TennCare Joint Committee for the Review of Narcotic Management Meeting Minutes

April 29, 2008

In attendance:
Pain Management Specialist/Board of Medicine Member: Jim Roth, MD
Board of Pharmacy Member: Todd Bess, PharmD
DUR Committee Members: Philip E. Johnston, PharmD
PAC Committee Members: Lynn Knott, PharmD
MCAC Committee Members: Charles Ball, MD
TennCare Representatives: David Beshara, RPh, Bill Hudson, PharmD, Nicole Woods, PharmD
First Health: Alan Daniels, DPh, Leslie Pittman, PharmD, Tracey Lovett, PharmD

The meeting was called to order, and Dr. Nicole Woods presented a brief overview of the various committees that were represented at this meeting. The state clarified that an oncologist was also invited but was unable to attend the meeting. It was explained that the purpose of the meeting was to focus on appropriate use of short-acting narcotics (SAN), identify inappropriate use of SAN, and determine what constitutes standard of care regarding the use of SAN. Information presented at this meeting would summarize the outcomes of the long-acting narcotic (LAN) initiative, provide an update on the use of the Tennessee Controlled Substance Database (CSD), and highlight current short-acting narcotic utilization within the TennCare pharmacy population.

Outcomes from the Long-Acting Narcotic Initiative

Dr. Leslie Pittman presented background information on the key directives from the TennCare Joint Committee for Narcotics Review meeting, which was held on January 23, 2007 to address long-acting narcotic management. She also presented outcomes data that graphically depicted the impact of the long-acting narcotic initiative.

- Directives from the committee regarding the LAN initiative included the following:
  - PA requirement for LAN narcotic doses > 200 mg of morphine or equivalent
  - Incorporation of controlled substance agreements into practice
  - Performance of random drug screens, pill counts, and pharmacy checks
  - Exemption of cancer, HIV/AIDS, hospice and sickle cell disease patients from the controlled substance agreements, etc.
  - Provider Practice Analysis activity targeting prescribers writing for > 400 mg morphine or equivalent

- Implementation of the LAN initiative began October 1, 2007. Data presented on the impact of the LAN initiative reflected a pre-period (3 months before LAN implementation) and a post-period (3 months after LAN implementation). It was noted that the LAN costs for December 2007 were 1.3 million as opposed to the 1 million that was listed on the slide. As a result of this change the average monthly reduction in cost...
is 6.8%. Dr. Pittman pointed out that cost savings was not a primary goal of the LAN initiative. However, due to the changes put in place, the pharmacy program has experienced a monthly reduction in cost along with decreases in the total number of claims and in the number of claims exceeding the threshold. The number of LAN claims above the 200 mg threshold showed approximately 800 claims prior to implementation and decreased to approximately 400 claims in the post-period. This data revealed a monthly reduction in the number of claims exceeding the threshold of around 51%. The number of LAN claims pre-implementation was approximately 5,500 and post-implementation was approximately 5,300. This data showed about a 3% monthly reduction in total LAN claims as a result of the initiative. The goal of the initiative was to target inappropriate use/misuse of LAN and to ensure patient safety. The data confirmed that the biggest impact was seen on the number of claims exceeding the threshold. Within the TennCare population, the volume of short-acting narcotics (SAN) received is 10 times the volume of long-acting claims. A graph depicting short-acting narcotics (both combination products as well as single agent narcotics) gave a snapshot picture of SAN utilization from August 2007 – March 2008. During the period of time from August 2007 to December 2007, there was a notable decrease in the number of short-acting narcotic claims among TennCare recipients. At this time it is uncertain as to whether the CSD and/or the long-acting narcotic initiative contributed to this effect.

- The committee stated that due to low uptake, they did not feel that the education programs being offered across the state for medical providers and the availability of the CSD were directly affecting the narcotic utilization of the pharmacy program.

