

**New Jersey Drug Utilization Review Board
Annual Report**

July 1, 2010 through June 30, 2011

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I. Acknowledgements

The Prospective Drug Utilization Review (PDUR) process for State Fiscal Year (SFY) 2011 was made possible by the hard work and commitment of the following members of the New Jersey Drug Utilization Review Board:

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In addition, the following employees assisted the drug utilization review process:

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II. Executive Summary

In accordance with Public Law 1998, chapter 41, the State of New Jersey Department of Human Services and the Department of Health and Senior Services are required by December 1st of each calendar year to provide an annual report, with copies to the United States Department of Health and Human Services, the Governor, the Legislature, the New Jersey Pharmacists Association and the Medical Society of New Jersey. The report includes a description of the highlights and opportunities identified by the New Jersey Drug Utilization Review Board (NJDURB) for the period beginning July 1, 2010 and ending June 30, 2011.

It is important to note that requirements for the Drug Utilization Review (DUR) annual report submitted to the United States Department of Health and Human Services by the New Jersey Division of Medical Assistance and Health Services (DMAHS) differ from those indicated by Public Law 1998, chapter 41 (Appendix A). Information included in this annual report will serve as input for the federal DUR report.

The NJDURB met quarterly during State Fiscal Year (SFY) 2011. The Board reviewed and discussed drug utilization data for a number of different drug classes as well as individual drugs of interest. Eight prior authorization protocols were reviewed and recommended, as well as additional claims processing edits or interventions designed to more effectively monitor drug utilization. The NJDURB spent \$9,991.31 in SFY 2011.

As part of the Prospective Drug Utilization Review (PDUR) process, interventions recommended by the NJDURB are designed to prevent adverse drug events; the overutilization/underutilization of medications; protecting the patient; and preventing fraud, waste and abuse. These interventions offer pharmacists additional information and opportunities to consult with patients and prescribers. The PDUR program has clearly demonstrated its ability to influence and, in some cases, dramatically change prescribing patterns ultimately encouraging appropriate drug utilization; improved health outcomes; and the avoidance of unnecessary drug costs.

Appendix B indicates over \$35 million in estimated cost savings for SFY 2011 for State pharmacy benefit programs through the Medical Exception Process (MEP).

It is important to note that the estimated cost savings in this Report are based on a recalculation performed by DMAHS that further eliminates duplication errors and better reflects the added value of the PDUR program.

The savings are an added value for the State. PDUR edits, such as drug-drug interactions, duplicative drug therapies, and excessive daily dosage, are designed to ultimately encourage appropriate drug use and improve the quality of pharmaceutical services provided by the State of New Jersey.

The cost of administering the MEP through Molina Medicaid Solutions for the period July 1, 2010 through June 30, 2011 was \$5,759,894.

III. Background

The NJDURB is responsible for reviewing and recommending prospective and retrospective components of the DUR process. These processes are intended to improve medication utilization and quality of care.

The PDUR consists of interventions performed by a pharmacist prior to a drug being dispensed to NJ FamilyCare/Medicaid, Pharmaceutical Assistance to the Aged and Disabled (PAAD), Senior Gold, Cystic Fibrosis and AIDS Drug Distribution Program (ADDP) beneficiaries who receive drug benefits through the State's pharmacy benefit programs. These interventions include consultations with the patient and the prescriber regarding drug utilization, including severe drug-drug interactions; maximum daily dosage having been exceeded; therapeutic duplication (the use of more than one drug from the same drug class); and situations where the recommended duration for a drug's use has been exceeded.

Retrospective Drug Utilization Review (RDUR) utilizes the same DUR criteria. However, these reviews are performed using a beneficiary's claim history after medications have been dispensed. These reviews are important for evaluating prescribing patterns. Using both PDUR and RDUR outcomes, the Board can recommend educational outreach designed to encourage appropriate drug use and quality assurance.

The NJDURB recommends PDUR and RDUR standards to address problem types such as duplication of drug therapy; inappropriate dosing; drug-drug interactions; drug-disease contraindications; and inappropriate therapeutic usage. Commissioners for the Department of Human Services and Health and Senior Services then consider these standards for approval. These standards are supported by the State's point-of-sale (POS) claims processing system. The POS system provides pharmacists clinically significant DUR information for consulting with patients prior to a prescription being dispensed.

