requirement number 1.

Mr. Monaghan requested clarification from Ms. Meyers that because Agenda Item V. is an action item, it cannot be addressed until the chairman is in attendance. A quorum of the committee is present. Gabriel Lither, DAG, provided clarification stating that the meeting can proceed, action items can be voted upon, and a board member can act in the chairman's place until he arrives. It is appropriate that Mr. Macdonald continue to conduct the meeting.

Ms. Meyers requested that Agenda item II., approval of the August 2, 2007, minutes be considered at this time.

Discussion and Approval of August 2, 2007 Minutes.

MOTION: **Paul Oesterman motioned to accept the minutes as presented.**
SECOND: **Marjorie Uhalde**
VOTES: **Unanimous**

MOTION CARRIED

V. Presentation of Report by First Health Services on Evidence-Based Drug Therapy for Patients with Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD).

Mr. Monaghan stated that this item was originally referred to the DUR Board by the Pharmacy and Therapeutics Committee (P&T) to consider relaxing the current prior authorization (PA) criteria for this therapeutic class. It has been addressed by this board at the last three meetings with no conclusion reached. At the last meeting, data was presented which indicated that 75% of these agents are being prescribed by psychiatrists, child psychiatrists, or pediatricians. The majority of usage is in the 7 to 15 year old age group and 97% of the PA requests are being approved. It was requested at the last meeting that information regarding evidenced-based drug therapy be presented at this meeting. Mr. Monaghan presented articles and references. He stated that evidence supports that the drugs in this class are effective for ADHD. The evidence does not support the fact that there is any significant difference in outcome between the different agents used. The bigger issue seems to be if the drugs are over or under utilized and if the diagnoses are being made appropriately.

Paul Oesterman asked how much time and man-hours are spent on the PA process. Mr. Monaghan responded that on the FHSC side, it's approximately fifteen minutes per request. Most requests are received via fax. If the correct boxes are checked on the fax form, the request is approved. Approximately 50% of the current total PA requests are related to ADHD.

Mr. Macdonald asked what percent of those requests is for adults and Mr. Monaghan replied approximately 20%.

Chairman David England joined the meeting at 1:28 p.m.

Mr. England stated that based on the discussion at the last meeting regarding an exemption from the PA process for specialists, he is not comfortable setting that type of precedence. He felt criteria should be set and implemented. He suggested a review of the diagnostic criteria and recommended eliminating the TOVA criteria in and of itself as it would not justify an ADHD diagnosis or use it in addition to the DSM-IV criteria.

Dr. Uhalde agreed that setting this type of precedence would pose a problem for family practice and internal medicine physicians.

Dr. Rubin felt strongly that the current criteria should not be changed and a data bank be established to determine the long term effects of psycho stimulants.

Mr. England felt the that the current PA criteria is following the diagnostic criteria and Mr. Monaghan responded that, in general, the criteria reflect the criteria of the American Academy of Pediatrics as well as other evidence-based criteria.

After discussion, the committee was in favor of conducting audits to validate that criteria is being met. Ms. Meyers stated that these will not be onsite audits but possibly a mail-in form requesting information on recipient records identified for the audit. The physicians on the committee agreed that it would not be disruptive to their practice if they are informed in advance of what information they need to have collected and prepared for auditing purposes. DHCFP and FHSC will prepare a proposed audit process and present recommendations at the next meeting.

Due to technical difficulties with audio recording equipment, Mr. England called for a ten minute break at 1:50 p.m.

Chairman England called the meeting to order at 2:00 p.m.

VI. Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) Agents

Public Comment

Lisa Durette, M.D., addressed her request for removing the prior authorization process for some specialists. She clarified that would be for medications on the Preferred Drug List (PDL) only. In reference to Dr. Rubin's comments regarding the long term effects, this drug class has 20-30 years of longitudinal data documenting safety. She supported the concept of a mail-in audit process versus the PA process. She commented that speaking for her office, the PA process is time-consuming between phone calls and faxes. She said that it was clarified at the last meeting that the PA process can be done via phone, but she stated that she can spend 10-15 on the phone per patient to obtain an answer. Mr. England confirmed with Mr. Monaghan that staff versus the practitioner can call for a PA but Dr. Durette stated that many child and adolescent psychiatrists do not have the staff.

Debbie Meyers informed Dr. Durette that the Pharmacy Web-PA system is now available which allows providers to request PAs online and receive real-time responses. Instructions for access are posted at nevada.fhsc.com, announcement 158. Mr. Monaghan added that FHSC staff is also available to provide onsite training.