**Update on the Statewide Controlled Substance Database**

- Dr. Todd Bess presented information on controlled substance utilization within Tennessee and provided an update on the statewide Controlled Substance Database. This information had been put together by the Tennessee Board of Pharmacy and presented to pharmacists at continuing education (CE) events across the state.
  - Accidental drug overdoses in Tennessee affect both major metropolitan counties as well as small rural counties within the state. The majority of drugs listed on death certificates are narcotic analgesics. The National Survey on Drug Use and Health showed 6.3 million Americans ≥12 years of age used prescription meds for nonmedical reasons in the previous 30 days, and 4.7 million of these utilizers listed pain relievers as the designated prescription medication. In 2000, 2.5 million Americans used opioid analgesics for nonmedical reasons. Over half (55.7%) of these prescriptions are being obtained from family and friends.
  - The CSD has two components: Data Collection Portal and the Prescription Monitoring Portal (PMP). Data collection began on December 1, 2006. Data is reported and collected from dispensers twice a month. Data is compiled and cleansed by an outside company, Optimum. The prescription monitoring portal is the search engine. This portal allows medical professionals to search the patient’s history prior to prescribing. Regulatory boards can also use the CSD to obtain statistical reports. A password is needed to gain access. To obtain access to the CSD, a practicing health professional or regulatory board must contact Kolleen Matthews at the Tennessee board of Pharmacy. Any technical
issues with the CSD can be handled by Ms. Matthews. Currently, there are 20.7 million prescriptions in the CSD and receive 1.7 million prescriptions each month. Tennessee has about 6,000 licensed pharmacists, of which 1,864 are using the CSD (30% utilization). Approximately 30,000 prescribers are licensed in Tennessee and 3,571 are using the CSD (11% utilization). Information retrieved from the CSD reveals that the top 5 drugs dispensed from January 2007 to December 2007 were: 1) hydrocodone, 2) Ambien®, 3) propoxyphene, 4) Lunesta®, and 5) oxycodone.

- Discussion took place around whether health professionals were using the CSD and if the Board of Pharmacy kept track of the number of inquiries. Dr. Bess stated that currently the committee has not looked into the amount of utilization from professionals who are signed-up to utilize the CSD due to the committee being preoccupied with waiver requests. Dr. Ball stated that he was aware of several physicians signed up with the CSD who faithfully check the system prior to determining their care plans. It was pointed out that pharmacists informed about the CSD also find the system helpful. While uptake of the CSD is slow, many health providers say it has made a significant impact on providing appropriate care and preventing misuse or abuse of controlled drugs.

- The board was asked about accessibility of the CSD for Emergency Rooms (ER). Dr. Jim Roth commented that in his immediate practice area, providers continually use the database and have free access with a computer that is located in the physician lounge area. Dr. Ball agreed that accessibility is usually not a problem. The committee felt that perhaps targeting ERs to make sure they are fully aware of the CSD would be a good start to ensure health providers are aware of this valuable tool.

- The committee was asked about the effectiveness of Suboxone® treatment programs. Overall, Dr. Roth commented that the programs are effective and suggested that perhaps state-funded treatment programs could provide an outlet for patients to receive rehabilitation. Most of these patients get in a vicious cycle that is very hard to overcome without some form of support/resources. David Beshara asked the committee to quantify the number of people in the state who may fall in this category. Dr. Roth felt these types of patients had a significant impact on the system and was unable to quantify this number based on his experience alone.
  - Dr. Roth stated that Suboxone® itself can become a huge problem. Many physicians treat addiction with Suboxone® differently. Suboxone® is highly addictive. Approximately 8 mg of Suboxone® has a morphine equivalent of 240 mg. There is no standard withdrawal schedule but, most patients should be slowly tapered off to prevent withdrawal.
  - The committee was asked if a patient currently receiving Suboxone® receives a prescription for hydrocodone or some other controlled substance for pain would this scenario be considered inappropriate care and a possible reason to dismiss the patient from care. Dr. Roth commented that this scenario would not be considered appropriate care and that patients should not be receiving both Suboxone® and a subsequent controlled drug. He confirmed that this could constitute possible grounds for a physician to discontinue care.
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 and expanding clinical criteria 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 prevent misuse and abuse while ensuring access for the patients who truly need these medications.