The official NJDURB website may be found at www.nj.gov/humanservices/dmahs/boards/durb/.

IV. Findings

A. Overview of Activities/Interventions and Impact on Quality of Care

Highlights of Board Activities During SFY 2011 Include:

- **Oxycodone Controlled Release:** The NJDURB reviewed and recommended a protocol for the safe and efficient use of a controlled release (CR) formulation of oxycodone. Oxycodone is FDA-approved for the treatment of moderate to severe acute or chronic pain. However, according to the Drug Abuse Warning Network (DAWN), a national public health surveillance system, instances of abuse and emergency department episodes related to this product had increased significantly since 1996. When considering this protocol, the Board reviewed substance-related calls to the New Jersey Poison Control Center for the period 2007 thru 2009 which confirmed a substantial increase in oxycodone abuse-related incidents. The Board was also cognizant of the importance of uninterrupted access to pain medication for patients that need these medications for the treatment of pain. However, the abuse pattern for oxycodone in New Jersey, similar to that of a national trend, called for some form of intervention. The protocol allows uninhibited access for the most vulnerable patients, including cancer patients (sometimes undertreated) while demonstrating an effort to minimize abuse and limit inappropriate exposure to this drug sometimes resulting in life threatening or even fatal outcomes. The Board also recommended an educational Newsletter (Volume 1, No. 7) that was approved and distributed to pharmacy and prescriber communities. DURB Educational Newsletters may be found at www.nj.gov/humanservices/dmahs/boards/durb/.
Outcome: Based on claim payments, overall oxycodone controlled release utilization decreased by 39% in 2011 compared to 2010.
- **Proton Pump Inhibitors – Duration of Use:** The Board recommended a protocol to monitor risks associated with the use of proton pump inhibitors, also known as “PPIs,” commonly prescribed heart burn and ulcer medications. DURB members considered the FDA’s decision to revise the labeling of these products which was based on seven studies, six of which reported an increased risk of fractures to the hip, wrist, and spine. Other studies asserted that “the benefits of PPIs may not justify the risks for many users.” One of these risks was the recurrence of clostridium difficile infections. The protocol recommended prior authorization for patients receiving high dose PPIs (twice daily) for greater than 60 days and generating a reminder to prescribers whose patients have been on PPIs for greater than 12 months. The purpose was to encourage prescribers to re-evaluate the risks and benefits of continuing PPI therapy.
- **Pulmonary Arterial Hypertension (PAH):** The Board reviewed and recommended a protocol for the safe and efficient use of drugs used in the treatment of Pulmonary Arterial Hypertension (PAH). PAH is high blood pressure in the arteries of the lungs. The protocol was in line with recommendations released by the American College of Chest Physicians and the expert consensus of the American College of Cardiology Foundation and

American Heart Association which encouraged prudence in selecting and combining these products based on efficiency and cost effectiveness concerns.

- **Megestrol acetate (Megace[®]) suspension:** The Board reviewed and recommended a protocol for the appropriate and prudent use of megestrol acetate (Megace[®]) suspension. Megace[®] is prescribed for managing symptoms of advanced cancers and for treating weight loss in patients with AIDS. The Division acknowledged the escalating use of this product outside the narrow population for which it was intended.
Outcome: Based on claim payments, overall utilization of this drug decreased by 17% in 2011 compared to 2010.
- **Rheumatoid Arthritis:** The Board reviewed and recommended a protocol for the safe and efficient use of Rheumatoid Arthritis (RA) drugs, otherwise referred to as Disease Modifying Anti-Rheumatic Drugs or DMARDs. The 2008 Task Force Panel of the American College of Rheumatology (ACR) recommended the use of biologic DMARDs only after failure of non-biologic DMARD use, except in patients with moderate to severe deforming RA.
- **Tesamorelin (Egrifta[®]):** The Board reviewed and recommended a protocol for Tesamorelin (Egrifta[®]), a synthetic growth hormone releasing factor analogue. This product was the first approved for the treatment of lipodystrophy, a condition in which excess fat develops in different areas in the body of HIV patients.
- **Boceprevir (Victrelis[®]):** The Board recommended a protocol for boceprevir (Victrelis[®]), a new product for the treatment of chronic hepatitis C virus. This medication, a protease inhibitor, is the first in a class of drugs used for the treatment of this disease.
- **Short-acting opioids after 90 days:** The Board reviewed and recommended a protocol for the safe and efficient use of short-acting opioids in non-cancer patients after 90 days of therapy. The purpose of this protocol is to encourage prescribers to transition patients to long-acting opioids which are associated with fewer adverse effects than “as needed” or “PRN” short-acting opioids when used in this patient population.
- **Over-the-Counter (OTC) Drug Conversion Initiative:** The Board reviewed the success of the OTC conversion initiative that was recommended and implemented in 2006. For the Calendar Year ending December 2010, the State cost avoided \$20,901,370 in claim payments as the result of this initiative, in which practitioners voluntarily prescribed OTC alternatives to prescription-only drugs, including PPIs, non-sedating antihistamines, and ophthalmic drugs.
- **HMO Carve-in:** The Board discussed the State’s plan to transition its fee-for-service aged, blind and disabled (ABD) populations into managed care by October 1, 2011. ABD pharmaceutical benefits were also carved into managed care on July 1, 2011. The NJDURB is working with the State to develop plans

