Department of Health and Human Services
Division of Medical Assistance

NORTH CAROLINA MEDICAID
CONTROLLED SUBSTANCES TASK FORCE
Minutes
December 7, 2009

The North Carolina Medicaid Controlled Substances Task Force met on Monday, December 7, 2009, at 3:00 p.m. in room 297 of the Kirby Building.

Agencies represented: DMA, DMA-PI, DMH/DD/SAS, Five County MHA, AcessCare, DMA-BH, Community Care, Governor's Institute, Project Lazarus, NCCN, DPH, NCAP, DMH/DD/SAS-CSRS, Pain Specialists, SBI, NCBOP, Community Pharmacy, Family Medicine and Carolinas Poison Center

The meeting was called to order. Participants introduced themselves.

The minutes from the Controlled Substances Task Force meeting held on October 5, 2009 were reviewed. No changes or corrections were noted. A motion was made and seconded to approve the minutes. Participants unanimously approved the minutes.

Mission Statement

The current mission statement compiled from feedback via email from participants is: *To examine the scope of controlled substances misuse in the NC Medicaid population and to identify recommendations to maximize appropriate use, minimize the potential for misuse, and promote evidence-based treatment options for these prescription medications.*

Comments from participants regarding the mission statement:

- The term "misuse" includes abuse and diversion.
- Assumption that addiction treatment is included in the treatment options.
- Should evidence-based protocols for providers be included which would require a pain contract.
- Remove "for these prescription medications" from the end of the statement; therefore the statement would end with promote evidence-based treatment options.

The participants agreed and approved the following revised mission statement:
To examine the scope of controlled substances misuse in the NC Medicaid population and to identify recommendations to maximize appropriate use, minimize the potential for misuse, and promote evidence-based treatment options.

Targeted Medication Lock-In Program

A clinical subgroup was formed that consisted of physicians and pharmacists involved with the Controlled Substances Task Force. The clinical subgroup recommended the following Targeted Medication Lock-in criteria: (**please note: the following is the original criteria prior to discussing at the task force meeting)

NC Medicaid recipients will be "Locked-In" to ***one pharmacy*** *and* ***one prescriber*** *if the following criteria are met:*

1. ***Recipients who have at least ONE of the following***

*a. Benzodiazepines: ≥ **4** claims in the past 120 days*
*b. Opiates: ≥ **4** claims in the past 120 days*
*c. Tramadol: ≥ **4** claims in the past 120 days*
*c. Skeletal muscle relaxants: ≥ **4** claims in the past 120 days*
*d. Stimulants: ≥ **4** claims in the past 120 days*

OR

2. ***Targeted medications include opiates, tramadol, benzodiazepines, stimulants, and skeletal muscle relaxants****.*
   *Targeted medications: ≥ **6** claims in the past 120 days for a targeted medication from **> 3** prescribers*
   OR
   *Targeted medications: ≥ **6** claims in the past 120 days for a targeted medication filled at ≥ **3** pharmacies.*

OR

3. *Referral from a provider, DMA or CCNC.*

Comments from participants regarding lock-in criterion 1**:**

- If a recipient is receiving a benzodiazepam every month for four or more months, they would be locked-in to one provider.
- If a recipient who was locked-in to a prescriber went to go to the Emergency Room for a broken arm, or if they had a dental procedure and needed a controlled substance, how would they get a controlled substance for that emergent or occasional situation?
- Could we recommend that Medicaid prescribers check the Controlled Substance Reporting System (CSRS) prior to writing a prescription for a controlled substance?
- Not sure how it could be mandated to have prescribers check the CSRS prior to writing a prescription for a controlled substance.
- It would be easier to lock a recipient in to one pharmacy instead of one prescriber.
- Change criterion 1 to > 4 claims in the past 120 days. This would eliminate locking in recipients getting their monthly routine medications.
- Consult with the North Carolina College of Emergency Physicians to get their comments on the criteria.
- Evidence with addiction is with a risk management approach. There is little evidence that benzodiazepines work long term and after several months, you cross the addiction-risk line. The risk of increasing quantity used becomes a parameter in determining who to monitor for potential addiction.
- When recipients have signed a controlled substance contract or pain management agreement with a physician, they understand that they are to get their controlled substances from one physician. If the recipient goes to the Emergency Room (ER), the recipient should let the ER physician know that they have signed a controlled substance contract. The ER physician should then contact the physician who the contract/agreement is with. Patients should understand the controlled substance contract they signed with the physician and that they cannot get controlled substances from any ER physician. Most practices have a physician on call, so the ER physician can contact the on-call physician.
- The Medicaid rules should include a pain management agreement.
- All of the providers who take care of Medicaid patients should have a physician on call.

