

COMPARISON OF HEALTHCARE USE AND COSTS OF ADULT PATIENTS WITH “PURE OBSESSIVE-COMPULSIVE DISORDER” VERSUS “PURE DEPRESSION”: NINE-YEAR CLAIMS ANALYSIS OF FLORIDA MEDICAID ENROLLEES

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BACKGROUND

Obsessive-compulsive disorder (OCD) is a relatively rare but extremely debilitating anxiety disorder that may be associated with the frequent use of general medical services.¹⁻³

OBJECTIVE

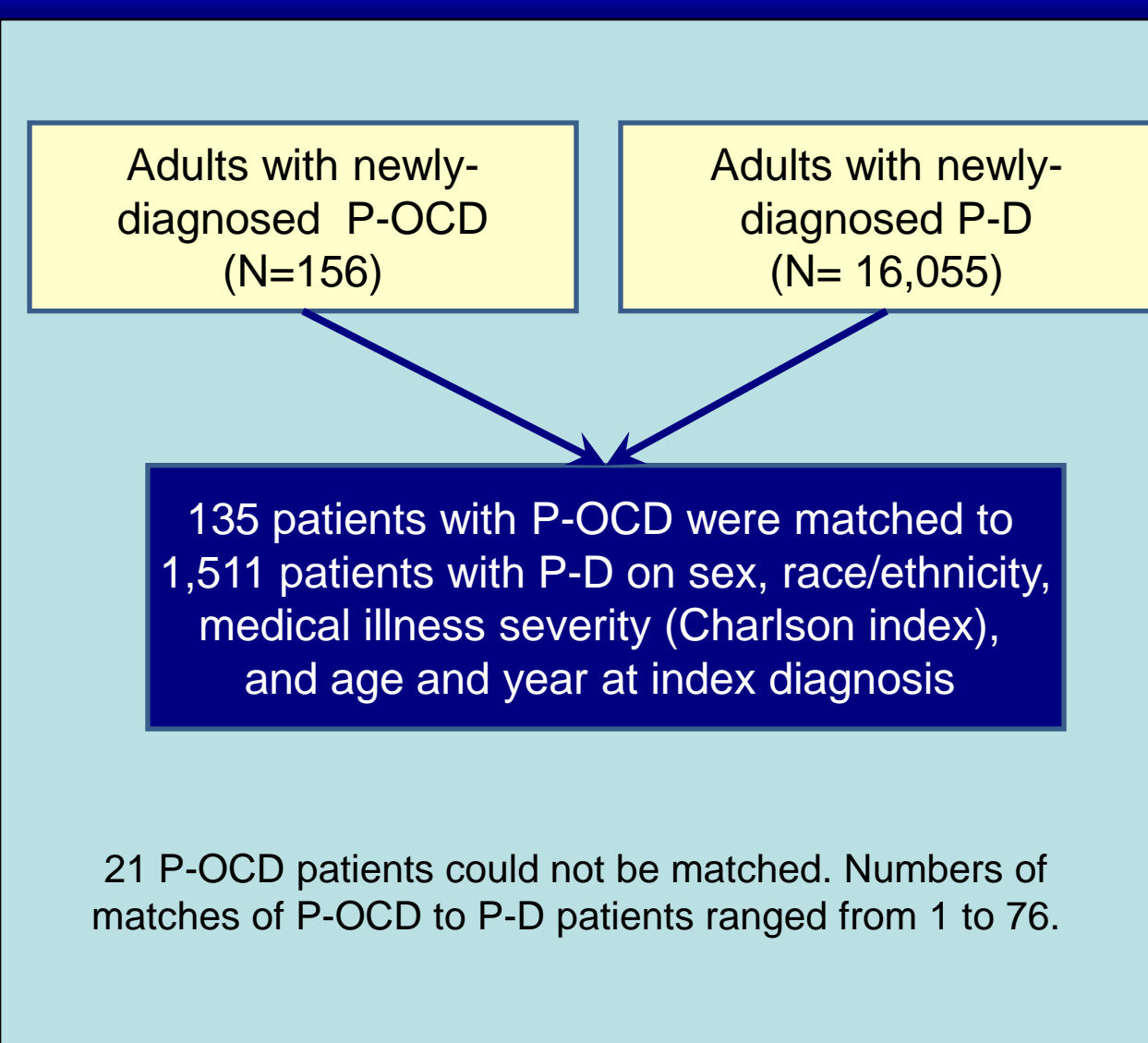
To compare healthcare utilization and costs of newly-diagnosed patients with “pure OCD” (P-OCD; OCD in the absence of bipolar disorder, psychoses, or depression) to a matched sample of newly-diagnosed patients with “pure depression” (P-D; depression in the absence of bipolar disorder, psychoses, or OCD).