for monitoring the quality of pharmaceutical care now being provided by managed care.

All the recommendations made by the Board in SFY 2011 were approved by the Commissioners of Human Services and Health and Senior Services.

Additional information regarding DURB activities may be found at www.nj.gov/humanservices/dmahs/boards/durb/

B. Assessment of Costs

Drug Utilization

The MEP approved 367,658 claims between July 1, 2010 to June 30, 2011. The Top five categories of drugs prior authorized by the MEP unit include pain medications, proton-pump inhibitors, dietary supplements, atypical antipsychotics, and skeletal muscle relaxants. See Table A below.

Top five categories of drugs receiving the most denials by the MEP unit include proton-pump inhibitors, sedative-hypnotics, pain medications, dietary supplements, and non-steroidal anti-inflammatory drugs or NSAIDs. See Table B below.

Major reasons for prior authorizations being denied were multiple prescribers; dosage and durations of therapy above established DUR standards; clinical criteria not met; inappropriate diagnoses; and other drug(s) causing drug-drug interactions.

Table A

Top 5 Authorized Drug Categories:

Therapeutic Category (STC)	Claim Count	Estimated Payment Amount
Pain Meds (H3A)	94,679	\$ 27,939,381
Proton-PumpInhibitors (D4J)	28,253	\$ 5,037,562
Dietary Supplements (C5F)	21,452	\$ 3,681,047
Atypical Antipsychotics (H7T)	19,631	\$ 9,544,472
Skeletal Muscle Relaxants (H6H)	18,616	\$ 568,817

Table B

Top 5 Denied Drug Categories:

Therapeutic Category (STC)	Claim Count	Estimated Cost-Savings
Proton-Pump Inhibitors (D4J)	12,653	\$ 1,077,673
Sedative-Hypnotics (H2E)	9,622	\$ 485,592
Pain Meds (H3A)	7,922	\$ 1,080,520
Dietary Supplements (C5F)	4,534	\$ 561,630
NSAIDs (S2B)	2,589	\$ 204,185

The PDUR program utilized by the State in SFY 2011 is supported by various edit tables designed to provide maximum flexibility for the State to apply PDUR interventions. These tables include standards for individual Generic Code Numbers or Specific Therapeutic Classes; minimum age; maximum age; relationships between a claim's reported metric quantity and days supply; and effective dates. These tables also allow for an immediate denial; the override of a claim denial with prior authorization; or a 30 day supply of a drug to be dispensed. During this 30-day period, interventions with the prescriber take place to determine medical necessity for a drug's use. These tables are designed to prevent adverse events; protect the patient; and prevent fraud, waste and abuse.

Medical Exception Process

The cost of administering the MEP through Molina Medicaid Solutions for SFY 2011 was \$5,759,894.

C. Recommendations

In order to improve the State's DUR program, it is recommended that the Board continue its role of monitoring drug utilization for medications provided fee-for-service or by Medicaid managed healthcare for the purpose of ensuring appropriate drug utilization and minimizing potential fraud waste and abuse. Specific to managed care-provided pharmacy benefits, the Board is recommending its continued focus on drug utilization to (1) ensure that State-approved DUR protocols are implemented; (2) evaluate health outcomes based on their application; and (3) determine the impact of inappropriate drug utilization on HMO prescription drug costs. The DURB should partner with Medicaid managed care to promote educational programs intended to influence, and in some cases, dramatically change prescribing patterns to ultimately encourage appropriate drug utilization, improved health outcomes and the avoidance of unnecessary drug costs.