**Short-Acting Narcotic Utilization and Management**

- Dr. Alan Daniels presented data on short-acting narcotics for the TennCare pharmacy program. Narcotic analgesics have been the number one therapeutic class by claim volume for the past 3 years. Narcotic usage accounts for 9% of all prescription claims (short-acting = 8.5% and long-acting = 0.5%). The short-acting narcotic usage on a per member per year (PMPY) level showed that TennCare falls in the middle compared to other state Medicaid programs with a 3.738 rate of SAN claims per utilizing member per year. The average number of SAN claims per utilizing member per year across the 6 states included in the analysis averaged 3.86 overall. Dr. Daniels and Dr. Woods both agreed that, although this data suggests our utilization is similar to several other Medicaid states, we must remember that Medicaid programs vary and most states are not very aggressive in managing their narcotic utilization.

- The top 200 prescribers based on number of SAN claims were reviewed over a 3 month period. The Department of Health and the NPI database were used to determine prescriber specialty. After researching specialty data it was concluded that 33% of the prescribers were mid-level practitioners, 32% were family medicine or general practice, 10% were internal medicine, and 6% were anesthesiology.

- Data was presented that dealt with short-acting narcotic utilization. It was found that 60% of the SAN utilization is attributed to hydrocodone/APAP, approximately 13% is oxycodone/APAP, and Morphine® IR has a minor role at 0.4% utilization. The low morphine utilization is surprising since Morphine® ER plays a major role in utilization with the long-acting narcotics.

- Hydrocodone/APAP and oxycodone/APAP were further evaluated by looking at the number of claims received over a 6 month period. The distribution was pretty similar for both drugs. Further evaluation of patients receiving 13 or more claims revealed that the majority of this use involved long-term care patients. Overall, it seems there are a high number of claims for one time use on both charts.
  - The committee asked if this data included all diagnoses (i.e. HIV, cancer, etc.). Dr. Daniels stated that yes this included all diagnoses due to the difficulty of separating this information out. The committee felt that retrieving the number of doses and day supply would also be beneficial to determine usage patterns. David Beshara stated that the program only allows for a 1 month supply, so the data...
presented is indicative of 30 days or less. The committee felt that even among recipients receiving only 1 prescription over a 6 month period, if the patient was receiving a high number of doses there could still be room for improvement.

David Beshara brought up the “cost of intervention,” stating that before decisions are made on how to manage the SAN utilization, we must keep in mind that an intervention for a particular narcotic may outweigh the cost of the drug, as well as put a strain on the provider community if we intervene excessively.

- The committee asked whether the goal of the meeting was to: 1) decrease SAN utilization, 2) decrease cost, or 3) increase provider education on appropriate use of SAN. David Beshara commented that decreased cost was not a primary goal and cost could possibly be increased due to parameters that may be set. He stated that the major goal is to determine a “standard of practice,” focus on patients outside of the standard, and provide a trigger point to identify those outliers. In other words, what is a typical dose/duration for an initial SAN prescription? Is there a trigger point for a patient with no prior history receiving a high dose/duration for SAN? Dr. Johnston felt that appropriate parameters for acute pain based on the articles received would probably fall around a 5-day, 20-dose prescription for acute pain associated with sprains, fractures, etc.

- The committee wanted to confirm that average dose per prescription could be obtained if further evaluation was needed. It was explained that this information could be obtained; however, diagnosis information is much harder to obtain.

- David Beshara said that perhaps a patient population receiving 4 or 5 claims over a 6 month period may require a different strategy than a patient population who is receiving a 1 time or initial prescription.