Comments regarding Criterion 2:

- Be consistent with the language in the criteria. Change ≥ 6 claims, to > 5 claims.
- The claims would only include Medicaid claims, not cash payments.

- Should we look at units instead of number of claims? Quantity limits were discussed.
- How many recipients would be involved if the units were limited? Patients develop tolerance therefore will need a higher dose or more units. Patients on tramadol who are slow metabolizers of 2D6, will have less effect from a standard tramadol dose.
- The criteria should not be so restrictive that the practitioner is not allowed to treat the patient's pain without jumping through hoops; therefore patients will be under-treated.
- Keep the criteria simple. Start broad and use the data to set the limitations.
- The criteria are trying to encourage best practice by having one provider. The lock-in is not a punishment, but if expeditious, will encourage the best practice and ensure the physician and patient knows where the medications will be coming from.
- Criterion 2 would capture the outliers and would not be too restrictive. Therefore, eliminate criterion 1 and start with criteria 2 and 3.
- Criterion 2 is set up to capture six claims and three prescribers. If one prescriber wrote prescriptions for 6 controlled substances it would not be captured under these criteria.
- The recipients who are locked-in would receive a letter prior to them being locked-in.
- Share criteria with the NC Medical Society to get their thoughts/comments.
- About 90-95% of the pharmacies are reporting to the CSRS.
- That statute for the CSRS states that the Division of Medical Assistance is entitled to data from the system for the purpose of administering the State Medical Assistance Plan.
- Medicaid claims could be identically matched in the CSRS. If a person pays cash for a prescription, then the name may not match up exactly.
- Once we get the criteria specified, then we will submit it to the Physicians Advisory Group (PAG) for policy change.
- Work with the task force to look at the next steps. Part 2 could look at chronic opioid use.
- Is there a way to get the prescribers to use the CSRS?
- Look at the Medical Board's policy on using the CSRS. The NC Medical Society has adopted wording recommending using the CSRS.
- The law will not allow the CSRS to provide names of prescribers who have not registered with the CSRS. The CSRS can provide the number of practitioners in a county who are using the system, but could not provide individual names. The data from the CSRS could show counties with the highest rates of usage.
- The CSRS has prescription rates with deaths per county already mapped out. This could be linked to the number of physicians who are registered to use the CSRS in each county as well as the number of physicians in each county. A task force member agreed to help collect this data.
- If we identified recipients who were paying cash for narcotic prescriptions, what would we do with that data?
- The participants agreed to limit the lock-in criteria to 2 and 3, although they would like to see the number of recipients who would be captured by different criterion scenarios.

Revised Targeted Medication Lock-In Program

NC Medicaid recipients will be "Locked-In" to ***one pharmacy*** *and* ***one prescriber*** *if the following criteria are met:*

1. ***Targeted medications: > 5 claims in the past 120 days for a targeted medication from > 3 prescribers***
   OR
   Targeted medications: > 5 claims in the past 120 days for a targeted medication filled at ≥ 3 pharmacies.
   Targeted medications include opiates, tramadol, benzodiazepines, stimulants, and skeletal muscle relaxants.

OR

2. Referral from a provider, DMA or CCNC.

- Glenda Adams will have reports generated looking at different variations of the criteria to see the number of recipients who would be affected. The reports will be emailed to the task force for review and comments.

The meeting was adjourned at 4:30 p.m.

Action items:

- *Contact the North Carolina College of Emergency Physicians to get their comments regarding the lock-in criteria. A task force member will provide names and contact information.*
- *Generate a report to show the actual number of recipients who would be locked-in based on the criteria and variations of the criteria. This will show the number of recipients who potentially could be involved depending on the criteria. Determine the number of recipients who are already locked-in to a pharmacy through the FORM program.*
- *Generate a report to look at the number of units per month of the targeted medications recipients are receiving.*
- *Send report summaries out to the task force participants for their review and comments.*
- *Submit criteria to NC Medical Society to get their comments and buy-in on the criteria.*
- *Provide Washington State's link to the task force for their review.*
- *CSRS to provide a map that shows prescription rates with the number of deaths per county and include the number of prescribers in the county who are registered with the CSRS compared to the total number of prescribers in that county.*