V. Acronyms

ADDP	AIDS Drug Distribution Program
DMAHS	Division of Medical Assistance and Health Services
DUR	Drug Utilization Review
DURB	Drug Utilization Review Board
HIV	Human Immunodeficiency Virus
MEP	Medical Exception Process
NJDURB	New Jersey Drug Utilization Review Board
OTC	Over-the-Counter
PA	Prior Authorization
PAAD	Pharmaceutical Assistance to the Aged and Disabled
PDUR	Prospective Drug Utilization Review
POS	Point-of-Sale
PPI	Proton Pump Inhibitor
RDUR	Retrospective Drug Utilization Review
SFY	State Fiscal Year

VI. Appendices

Appendix A

P.L. 1998, Chapter 41, approved June 30, 1998, as amended and supplemented

§ 30:4D-17.6. Definitions

As used in this act:

“Beneficiary” means a person participating in a State pharmaceutical benefits program.

“Board” means the Drug Utilization Review Board established pursuant to section 2 of P.L.1998, c. 41 (C.30:4D-17.17a) in connection with State pharmaceutical benefits programs.

“Compendia” means those resources widely accepted by the medical professions in the efficacious use of drugs which is based on, but not limited to, these sources: the “American Hospital Formulary Services Drug Information,” the “U.S. Pharmacopeia-Drug Information,” the “American Medical Association Drug Evaluation,” and the peer-reviewed medical literature, and information provided from the manufacturers of drug products.

“Criterion” means those explicit and predetermined elements that are used to assess or measure drug use on an ongoing basis to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

“Department” means the Department of Human Services.

“Drug Interactions” means the occurrence when two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present or that leads to the interference with the effectiveness of one or any of the drugs.

“Drug-disease contraindication” means the occurrence when the therapeutic effect of a drug is adversely altered by the presence of another disease or condition.

“Intervention” means a form of educational communication utilized by the Board with a prescriber or pharmacist to inform about or to influence prescribing or dispensing practices.

“Medicaid” means the program established pursuant to P.L.1968, c. 413 (C.30:4D-1 et seq.).

“Over-utilization or under-utilization” means the use or non-use of a drug in quantities such that the desired therapeutic goal is not achieved.

“PAAD” means the program of pharmaceutical assistance to the aged and disabled established pursuant to P.L.1975, c. 194 (C.30:4D-20 et seq.).

“Prescriber” means a person authorized by the appropriate State professional and occupational licensing board to prescribe medications and devices.

“Prospective drug utilization review” means that part of the drug utilization review program that occurs before the drug is dispensed and is designed to screen for potential drug therapy problems based on knowledge of the patient, the patient’s continued drug use and the drug use criteria and standards developed by the board.

“Retrospective drug utilization review” means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug data against criteria and standards developed by the Board on an ongoing basis with professional input.

“Standards” means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the beneficiary database.

“State pharmaceutical benefits program” means the following programs: Medicaid, PAAD, Senior Gold, the AIDS drug distribution program, and any other State and Federally funded pharmaceutical benefits program.

“Therapeutic appropriateness” means drug prescribing and dispensing based on rational drug therapy that is consistent with the criteria and standards developed pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a).

“Therapeutic duplication” means the prescribing and dispensing of the same drug or of two or more drugs from the same therapeutic class when overlapping time periods of drug administration are involved and when the prescribing or dispensing is not medically indicated.

HISTORY: L. 1993, c. 16, §1; amended 1998, c. 41, §1.

§ 30:4D-17.17a. Drug Utilization Review Board

a. There is established the Drug Utilization Review Board in the department to advise the department on the implementation of a drug utilization review program pursuant to P.L. 1993, c. 16 (C. 30:4D-17.16 et seq.) and this section. The board shall establish a Senior Drug Utilization Review Committee to address the specific prescribing needs of the elderly and an AIDS/HIV Drug Utilization Review Committee to address the specific prescribing needs of persons with AIDS/HIV, in addition to such other committees as it deems necessary. It shall be the responsibility of each committee to evaluate the specific prescribing needs of its beneficiary population, and to submit recommendation to the board in regard thereto.

