Louisiana Department of Health
Health Plan Advisory 17-23
Revised August 6, 2020

Drug Utilization Review (DUR) Program

The managed care organizations (MCO) shall maintain a Drug Utilization Review (DUR) program in accordance with Section 6.3.7 of the contract with the Louisiana Department of Health (LDH) and the Centers for Medicare and Medicaid (CMS) Managed Care Final Rule (CMS-2390-F). The Prospective DUR Program, Retrospective DUR Program and Educational DUR Program standards implemented by the MCO shall be consistent with the standards established by LDH as per Section 6.3.7.4 of its contract. LDH will send the MCO specific DUR criteria to implement after the Medicaid DUR Board has reviewed and approved proposed criteria. The MCOs and Fee for Service (FFS) Medicaid Program will implement new and revised DUR criteria as voted on by the Medicaid DUR Board.

Any revisions to the MCO's DUR policy and procedures or utilization review process/procedure and included standards shall be approved by LDH prior to implementation. At a minimum, the MCO DUR programs shall include all Medicaid DUR Board initiatives and submit new initiatives to LDH to include on the Medicaid DUR Board agenda at least 45 days in advance of the DUR Board meeting.

The MCO shall provide a detailed description of its DUR program annually to LDH to comply with ~~new~~ CMS DUR annual reporting requirements as per the Managed Care Final Rule. The annual report to the state will be due six weeks after LDH sends the CMS template to the MCOs. The MCO shall be responsible for developing responses to any questions posed by CMS on the annual report and coordinating its response through LDH. MCOs are required to program their claims processing systems to capture claim level data that is required by CMS for incorporation into the DUR Annual Report. Data capture shall be available within 90 days of this advisory.

The MCO DUR program shall contain the following components:

Prospective DUR Program

Refer to Section 6.3.7.3.1 of the contract for Prospective DUR Program requirements. Each inappropriate therapy edit identified through the Prospective DUR Program shall be coded with an individual denial description, which shall be reported separately.

Some DUR prospective criteria will allow for a soft edit or a pharmacist override. MCOs shall align NCPDP compliant POS edits and overrides. When the pharmacist receives a prospective DUR alert message that requires a pharmacist's review, the MCO POS system shall have the capability to allow the pharmacist to override the alert using the appropriate National Council for Prescription Drug Programs (NCPDP) "conflict, intervention and outcome" codes. POS overrides shall be implemented upon LDH direction. The MCO shall identify the top 10 pharmacies that have the most edit overrides and report them on the revised monthly DUR report (RX162).

Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code, depending on the Medicaid DUR Board approved criteria. Diagnosis codes shall be supplied by the prescriber on the prescription or transmitted verbally from the prescriber's office to the pharmacist. The pharmacist shall enter the diagnosis code at POS in NCPDP field 424-DO (diagnosis code).

MCO reporting, in accordance with the new CMS Managed Care Final Rule, shall include but not be limited to, the following:

Top drug claims data reviewed by the DUR Board (See Table 1 in FFS DUR Annual Report):

1. Top 10 prior authorization (PA) requests by drug name;
2. Top 10 PA requests by drug class;
3. Top five claim denial reasons other than eligibility (e.g. quantity limits, early refill, PA, therapeutic duplications, age limits);
4. Top 10 drug names by amount paid;
5. From data in number 4, a determination of the percentage of total drug expenditures;
6. Top 10 drug names by claim count; and
7. From data in number 6, a determination of the percentage of total claims represented by the top 10 drugs.

MCO programming for capturing required DUR reporting by CMS shall be completed within 90 days of issuance of this advisory. The MCO shall comply with all final reporting requirements and/or template produced by CMS.

