Medicaid Drug Utilization Review Board and Program

Sunset Overview

Purpose

The Utah Medicaid Drug Utilization Review Board and Program was established by SB 202, Drug Utilization Review Board, during the 1992 General Session.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), State Medicaid programs have been using drug utilization review (DUR) for decades to monitor and address patterns of prescription drug misuse. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) mandated the use of DUR as part of the Medicaid outpatient prescription drug benefit. Specifically, federal law (Section 1927, Social Security Act; 42 CFR 456.703) requires state DUR programs to include the following components:

- prospective drug review;
- retrospective drug use review; and
- an educational program.

The prospective DUR consists of three components—point-of-sale review, drug counseling, and profiling. The retrospective DUR uses claims data and other records to monitor issues such as overutilization, drug-disease contraindication, and appropriate use of generic products.

The educational program must be administered by the state to provide information to practitioners on common drug therapy problems and to improve prescribing and dispensing practices.

The Utah DHHS Medicaid Drug Utilization Review Program website currently lists the following interventions, which are communications with a prescriber or pharmacist intended to inform or influence prescribing or dispensing practices:

- Attention Deficit Hyperactivity Disorder (ADHD) Stimulants
- Antidepressant Medication Management (AMM)
- Antipsychotics in Children
- Hemophilia Medication Management
- Hepatitis C Medication Adherence
- Opioids in Combination with Other High-Risk Medications
- Opioid Limitations

In addition to the establishment of a DUR program, federal law (Section 1927, Social Security Act; 42 CFR 456.716) requires each state to establish a Drug Use Review Board that is responsible for overseeing the activities of the DUR program. The board also must submit an annual report detailing its activities, interventions, quality of care impacts, and estimated cost savings.

Utah's DUR Board meets monthly and has various resources publicly available on its website.

The following are links to the DUR Program's three most recent annual reports:

- 2024

- 2023
- 2022

Current Committee/Program Funding*

FY 26 Funding Appropriated/Available under the purview of the program	FY 27 Funding Appropriated/Available under the purview of the program
$211,000.00 General Fund	$0.00

**Committee/Program Funding information provided by the Department of Health and Human Services.*

Current Sunset Date

July 1, 2027 (Utah Code Section 63I-1-226)

Sections of Code that Sunset

- 26B-3-302
- 26B-3-303
- 26B-3-304
- 26B-3-305
- 26B-3-306
- 26B-3-307
- 26B-3-308
- 26B-3-309

~~**26B-3-302. DUR Board -- Creation and membership -- Expenses.**~~

~~(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.~~

~~(2)~~

~~(a) Except as required by Subsection (2)(b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.~~

~~(b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.~~

~~(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.~~

~~(d) The executive director shall provide for geographic balance in representation on the board.~~

~~(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.~~

~~(4) The membership shall be comprised of the following:~~

(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;
(b) one physician in this state who is actively engaged in academic medicine;
(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;
(d) one pharmacist who is actively engaged in academic pharmacy;
(e) one person who shall represent consumers;
(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and
(g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.

(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.

(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.

(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(a) Section 63A-3-106;
(b) Section 63A-3-107; and
(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

26B-3-303. DUR Board -- Responsibilities.

The board shall:

(1) develop rules necessary to carry out its responsibilities as defined in this part;

(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;

(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:
(a) therapeutic appropriateness;
(b) overutilization or underutilization;
(c) therapeutic duplication;
(d) drug-disease contraindications;
(e) drug-drug interactions;
(f) incorrect drug dosage or duration of drug treatment; and
(g) clinical abuse and misuse;

