

Prescription Pain Medication Management and Education Program
Policy, Insurance, and Incentive Work Group

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3:00-4:30pm

Dennis Harston—Altius
Jerry Shields—Blue Cross Blue Shield
Darlene Benson—Medicaid
Michael Deily—Medicaid
Lynn Webster—LifeSource
Carla Cook—Molina
Kathy Hoenig—Molina
Trisha Keller—Violence & Injury Prevention Program
Thomas Jones—Medicaid

Medicaid:

currently there is an unstable provider field (losing providers that will take Medicaid patients).

Cause may be: amount of \$, policies (although this is usually not the problem)

They are working on getting mental health component and primary care provider (pcp)

Restriction program: 1 provider, 1 pharmacy, 1 ER

They've lifted the prior authorization requirement (in the past 2 weeks)

They pay \$400 for care/treatment

Only 1 pain doctor is currently seeing children

Use 6 point approach to assess for addiction/mental health problems

Molina:

CMS (Center for Medicare/Medicaid services)—Molina just goes with what CMS (government) tells them

Use integrated care: physician, psychiatrist, mental health all in one office.

Rx for oxycontin requires pain specialist referral

Quantity limits

Prior authorization

Generics on formulary

Case managers

High utilization

Pain specialists are covered as needed

High turnover from nurses

Mental health and pharmacy rules are already set with Medicaid

Medicare—can make referrals

Telephonic disease management utilized

Regence:

Driven by what the employer groups want (some are stricter→won't authorize an oxycontin fill unless authorized by oncologist)

60 units per month, 2 fills

Patient and provider get a letter after the 2nd fill. Requires justification why patient should keep getting more

Too many dr. visits in a period of time=patient gets kicked out

Employer groups are getting involved→proactive (they aren't concerned with the cost of the plan as much as the health outcomes)

Self funded groups can make up their own restrictions

Non self funded groups follow the regular plans

Altius:

Some Controlled Substances are subject to prior authorization (oxycontin)

Limit Actiq to FDA indication (only given to people with malignancy)

Support Suboxone, but require prior auth.

Claims review process for:

Narcotic overuse program (lock-in program to 1 pharmacy, 1 doc)—send series of letters. Patient can select their pharmacy.

Pilot: drug poisoning profile (looking at claims data for whether intervention could have helped).

ER claims reviewed for chronic pain

Discussion:

Lynn: there is no research to support that Actic is abused

Others: Actic is overutilized and the demand is in excess of the recommendations. It is only covered for breakthrough pain.

Who can write RX if on restricted program and doctor is out of town?

If a patient has sold his/her pain meds, by law Dr. can't prescribe to them anymore

Medicaid works with Medicaid Fraud if patients sell meds

Does limiting the # of pills force doctors to long acting opioids

Educating the employer groups may help drive good insurance policy/protocol

Integrated care:

Utah Valley Mental Health is difficult to get info on Medicaid/pain patients. It is not integrated (not all in one place)

1. neuropsychiatric
2. pain specialist
3. physical therapist

Idea: have a self-help group

Idea: covering a gym pass for patients recovering from pain

What factors lead to ER overdose visits?

Call in Deb Falvo to talk about Utah Valley Mental Health

Not referring to mental health due to: time, education, reimbursement

Need integrated model: there is a stigma of calling for mental health care—so the integrated model is better when mental health check is part of the standard routine

Stratify into groups: low, moderate, and high risk (high risk must be managed by pain specialists)

Blended funding—MH, Pain specialist, case managers

Risk factors for deaths: benzos in combination, sleep apnea (70% of patients on mod to high risk opioids)

Need policy with insurance groups