Mr. Monaghan pointed out that the Board may want to consider adding an ICD-9 code edit that would allow pharmacies to fill these medications with an approved diagnosis similar to the Coreg® edit. If the CHF diagnosis code is included on the prescription for Coreg®, the PA process is bypassed. The prescriber would be required to include the diagnosis code on the prescription and the pharmacy in turn would be required to enter the diagnosis code when processing the prescription.

Dr. Durette stated that she is in favor of the State allowing an ICD-9 code override edit on prescriptions for this drug class. She recommended ICD-9 codes 314 and 314.01.

Mr. England and Mr. Monaghan agreed that additional awareness training would be needed for pharmacists filling these medications.

Joe Schwab, Novartis, questioned if the Coreg® edit was for the first line treatment of cardiac disease and stated that the ADD/ADHD drugs are for the first line treatment of this disorder. Considering the 97% PA approval rate, he supported the ICD-9 code edit path for these medications.

Mr. England asked Mr. Macdonald, as a representative of the Nevada State Board of Pharmacy, if the inclusion of an ICD-9 code on the prescription is a violation of privacy. Mr. Macdonald replied that pharmacies maintain this information in compliance with HIPPA requirements. Mr. Monaghan added that one of the advantages of e-prescribing, once it's on board, is that the diagnosis code will automatically be transmitted to the pharmacy as a required field.

Will Townsend, Southern Nevada Health District, asked Mr. Monaghan in what type of ADD are these medications affective. He stated that from the literature he has reviewed, there is an association between lead poisoning and the development of ADD and ADHD. Mr. Monaghan explained that his literature search for evidence-based therapy picked up the treatment of the patient after he/she had been diagnosed with ADHD. His data did not include the requested information.

Discussion and Action by Board Concerning Revisions to Clinical Prior Authorization Criteria for Drugs Used to Treat Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder in Adults and Children

Paul Oesterman commented that the Board is at the point of addressing two issues. One is the prior authorization and the current requirements which may be eliminated by the use of an ICD-9 code on the prescription, and secondly, the audit to validate the diagnosis. He asked how difficult

it would be to implement the ICD-9 edit. Mr. Monaghan responded that it is not a difficult process to implement. It is a matter of provider communication and coding within the system.

Mr. England expressed concern that providers would be able to game the system if the Board implemented the ICD-9 edit. Dr. Rubin stated that the ability to deceive the system would be the same as it is now. Mr. Monaghan agreed and stated a proposed audit program can be presented at the next meeting.

Debbie Meyers stated that once a report has been developed, the audit will need to be at a level that can be accessed and reviewed. DHCFP will need to determine what is reasonable and within their capability in terms of resources.

Mr. England asked Mr. Lither if there is a state law or criteria that states that a certain percentage of records are required to be audited or is it at the discretion of the Board. Mr. Lither replied that he is not aware of a state law that addresses that issue. Mr. Lither suggested utilizing a statistically valid sample.

MOTION: Keith Macdonald motioned that a proposed audit plan be presented at the next meeting, and a proposed action plan to address provider gaming if the ICD-9 code edit is implemented.
SECOND: Paul Oesterman
VOTES: Unanimous
MOTION CARRIED

Paul Oesterman referred to page 2, section 1.a. of the criteria and expressed concern regarding patients in transition from short to long-acting agents or visa versa. He stated that some patients are continuously on both short and long-acting products. Where would this fall within the current PA process?

Mr. Monaghan stated that the edits are set up to allow claims for a short and long-acting form of the same drug to go through. If there are two different types of drugs; e.g., Strattera® and Adderal®, the claim will reject. Dave England requested that this be clarified in the criteria.

2:11 – Dr. Rubin excused himself from the meeting.

VII. Nevada Medicaid Pharmacy Lock-In Program

Public Comment

No comment.

Presentation by DHCFP on the Proposed Policy for the Nevada Medicaid Pharmacy Lock-In Program

Jeff Monaghan introduced the concept of a recipient lock-in program. He referred to the lock-in criteria in the meeting binder and stated that these are historical criteria that were discussed several years ago by the DUR Board. Although these criteria are helpful, he stressed the need for flexibility in determining thresholds for lock-in. The historical criteria should be considered guidelines for the DHCFP and FHSC to consider, but should not be applied without a high-level clinical review for appropriateness. Also, the volume of recipients impacted could be unmanageable if the criteria are applied capriciously.