Retrospective DUR Program (RetroDUR)

Retrospective DUR Program requirements are outlined in the MCO contract at Section 6.3.7.3.2. At a minimum, the MCO shall implement all of the DUR Board approved retrospective initiatives. An implementation timeline for retrospective interventions will be coordinated through LDH. Retrospective interventions are defined as communication from the MCO through intervention letters to the provider when DUR criteria are met. ~~If the number of cases which are identified for intervention exceeds 250 cases per month, the MCOs shall develop a weighting system to prioritize the cases identified. The weighting system must be approved by LDH.~~

Intervention letters, including member profiles, shall be sent to selected prescribers and/or pharmacy providers and include the following:

- Cover sheet (template will be provided by LDH);
- Response sheet (template will be provided by LDH);
- Additional enclosures, if applicable (examples include recommendations and supportive clinical guidelines if not included in cover sheet); and
- Member profile. In order to display drug utilization patterns, the MCO shall generate member profiles to send to the prescriber and/or pharmacy provider. The member profiles shall be composed of the following elements:
    - Member information – name, Medicaid ID, date of birth and gender – should be included in the header on every page;
    - Prescription claim information, including drug name; National Drug Code (NDC); prescription number; diagnosis (if provided); date of service; quantity dispensed; days' supply; pharmacy information such as name, address and National Provider Identifier (NPI) number; and prescriber information (name, address, NPI);
    - Physician administered drugs (optional for now); and
    - Exception criteria and description should be displayed at the beginning of the member profile (e.g. 1-Famotidine: exceeds maximum recommended dose (80 mg/day); 2-Contraindication: dorzolamide/timolol ophthalmic for patient with asthma; 3-Possibility of patient non-compliance with anti-diabetes therapy).
    - Member profiles shall exclude line items that contain any substance use disorder (SUD) diagnosis, drugs, and providers (such as clinicians, prescribers, and facilities) who solely treat SUD. Please see Part 2 of the Code of Federal Regulations, Title 42, Chapter 1, Subchapter A.

Member profiles shall be incorporated into the Retrospective DUR Program within 90 days of this advisory.

To determine if intervention letters are necessary, the MCO shall have a clinician or a team of clinicians evaluate the member profile before sending the intervention letter. Clinicians shall be pharmacists, nurses, or physicians. The clinician must be familiar with current clinical guidelines. The purpose is to send only meaningful information to the prescriber/pharmacist that will enable them to improve the member's care.

The MCO shall track and report prescriber/pharmacist responses to intervention letters through standing reporting established by LDH. Reporting shall include, but not be limited to, the following for the DUR annual report to CMS:

- Retrospective DUR Educational Outreach Summary. Rank of the top 10 interventions: number of hits (numerator)/number of claims (denominator). This is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary reports should be limited to the top 10 problems with the largest number of exceptions including the results of RetroDUR screening and interventions.
- Summary of Medicaid DUR Board Activities. LDH/DXC will supply this information to the MCO for inclusion in its CMS Annual report. Separately, the MCO shall include additional MCO-initiated activities which have been approved by LDH.
- Generic Drug Substitution Policies. The description of policies that may affect generic utilization percentage.
- Generic Drug Utilization Data. This includes the number of generic claims, total number of claims and generic utilization percentage. CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S (Single Source), N (Non-Innovator Multiple-Source), or I (Innovator Multiple-Source). This file will be made available from CMS to facilitate consistent reporting across states with this data request.
- Innovative Practices. Describe in detailed narrative form any innovative practices that are believed to have improved the administration of the MCO's DUR program, the appropriateness of prescription drug use, and/or have helped to control costs (i.e. disease management, academic detailing, automated prior authorizations, continuing education programs).
- E-Prescribing Activity Summary. Describe all development and implementation plans/accomplishments in the area of e-prescribing.
- Executive Summary.
- ~~Cost avoidance by measuring expenditures per therapeutic class for targeted members before and after the intervention.~~

Within the LDH standing report, retrospective intervention reporting shall also include but not be limited to the following for the Medicaid DUR Board (six months after intervention letter sent):

- Number of member profiles reviewed. This is the number of member profiles reviewed by the clinician. One member profile is one member; one member profile can have more than one intervention.
- Number of member profiles with intervention letters issued. More than one provider can get a letter for the same member; one letter can address more than one intervention.
- Number of responses and response rate.

Educational DUR Program

Educational DUR Program requirements are included at Section 6.3.7.3.3 of the MCO contract. MCOs shall educate prescribers, pharmacists and members on therapeutic appropriateness when overutilization or underutilization occurs and other clinical initiatives.