~~(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;~~
~~(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;~~
~~(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;~~
~~(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;~~
~~(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;~~
~~(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;~~
~~(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;~~
~~(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;~~
~~(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Medical Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;~~
~~(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;~~
~~(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:~~
~~(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;~~
~~(b) potential or actual severe or adverse reactions to drugs;~~
~~(c) therapeutic appropriateness;~~
~~(d) overutilization or underutilization;~~
~~(e) appropriate use of generics;~~
~~(f) therapeutic duplication;~~
~~(g) drug-disease contraindications;~~
~~(h) drug-drug interactions;~~
~~(i) incorrect drug dosage and duration of drug treatment;~~
~~(j) drug allergy interactions; and~~
~~(k) clinical abuse and misuse;~~
~~(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:~~
~~(a) the name and description of the medication;~~
~~(b) administration, form, and duration of therapy;~~
~~(c) special directions and precautions for use;~~

(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;
(e) techniques for self-monitoring drug therapy;
(f) proper storage;
(g) prescription refill information; and
(h) action to be taken in the event of a missed dose; and
(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:
(a) the name, address, age, and gender of the recipient;
(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;
(c) the pharmacist's comments on the individual's drug therapy;
(d) name of prescriber; and
(e) name of drug, dose, duration of therapy, and directions for use.

26B-3-304. Confidentiality of records.
(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63G, Chapter 2, Government Records Access and Management Act.
(2) The board shall establish procedures ensuring that the information described in Subsection 26B-3-304(16) is held confidential by the pharmacist, being provided to the physician only upon request.
(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

26B-3-305. Drug prior approval program.
(1) A drug prior approval program approved or implemented by the board shall meet the following conditions:
(a) except as provided in Subsection (2), a drug may not be placed on prior approval for other than medical reasons;
(b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior approval;
(c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);
(d) the board shall consider written and oral comments submitted by interested parties prior to or during the hearing held in accordance with Subsection (1)(b);
(e) the board shall provide evidence that placing a drug class on prior approval:
(i) will not impede quality of recipient care; and

(ii) that the drug class is subject to clinical abuse or misuse;

(f) the board shall reconsider its decision to place a drug on prior approval:

(i) no later than nine months after any drug class is placed on prior approval; and

(ii) at a public hearing with notice as provided in Subsection (1)(b);

(g) the program shall provide an approval or denial of a request for prior approval:

(i) by either:

(A) fax;

(B) telephone; or

(C) electronic transmission;

(ii) at least Monday through Friday, except for state holidays; and

(iii) within 24 hours after receipt of the prior approval request;

(h) the program shall provide for the dispensing of at least a 72-hour supply of the drug on the prior approval program:

(i) in an emergency situation; or

(ii) on weekends or state holidays;

(i) the program may be applied to allow acceptable medical use of a drug on prior approval for appropriate off-label indications; and

(j) before placing a drug class on the prior approval program, the board shall:

(i) determine that the requirements of Subsections (1)(a) through (i) have been met; and

(ii) by majority vote, place the drug class on prior approval.

(2) The board may, only after complying with Subsections (1)(b) through (j), consider the cost:

(a) of a drug when placing a drug on the prior approval program; and

(b) associated with including, or excluding a drug from the prior approval process, including:

(i) potential side effects associated with a drug; or

(ii) potential hospitalizations or other complications that may occur as a result of a drug's inclusion on the prior approval process.

26B-3-306. Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under Sections 26B-3-302 through 26B-3-309.

26B-3-307. Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).

(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:

(a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and

(b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:

(i) therapeutic appropriateness;

(ii) overutilization or underutilization;

(iii) therapeutic duplication;

(iv) drug-disease contraindications;

(v) drug-drug interactions;

(vi) incorrect drug dosage or duration of drug treatment; and

(vii) clinical abuse and misuse.

(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) therapeutic duplication;

(b) drug-drug interactions;

(c) incorrect dosage or duration of treatment;

(d) drug-allergy interactions; and

(e) clinical abuse or misuse.

(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician or physician assistant. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

26B-3-308. Penalties.

Any person who violates the confidentiality provisions of Sections 26B-3-302 through 26B-3-307 is guilty of a class B misdemeanor.

26B-3-309. Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of Sections 26B-3-302 through 26B-3-307.