Dave Wuest presented a report which included patients with ten or more prescriptions for controlled substances from three or more pharmacies and one or more prescribers. The time period reported is fourth quarter 2006. Mr. Wuest stated that the most reliable indicator for abuse was the number of pharmacies utilized. He indicated that there be flexibility in terms of the criteria used to determine which recipients would be reviewed for possible inclusion in the program.

Discussion and Action by Board to Approve the Proposed Policy for the Nevada Medicaid Pharmacy Lock-In Program

Paul Oesterman asked what the process for pharmacy selection is. Ms. Meyers replied that once recipients have been identified, the records will be referred to the Surveillance and Utilization Review Unit (SURS) for review. If SURS determines that there is a problem, the recipient will be notified. The recipient will have ten days to select a pharmacy of their choice. If the recipient has not made a selection at the end of the ten days, a pharmacy will be chosen by Medicaid. The recipient has the right to request a hearing before placement in the pharmacy lock-in program by submitting a written request within thirty days of the receipt of Medicaid's notice of intent to place them in the lock-in program.

Keith Macdonald suggested looking at the impact on transportation costs if recipients were required to use only one pharmacy.

Paul Oesterman commented that many drug-seeking patients will use several physicians and pharmacies utilizing their third party payor at some and cash at others. He asked how all prescriptions the recipient is getting will be incorporated.

Ms. Meyers stated that the State will work with the Controlled Substance Abuse Task Force to find out all prescriptions received regardless of payment source.

MOTION:	**Keith Macdonald motioned to pursue the pharmacy lock-in program as presented with further details to be outlined and presented at the next meeting.**
SECOND:	**Paul Oesterman**
VOTES:	**Unanimous**
MOTION CARRIED	

VIII. Retrospective Drug Utilization Review for CY2008

Public Comment

No comment.

Presentation by First Health Services and Discussion by Board of Topics for Retrospective Drug Utilization Review for CY2008

Jeff Monaghan referred to the list in the Board's binder of proposed RetroDUR topics for CY 2008, for discussion, as requested by the Board at the last meeting. Most of the topics included in the list were recommended by Chris Shea, Pharm.D., member of the Pharmacy and Therapeutics Committee, and Dave Wuest. The recommendations are based on the issues they have seen and encountered in their daily practices.

Dave Wuest presented an overview of the topics. He stated that FHSC is looking at ProDUR as a means to provide clinical information to the pharmacist that will be of value.

Discussion and Action by Board to Approve Retrospective Drug Utilization Review Criteria for CY2008

Mr. Macdonald stated that he is particularly pleased to hear that the program could provide a meaningful and helpful message to the pharmacist in their daily practice.

Jeff Monaghan asked that flexibility be given to revise or add topics based on new information impacting patient care. He stated that the Board will be kept apprised at each meeting of what topics are being addressed.

MOTION: **Steven Parker motioned to accept the proposed drug utilization review topics for CY2008.**
SECOND: **Paul Oesterman**
VOTES: **Unanimous**
MOTION CARRIED

IX. Nevada Medicaid Drug Utilization Review Annual Report Fiscal Year 2006

Public Comment

No comment.

Presentation by First Health Services of the Nevada Medicaid Drug Utilization Review Annual Report Fiscal Year 2006

Jeff Monaghan stated that since the report was presented to the Board at the last meeting, page 14, "Conclusion", has been revised to include a summarization of accomplishments during the reporting period and identifies the opportunities and recommendations for future drug utilization review.

Discussion and Action by Board to Approve Nevada Medicaid Drug Utilization Review Annual Report Fiscal Year 2006

MOTION: **Paul Oesterman motioned to approve the annual report as presented.**
SECOND: **Keith Macdonald**
VOTES: **Unanimous**
MOTION CARRIED

X. Public Comment

Kirk Huffaker, Schering Ploug, asked if each proposed RetroDUR topic will be up for discussion and approval prior to implementation. Mr. Monaghan replied that the topics have been approved therefore approval prior to implementation is not required. Results of each review will be presented at future DUR Board meetings.

XI. Date and Location of Meetings for CY 2008

The dates and locations for 2008 were presented.

XII. Adjourn

MOTION: **Keith Macdonald motioned for adjournment.**
SECOND: **Paul Oesterman**
VOTES: **Unanimous**
MOTION CARRIED

Meeting adjourned at 2:52 p.m.