TennCare Joint Committee for the Review of Narcotic Management Meeting Minutes

January 23, 2007

In attendance:
Anesthesiologist/Pain Management Specialist/Board of Medicine Member: Jim Roth, MD
Board of Pharmacy Member: Todd Bess, PharmD
DUR Committee Members: Bill Ingram, MD, Philip E. Johnston, PharmD
PAC Committee Members: Edward Capparelli, MD, Lynn Knott, PharmD
MCAC Committee Members: Charles Ball, MD
TennCare Representatives: David Beshara, RPh, Bill Hudson, PharmD, Jeff Stockard, DPh
First Health: Nicole Woods, PharmD, Suzan Ali, PharmD, MBA

The meeting was called to order, and all attendees introduced themselves.

Background Information:
Dr. Ali presented background information regarding narcotic utilization and management in the TennCare program.

- It was pointed out that narcotics have been the top therapeutic category based on claim volume among the TennCare population for at least the last 2 years.
- Data was presented on the dose distribution of various long-acting narcotics among the TennCare population in December 2006.
  - Dr. Roth expressed surprise that some patients were receiving as high as ten OxyContin® tablets per day. David Beshara stated that the purpose of today’s meeting was to identify how to target the patients, physicians, and pharmacies that all play a role in the use of these high doses of narcotics.
    - A question was posed as to whether these high doses were seen in specific patient populations (hospice, cancer patients, etc.)? Dr. Woods responded that the majority of these high doses are for suspected end-of-life patients with cancer or HIV/AIDS diagnoses. However, there are some high doses being used in patients with chronic back pain, diabetic neuropathy, etc.
    - Dr. Roth mentioned that for patients with a questionable diagnosis, it is reasonable to do a police check on these individuals. He stated that very few people need such high doses. Based on his personal experience, he has found that for every ten people referred to pain management, three do not have chronic, intractable pain, while seven do have require chronic pain medication. Of the seven individuals with chronic, intractable pain, two sell or divert their pain medications.
    - David Beshara mentioned that TennCare has the ability to refer patients they expect to be diverting to OIG for investigation.
David Beshara went on to explain that the goal of today’s meeting is to identify potential indicators or “trigger points” that may suggest a patient is abusing or diverting narcotic medications. And once these “trigger points” are identified, what should the appropriate course of action be once a patient reaches that “trigger point” – Should they be required to get a PA? Should the physician get a letter? Should the patient be referred to OIG? Ultimately, TennCare would like the Committee to identify these “trigger points” for patients, prescribers, and pharmacies in order to implement a coordinated strategy for appropriate prescribing of long-acting narcotics. Furthermore, David Beshara mentioned that a similar meeting may be held in the future to take the same sort of approach towards the short-acting narcotic medications.

Dr. Roth commented that while it is possible to get patients with chronic pain to zero on the pain scale, this complete pain relief only lasts 2-3 months. By aiming to get patients with chronic pain to somewhere between 4-6 on the pain scale, tolerance to pain medications can be prevented. Anti-inflammatory agents, muscle relaxants, and Neurontin® can be used to supplement narcotic medications.

- Information was presented on current TennCare narcotic management strategies. Current strategies include preferred/non-preferred listings on the PDL, the Pharmacy Lock-In program, a Therapeutic Duplication edit for narcotic analgesics, quantity limits, clinical criteria for select narcotic analgesics, provider education activities, and provider practice analysis activities targeting top narcotic prescribers.
  - A comment was made that these suggestions seem to be the right kinds of things to do. A question was posed as to what could be done to make these strategies more effective. It was stated that ratcheting down quantity limits, expanding clinical criteria, etc., may be reasonable options.
  - David Beshara pointed out that the purpose of these types of activities is not to prevent patients who need narcotic medications from receiving them, but to preventing misuse and abuse while ensuring access for the patients who truly need these medications.
    - Dr. Capparelli pointed out that even for hospice or cancer patients who need high doses of pain medications, there may be a family member who is diverting their pain medications.

**Proposals for Coordinated Narcotic Management:**

- Dr. Ali presented suggestions for further narcotic management strategies, including expanded provider education activities, implementation of clinical criteria for all the long-acting narcotics, stricter and/or expanded quantity limits, requirements for signed pain contracts, required enrollment in pain management programs, and referral to OIG/TBI.
  - A comment was made that the Controlled Substance Database will allow physicians to see cash prescriptions for narcotics. It was pointed out that this will help to make it more obvious which patients need to be better managed. In addition, it was recommended that provider education activities target the use and potential value of the Controlled Substance Database.
• Concern was expressed that patients may start going to states bordering Tennessee to obtain their narcotics once the Controlled Substance Database goes into effect. It was stated that Kentucky has had a Controlled Substance Database in place for some time now and there are patients from Kentucky now coming to Tennessee to get their narcotics.