The Board shall consist of 17 members, including the Commissioners of Human Services and Health and Senior Services or their designees, who shall serve as nonvoting ex officio members, and 15 public members. The public members shall be appointed by the Governor with the advice and consent of the Senate. The appointments shall be made as follows: six persons licensed and actively engaged in the practice of medicine in this State, including one who is a psychiatrist and at least two who specialize in geriatric medicine and two who specialize in AIDS/HIV care, one of whom is a pediatric AIDS/HIV specialist, four of whom shall be appointed upon the recommendation of the Medical Society of New Jersey and two upon the recommendation of the New Jersey Association of Osteopathic Physicians and Surgeons; one person licensed as a physician in this State who is actively engaged in academic medicine; four persons licensed in and actively practicing or teaching pharmacy in this State, who shall be appointed from a list of pharmacists recommended by the New Jersey Pharmacists Association, the New Jersey Council of Chain Drug Stores, the Garden State Pharmacy Owners, Inc., the New Jersey Society of Hospital Pharmacists, the Academy of Consultant Pharmacists and the College of Pharmacy of Rutgers, The State University; one additional health care professional; two persons certified as advanced practice nurses in this State, who shall be appointed upon the recommendation of the New Jersey State Nurses Association; and one member to be appointed upon the recommendation of the Pharmaceutical Research and Manufacturers of America.

Each member of the board shall have expertise in the clinically appropriate prescribing and dispensing of outpatient drugs.

b. All appointments to the board shall be made no later than the 60th day after the effective date of this act. The public members shall be appointed for two-year terms and shall serve until a successor is appointed and qualified, and are eligible for reappointment; except that of the public members first appointed, eight shall be appointed for a term of two years and five for a term of one year.

c. Vacancies in the membership of the board shall be filled in the same manner as the original appointments were made but for the unexpired term only. Members of the board shall serve with compensation for the time and expenses incurred in the performance of their duties as board members, as determined by the Commissioners of Human Services and Health and Senior Services, and subject to the approval of the Director of the Division of Budget and Accounting in the Department of the Treasury.

d. The board shall select a chairman from among the public members, who shall serve a one-year term, and a secretary. The chairman may serve consecutive terms. The board shall adopt bylaws. The board shall meet at least quarterly and may meet at other times at the call of the chairman. The board shall in all respects comply with the provisions of the "Open Public Meetings Act," P.L. 1975, c. 231 (C. 10:4-6 et seq.). No motion to take any action by the board shall be valid except upon the affirmative vote of a majority of the authorized membership of the board.

e. The duties of the board shall include the development and application of the criteria and standards to be used in retrospective and prospective drug utilization review. The criteria and standards shall be based on the compendia and developed with

professional input in a consensus fashion. There shall be provisions for timely reassessments and revisions as necessary and provisions for input by persons acting as patient advocates. The drug utilization review standards shall reflect the local practices of prescribers, in order to monitor:

- (1) therapeutic appropriateness;
- (2) over-utilization or under-utilization;
- (3) therapeutic duplication;
- (4) drug-disease contraindications;
- (5) drug-drug interactions;
- (6) incorrect drug dosage;
- (7) duration of drug treatment; and
- (8) clinical drug abuse or misuse.

The board shall recommend to the department criteria for denials of claims and establish standards for a medical exception process. The board shall also consider relevant information provided by interested parties outside of the board and, if appropriate, shall make revisions to the criteria and standards in a timely manner based upon this information.

f. The board, with the approval of the department, shall be responsible for the development, selection, application, and assessment of interventions or remedial strategies for prescribers, pharmacists and beneficiaries that are educational and not punitive in nature to improve the quality of care, including:

- (1) Information disseminated to prescribers and pharmacists to ensure that they are aware of the duties and powers of the board;
- (2) Written, oral or electronic reminders of patient-specific or drug-specific information that are designed to ensure prescriber, pharmacist, and beneficiary confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care;
- (3) The development of an educational program, using data provided through drug utilization review as a part of active and ongoing educational outreach activities to improve prescribing and dispensing practices as provided in this section. These educational outreach activities shall include accurate, balanced and timely information about drugs and their effect on a patient. If the board contracts with another entity to provide this program, that entity shall publicly disclose any financial interest or benefit that accrues to it from the products selected or used in this program;

- (4) Use of face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been designated by the board for educational intervention;
- (5) Intensified reviews or monitoring of selected prescribers or pharmacists;
- (6) The timely evaluation of interventions to determine whether the interventions have improved the quality of care; and
- (7) The review of case profiles prior to the conducting of an intervention.