- Dr. Daniels reported on the current management strategies in place for the short-acting narcotics within the pharmacy program:
  - Preferred Drug List (PDL), which identifies preferred and non-preferred drug products
  - Quantity limits (1200 mg hydrocodone/month, 1200 mg oxycodone/month, and 4 g of APAP/day) - There is currently no dose accumulator; we have to manually add the number of tablets that will obtain the maximum dose
  - Clinical criteria
  - Pharmacy Lock-In Program
  - Provider Practice Analysis, which evaluates the top 100 (specialist/non-specialist) prescribers of narcotics on a semi-annual basis.

- Graphs were presented depicting hydrocodone/APAP, oxycodone/APAP, and propoxyphene/APAP utilization by number of recipients and monthly dose received. Both hydrocodone/APAP and oxycodone/APAP have quantity limits and show quite a few recipients receiving above this dose through prior authorization. The maximum dose of propoxyphene/APAP is 6 tabs/day (3900 mg APAP/day); therefore this drug appears to be self-limiting with the 4 g/day maximum APAP dose.

- Dr. Beshara asked the committee for comments on why prescribing for propoxyphene was so high. The committee felt that the utilization was probably due to prescribers viewing this drug product as a weaker narcotic and prescribing it to offer the patient some type of narcotic analgesic. It was felt that propoxyphene/APAP is more effective than APAP alone. Dr, Knott commented
that, among elderly patients in long-term care, propoxyphene/APAP is rarely used and around-the-clock acetaminophen works quite well for arthritis pain.

- Oxycodeone IR showed high utilization of monthly doses greater than 2400 mg. Further research revealed recipients using very high doses over a long period of time and a large number of recipients receiving high doses for breakthrough pain. Based on the number of claims for morphine ER, the morphine IR utilization appeared quite low. Tramadol utilization exhibited no claims for greater than 8 tablets a day. The package insert states that the maximum dose is 400 mg/day and the graph shows that recipients are not receiving above the 400 mg/day maximum dose.

- 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:**

- The major narcotic management goals include: 1) appropriate access to narcotic medications while minimizing inappropriate use and/or abuse, 2) development of a coordinated strategy targeting patients, prescribers, and pharmacies, and 3) focusing on determining key indicators or “trigger points” and associating them with management initiatives.

- **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.

  - Dr. Woods stated the literature recommends that for chronic pain management 20-30% of one’s overall daily narcotic dose should be short-acting narcotic, with 70-80% of the daily dose long-acting narcotic. Dr. Woods asked the committee if they thought the 1200 mg/month dose limit on hydrocodone and oxycodone was appropriate. Dr. Roth expressed that the daily APAP dose should be evaluated first. He stated that he tries to keep his patients on \( \leq 1500 \text{ mg acetaminophen/day} \) for chronic pain. The committee felt that the APAP maximum daily dose limit should be less than 4 g/day for long-term users. Dr. Ball expressed that many prescribers may not consider the risks of APAP. Education to prescribers on APAP limits could be a great educational tool.

  - A comment was made that the large number of mid-level practitioners prescribing narcotics was alarming. Dr. Knott expressed that many mid-level prescribers do not know about the controlled substance database and may be naïve to the practices of drug addicts. David Beshara reminded the committee that he wanted to focus on the trigger points and programmatically how to address these issues.

  - The committee agreed that the APAP limit of 4 g/day should be maintained and perhaps lowering the limit for chronic use therapy. On mid-level prescribers, a suggestion was made that upon the prescribing of the third narcotic prescription; require patients to see a physician. In addition, educating providers on appropriate prescribing prior to implementing legal procedures could also be used as a management practice.

  - In general, the committee expressed agreement that the 1200 mg/month limit on hydrocodone and oxycodone products was reasonable, as it would allow for four 10 mg tabs/day.
The Committee also suggested a duration trigger to identify patients receiving SAN for > 6 months. It was suggested to require prior authorization for these patients to verify that they do indeed have a diagnosis of chronic, intractable pain.

Dr. Knott proposed flagging certain combination drug regimens as a trigger point. For example, patients receiving a combination of hydrocodone, alprazolam, and carisoprodol should be a red flag even if the quantities received are low.