• Dr. Roth mentioned that it is difficult to identify appropriate narcotic prescribing. He cited the McNeil case, where the court decided that there is no amount of narcotic that is too much - a physician can prescribe as high as they need to in order to control a patient’s pain. Now, the important thing is that physicians follow good medical practice. Dr. Roth stated that having a “trigger point” is reasonable, but often individuals who are diverting are receiving lower doses of narcotics. However, he pointed out that, as far as he was concerned, a high dose of OxyContin® would be 100 mg/day or more.
  o David Beshara pointed out that not all triggers need to be dose-related. If individuals thought to be diverting tend to doctor shop or pharmacy shop, the number of doctors or pharmacies can be built in as triggers to help identify these individuals who are diverting low doses of narcotics.
  o A comment was made that pharmacy checks can be helpful in situations of suspected doctor or pharmacy hopping, as well.

• A comment was made that Suboxone® can really help people with narcotic abuse problems, while Methadone clinics are often ineffective, expensive, and inconvenient for patients who have to travel long distances to get to a Methadone clinic.
  o A question was posed regarding the success rate of Suboxone® therapy. Dr. Roth responded that the success rate is pretty good, but it is important that therapy be tapered correctly.

• A question was posed as to whether laxative use associated with higher doses of narcotics could be used to identify those who are truly taking the narcotic versus diverting it. Dr. Roth stated that he doesn’t prescribe a large number of laxatives, and many patients do fine with OTC laxatives or high fiber diets. He stated that the Controlled Substance database would be a more useful tool in identifying those who are diverting.
  o A comment was made that pharmaceutical companies and the DEA’s ARCOS data may be useful sources of information on narcotic utilization, as well.

Committee Discussion of “Trigger Points” and Management Strategies:

• Patient “Trigger Points” and Management - The Committee was given the task of identifying potential indicators (“trigger points”) of narcotic misuse or abuse for patients, and subsequent management strategies for patients reaching these “trigger points”.
  o Dr. Woods presented a graph depicting TennCare utilization of sustained-release morphine, and mentioned that, while the majority of patients receive 60 mg or less per day, there are several patients receiving over 1200 mg/day, even up to 3200 mg per day. She asked the Committee whether the dose of a narcotic would be a reasonable “trigger point”, above which to implement some sort of narcotic management strategy (i.e., requiring a PA, sending a letter to the physician, etc)? And if so, what dose should serve as the threshold, and what management strategy should be associated with doses above that point?
  o Dr. Woods cited an article published in the New England Journal of Medicine by Ballantyne & Mao (2003) which stated that doses above 1 g morphine or morphine equivalent are often 5 or more times the dose
validated by literature and rarely result in satisfactory analgesia or improved function.

- Dr. Woods also mentioned other possible “trigger points” besides dose, including: average quantity of narcotic per day and quantity of narcotic per prescription.

- Dr. Ingram stated that he thought 200 mg/day should be the cutoff point above which patients should be referred to a pain center. He mentioned that for hospice patients, cancer patients, etc., this threshold should be set a bit higher.
  - Dr. Capparelli mentioned that in Newport, Tennessee (with 60% TennCare patients) it is difficult to get patients to a pain management clinic, as there are not many in the area and there is a long wait for the good programs. He mentioned that he thought a pain contract should help prevent “doctor hopping,” but 200 mg/day may be a little low. He recommended that TennCare look at where 90% of the patients receiving narcotics are at, and take 2 standard deviations above that dose to serve as the threshold.

- Dr. Powers suggested that it may be helpful to incorporate a combination of factors, such as top narcotics prescribers and dose.

- Dr. Roth suggested that patients receiving > 500 mg morphine (or morphine equivalent) for more than 6 months be triggered for chart review to ensure that the prescribing physician provides some sort of supporting documentation for the use of high doses of narcotic in this patient. In addition, he suggested that patients seeing 3 or more physicians within 3 months require a PA. Furthermore, he thought it would be useful if physicians were notified when patients were receiving narcotics from multiple physicians.

- Dr. Capparelli suggested that patients receiving narcotics from more than 2 pharmacies should also be required to get a PA.

- A suggestion was made to create a narcotic-specific PA form with check boxes for ease of use.
  - It was pointed out that the date of diagnosis should be required on the PA form in order to ensure patients are not receiving narcotics for an out-dated diagnosis.
  - Another suggestion was made to require that the specific type of cancer be indicated in situations of a cancer diagnosis.
  - It was also indicated that the form should address whether patients had been tried on other alternatives, such as NSAIDs, muscle relaxants, Neurontin®, SNRIs, etc.

- Dr. Ingram suggested that patients receiving > 200 mg morphine (or morphine equivalent) per day be required to have a signed pain contract.
  - Dr. Roth stated that any patient receiving narcotic pain medications for more than 3 months should be required to have a pain contract excluding the patient from receiving narcotics from other prescribers (with the exception of ER visits).

- David Beshara asked the Committee to come to a consensus on the dose above which a PA should be required for long-acting narcotics.
  - The consensus was >200 mg morphine (or morphine equivalent) and >160 mg OxyContin®.
  - It was suggested that the PA required for doses above this point include a requirement of a signed pain contract.
A question was posed to the Committee as to whether this PA initiative should target only new patients or both new and existing patients.