HISTORY: L. 1998, c. 41, §2; amended 2003, c. 262.

§ 30:4D-17.18. Responsibilities of department The department shall be responsible for:

- a. (Deleted by amendment, P.L.1998, c. 41).
- b. The implementation of a drug utilization review program, subject to the approval of the Commissioner of Health and Senior Services, to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes, including the approval of the provisions of any contractual agreement between the State pharmaceutical benefits program and other entities processing and reviewing drug claims and profiles for the drug utilization review program.

The program shall include both retrospective and prospective drug utilization review. Retrospective drug utilization review shall include an analysis of drug claims processing data in order to identify patterns of fraud, abuse or gross overuse, an inappropriate or medically unnecessary care, and to assess data on drug use against standards that are based on the compendia and other sources. Prospective drug utilization review shall include a review conducted by the pharmacist at the point-of-sale.

- c. (Deleted by amendment, P.L.1998, c. 41).
- d. (Deleted by amendment, P.L.1998, c. 41).
- e. The submission of an annual report, which shall be subject to public comment prior to its issuance, to the Federal Department of Health and Human Services by December 1st of each year. The annual report shall also be submitted to the Governor, the Legislature, the New Jersey Pharmaceutical Association and the Medical Society of New Jersey by December 1st of each year. The report shall include the following information:
 - (1) An overview of the activities of the board and the drug utilization review program;

- (2) Interventions used and their ability to improve the quality of care; however, this information shall not disclose the identities of individual prescribers, pharmacists, or beneficiaries, but shall specify whether the intervention was a result of under-utilization or over-utilization of drugs;
- (3) The costs of administering the drug utilization review program;
- (4) Any cost impact to other areas of the State pharmaceutical benefits program resulting from the drug utilization review program, such as hospitalization rates or changes in long-term care;
- (5) A quantitative assessment of how drug utilization review has improved beneficiaries' quality of care;
- (6) A review of the total number of prescriptions and medical exception requests reviewed by drug therapeutic class;
- (7) An assessment of the impact of the educational program established pursuant to subsection f. of section 2 of P.L.1998, c.41 (C.30:4D-17.17a) and interventions on prescribing or dispensing practices, total program costs, quality of care and other pertinent patient patterns; and
- (8) Recommendations for improvement of the drug utilization review program.
 - f. The development of a working agreement between the board and other boards or agencies, including, but not limited to: the Board of Pharmacy of the State of New Jersey and the State Board of Medical Examiners, in order to clarify any overlapping areas of responsibility.
 - g. The establishment of an appeal process for prescribers, pharmacists and beneficiaries pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq) and section 2 of P.L.1998, c.41 (C.30:4D-17.17a).
 - h. The publication and dissemination of medically correct and balance educational information to prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists and beneficiaries, including:
 - (1) potential or actual reactions to drugs;
 - (2) therapeutic appropriateness;
 - (3) over-utilization or under-utilization;
 - (4) appropriate use of generic drugs;
 - (5) therapeutic duplication;

- (6) drug-disease contraindications;
 - (7) drug-drug interactions;
 - (8) incorrect drug dosage or duration of drug treatment;
 - (9) drug allergy interactions; and
 - (10) clinical abuse or misuse.
- i. the development and publication, with the input of the Board of Pharmacy of the State of New Jersey, of the guidelines to be used by pharmacists, including mail order pharmacies, in their counseling of beneficiaries.
 - j. The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the drug utilization review program, that identifies individual prescribers, pharmacists, or beneficiaries. The board may have access to identifying information for purposes of carrying out intervention activities, but the identifying information may not be released to anyone other than a member of the board, except that the board may release cumulative non-identifying information for purposes of legitimate research. The improper release of information in violation of this act may subject that person to criminal or civil penalties.
 - k. The determination of whether nursing or long-term care facilities under 42 CFR 483.60 are exempt from the provisions of this act.
 - l. The establishment of a medical exception process by regulation.
 - m. The provision of such staff and other resource as the board requires.

HISTORY: L. 1993, c. 16, § 3; amended 1998, c. 41, § 3.