- Dr. Roth agreed that any young patients receiving any quantity of hydrocodone/APAP and Xanax® each month on a long-term basis is a definite red flag. Most pain management providers do not prescribe benzodiazepines because it lowers the threshold for pain.

Dr. Woods asked the committee what they considered to be an appropriate dose for the non-combination SAN products?

- Dr. Roth commented that he has some patients on rather high doses of oxycodone IR. He mentioned that he could put these patients on Oxycontin® and add a lower dose of oxycodone IR; however, he is very cautious with Oxycontin® due to the eagerness of patients wanting the drug (high street value, etc.).

Dr. Woods asked what should be done with extreme outliers. The Committee suggested reporting these individuals to TBI.

Prescriber “Trigger Points” and Management

- The committee was asked what parameters should be evaluated to determine prescriber “trigger points”. Do we evaluate the average monthly dose of SAN/prescription, average quantity/prescription, total prescription volume per month and/or a high ratio of SAN versus LAN?

- Dr. Ellis, an emergency room physician on the DUR board, was unable to attend the meeting, but sent a letter expressing to the committee that he felt that the CSD was a valuable tool. He stated that a few factors contribute to the low utilization of this database. The primary reason is lack of awareness of the database within the provider community. Dr. Ellis stated that providers as well as hospital administrators should have targeted education about the CSD in an effort to increase awareness and also increase accessibility in emergency rooms. Another factor contributing to low utilization is the time required to access the database.

- The committee also suggested requiring prescribers writing for SAN for greater than 3 months to check the CSD and to determine if the patient has any drug-related charges.

- Dr. Woods asked the committee if targeted education to our top narcotic prescribers focusing on the CSD would be a good management strategy.
  - The committee felt this would be a good strategy and would also like to obtain input from a nurse practitioner in order to gain more insight on mid-level prescribers and what strategies may be utilized to prevent misuse and abuse of narcotics while achieving appropriate prescribing.

- A question was asked as to whether any physicians should be exempt from these trigger points. The Committee expressed that all prescribers should be held to the same minimal standards.

- Finally, a suggestion was made to have outlier prescribers provide a handwritten/signed letter that explains the reason for such a high dose SAN, diagnosis
and narcotic monitoring activities incorporated into the plan of care for this patient.

- **Pharmacy “Trigger Points” and Management**
  - A comment was made that many large chain pharmacies do not have access to the CSD. Dr. Bess will continue to monitor this issue and any future movement of the Board of Pharmacy to address this problem.

**Review of Proposed Short-Acting Narcotic Strategies:**
- David Beshara expressed that based on the meeting’s discussion he saw 3 categories of prescribers that would be affected by the proposed narcotic management strategies:
  1) High volume prescribers (i.e. pain management specialists) that strive to develop and maintain a standard of care that is appropriate.
  2) The “nice” prescribers that try to please their patients and may be coerced into prescribing medications specifically requested by the patient.
  3) The prescribers who are extreme outliers and are aware they are not appropriately prescribing narcotic analgesics.
    - The committee was asked how to differentiate between these 3 prescriber categories to focus primarily on the third group. Dr. Ball stated that asking one vital question, “Does the patient have a chronic intractable pain diagnosis?” should help differentiate between the categories as well as determine the outliers who will need special focus.
- In closing, a summary of the committee’s suggested management strategies was provided:
  - Set quantity limits based on the acetaminophen component of combination products
  - Maintain the quantity limits of 1200 mg/month hydrocodone and oxycodone
  - Ensure the recipient has a documented diagnosis of chronic, intractable pain if receiving a SAN for >6 months
  - Provide targeted education to providers on the CSD (i.e. how to sign-up, access website, appropriate narcotic prescribing, etc.)
  - Require prescribers to access the CSD upon prescribing a third prescription for a SAN
  - Define outliers as providers who are 2 standard deviations above the mean
  - Periodically review pharmacy claims for outlier patients
  - Continue to use lock-in as a management strategy

The meeting was adjourned.