- The Committee responded that this is not just a problem with new patients, and all patients should be targeted. In order to make this an easier process, it was recommended that prescribing physicians be given sufficient prior warning that this is going to go into effect.

A suggestion was made to include a link to a sample pain contract on the TennCare website.

David Beshara asked the Committee what approach should be taken for patients receiving < 200 mg morphine (or morphine equivalent) per day, but receiving narcotics from multiple physicians.

- The Committee suggested incorporating a requirement that physicians check the Controlled Substance Database in situations where a patient has visited 4 or more MDs in a 3 month period. However, concerns were voiced over the time lag associated with the updating of information in the Controlled Substance Database. Furthermore, a suggestion was made to allow institutional or diagnosis exclusions for this requirement.

A question was posed as to whether there should be a second “trigger point” beyond 200 mg morphine, at which we would want to target the prescribing physician with a letter.

- The Committee recommended targeting physicians at doses of 400 mg morphine (or morphine equivalent) per day.
- It was pointed out that too many letters could be a hassle to prescribing physicians.
- A suggestion was made to include easy check boxes on the fax back form (i.e., have reviewed the patient and they require this dose, etc.), along with space at the bottom for comments. Additional suggestions to include questions as to whether the prescriber has performed a pill count, pharmacy check, Controlled Substance Database check, etc. were made.

David Beshara pointed out that TennCare and First Health would work together to develop a draft PA form and physician letter, which would be e-mailed to the Committee for further comments.

**Prescriber “Trigger Points” and Management** - The Committee was given the task of identifying potential indicators (“trigger points”) of narcotic misprescribing among physicians, and subsequent management strategies for prescribers reaching these “trigger points”.

A question was posed as to how we identify prescribers we would like to target without disadvantaging ER physicians and pain specialists. It was expressed that the Committee would like to target those high prescribers who lack detailed medical records or sufficient testing to support the patient’s diagnosis (i.e., no MRIs, X-rays, etc.).

David Beshara asked the Committee whether it would suffice for TennCare to target the top 10 prescribers (including nurse practitioners) and have field staff perform a chart review. If it appeared that the chart was lacking, these physicians could be reported to the Board of Medical Examiners.
- Dr. Powers pointed out that the physician would need to be able to respond to this review before it was reported to the Board of Medical Examiners.
  - Dr. Capparelli suggested looking at the top quantities of long-acting narcotics being prescribed to TennCare patients, and if many of these prescriptions were written by the same physician, targeting that physician for further review.

- **Pharmacy “Trigger Points” and Management** - The Committee was given the task of identifying potential indicators (“trigger points”) of inappropriate narcotic prescription filling among pharmacies, and subsequent management strategies for pharmacies reaching these “trigger points”.
  - A suggestion was made to look into pharmacies with a high percentage of cash claims for narcotics.
    - It was pointed out that an association between a pharmacy with a high percentage of narcotic prescriptions (especially cash prescriptions) and an overprescriber may be suggestive.

- **Exceptions to Established “Trigger Points”** – The Committee was asked to consider whether there were certain patients, prescribers, or pharmacies whom they would want to be subject to different “trigger points” (or exempt altogether).
  - It was stated that hospice patients and patients with sickle cell disease, AIDS, and metastatic cancer should be exempt.
  - A recommendation was made to include check boxes for these diagnoses on the PA form.
  - Concerns were voiced regarding post-operative patients having trouble obtaining their necessary pain medications.
  - Further concerns were voiced regarding patients who violate a pain contract with one physician by receiving narcotics from a second physician. If the first physician terminates the pain contract, the patient would have a period of time without a signed pain contract during which the patient may be unable to get his/her pain medications.

**Review of Proposed Long-Acting Narcotic Criteria:**
- Due to time constraints, the proposed long-acting narcotic criteria was not reviewed; however, it was stated that the information discussed throughout the meeting with regards to criteria and quantity limits would be used to update the proposed criteria accordingly.
  - Clarification was requested as to whether clinical criteria would be put in place for both preferred and non-preferred long-acting narcotics. The Committee was in agreement that criteria should be in place for all long-acting narcotics (not just the non-preferred products).
  - Concern was voiced that once a patient receives PA approval for a long-acting narcotic, he/she must remain able to receive the medication in the future. David Beshara stated that he anticipated indefinite grandfathering for the long-acting narcotic agents.
  - Regarding quantity limits for the long-acting narcotics, it was mentioned that dose optimization quantity limits would be implemented for the lower strength products, while higher strengths would have true quantity limits (based on the previous discussion of the dose threshold).
• A comment was made that the 80 mg generic oxycodone SR appears to have problems with its release mechanism, such that it is not the same as the branded product manufactured by Purdue.
  - Concern was expressed that questions pertaining to the generic product’s equivalence may be due to the increased street value of the brand versus the generic product.

It was mentioned that drafts of the PA forms, physician letters, and revised clinical criteria would be made available to the Committee via e-mail within the next month or two (sooner if possible). The goal is to have everything in place and ready for implementation by the time the Controlled Substance Database becomes available to physicians (anticipated July 2007).

The meeting was adjourned.