§ 30:4D-17.18a. Rules, regulations

The Commissioner of Human Services, pursuant to the “Administrative Procedure Act,” P.L.1968, c. 410 (C.52:14B-1 et seq.), and subject to the approval of the Commissioner of Health and Senior Services as appropriate, shall adopt rules and regulation to effectuate the purposes of P.L.1993, c. 16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a); except that, notwithstanding any provision of P.L.1968, c. 410 (C.52.14B-1 et seq.) to the contrary, the Commissioner of Human Services, subject to the approval of the Commissioner of Health and Senior Services, may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of P.L.1993, c. 16 (C.30.4D-17.16 et seq.) and section 2 of P.L.1998, c. 41 (C.30:4D-17.17a), which shall be effective for a period not to exceed six months and may thereafter be amended, adopted, or re-adopted by the Commissioner of Human

Services, subject to the approval of the Commissioner of Health and Senior Services, in accordance with the requirements of P.L.1968, c. 410 (C.52:14B-1 et seq.).

HISTORY: L. 1998, c. 41, § 4.

Appendix B

Molina Medicaid Solutions Cost Avoidance Reports

Claims represented in this report did not reappear for future payment and are considered an avoidance of inappropriate expenditures

July 1, 2010 – June 30, 2011

Edit	ADDP	GA	Sr Gold	FFS	PAAD	Grand Total
403	\$30,102	\$110,231	\$8,582	\$1,199,917	\$105,834	\$1,454,666
404	\$12,302	\$41,135	\$2,789	\$583,783	\$48,676	\$688,684
405	\$52,225	\$520,605	\$10,057	\$1,928,236	\$87,359	\$2,598,481
407	\$90,681	\$52,727	\$52,400	\$360,903	\$8,089	\$564,800
417	\$17,701	\$107,821	\$13,740	\$1,123,229	\$83,392	\$1,345,883
447	\$456	\$9,598	\$745	\$51,049	\$5,200	\$67,049
449	\$0	\$12,734	\$0	\$114,934	\$0	\$127,668
537	\$14,726	\$232,243	\$17,105	\$1,316,554	\$110,822	\$1,691,449
577	\$0	\$5,865,590	\$0	\$0	\$0	\$5,865,590
869	\$328	\$5,153	\$19	\$83,528	\$5,639	\$94,667
916	\$131,042	\$136,254	\$24,024	\$596,608	\$220,988	\$1,108,917
2007	\$398,450	\$2,852,207	\$29,803	\$11,265,488	\$192,770	\$14,738,718
2021	\$0	\$0	\$0	\$135,187	\$0	\$135,187
2038	\$0	\$12,021	\$0	\$933,539	\$0	\$945,560
2046	\$16,088	\$403,097	\$7,404	\$1,134,313	\$59,449	\$1,620,351
2047	\$7,435	\$5,251	\$11	\$29,148	\$139	\$41,984
2085	\$306	\$5,524	\$338	\$25,874	\$2,022	\$34,063
2100	\$0	\$382,251	\$0	\$2,071,098	\$0	\$2,453,349
2111	\$0	\$23,962	\$0	\$118,569	\$0	\$142,532
Grand Total	\$771,842	\$10,778,405	\$167,016	\$23,071,956	\$930,378	\$35,719,597

- Cost savings identified in this report reflect costs for DUR claims denied by a DUR edit for which no future paid claims were identified for the 60 day period following the date of denial.
- This report has been unduplicated by claim and edit.

Description of Edits

403 Duration Exceeded
 404 Duration Exceeded
 405 Possible Therapeutic Class Duplication
 407 Possible duplication of HIV therapy
 417 Generic Substitution Required
 447 Daily Dose Exceeds Recommended Limits
 449 "Inappropriate Narcotic Use"
 537 NJDURB Daily Drug Quantity Exceeded
 577 PA Required for WFNJ/GA Drug Coverage
 869 Possible Severe Drug-Drug Interaction
 916 Severe Drug-Drug Interaction
 2007 Prior Authorization Required
 2021 Medicare Part D Wraparound Drug Requires PA
 2038 First Fill of HIV or High Dose Narcotic
 2046 Prescription restricted
 2047 PA required: Prescriber/Drug Restricted
 2085 Maximum Allowable Cost (MAC) Override
 2100 Daily Dose Standard Exceeded
 2111 Cough and cold symptoms