METHODS

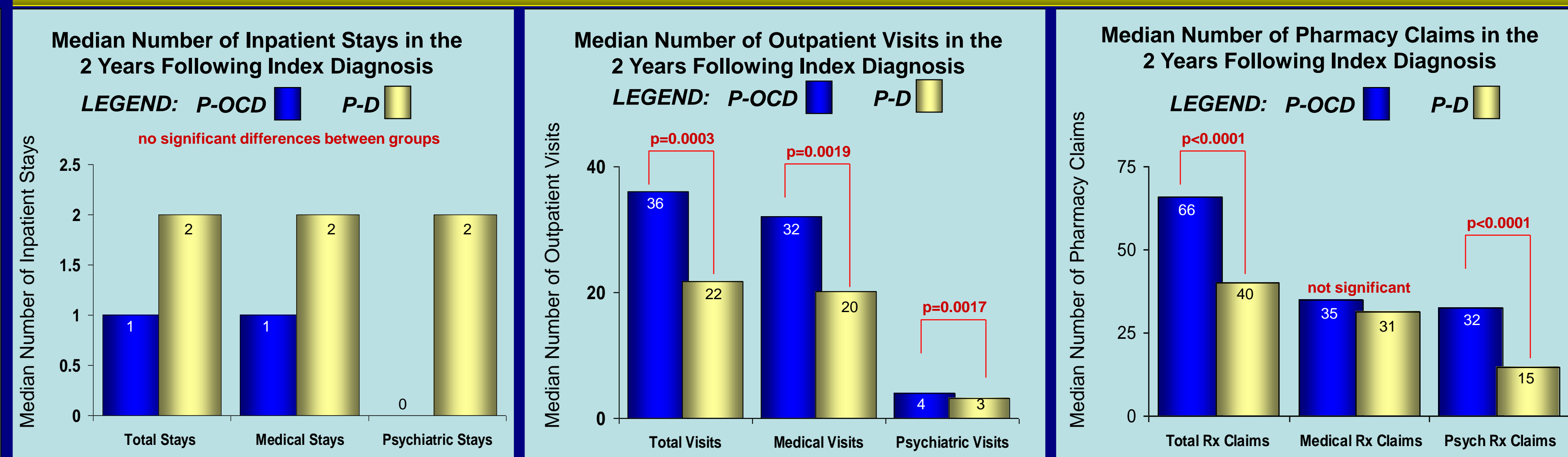
- Overview of Florida Medicaid Dataset:** Florida Medicaid provides healthcare for more than 5 million individuals. Computerized claims records contain basic demographic information, ICD diagnosis and CPT treatments codes, NDC drug codes, and payment data. Information is patient de-identified and fully compliant with the HIPAA Privacy Rule. Subjects were identified from enrollees in the Florida Medicaid program who had a paid claim from July 1997 through June 2006.
- Patient Identification:** Among patients with > 1 OCD diagnosis, we identified their 1st occurring (“index”) OCD claim. Those with 2 years of data preceding their index OCD claim were selected. Of these, P-OCD patients had no diagnoses of depression (ICD-9 296.2, 296.3, 296.9, 300.4, 309.0, 309.1, 311), psychoses (ICD-9 295, 298) or bipolar disorder (ICD-9 296) in the 2 years prior to and 2 years following their index OCD claim. P-D patients were identified similarly, except that the index claim was depression and the exclusion diagnoses included OCD rather than depression.
- Patient Matching:** Each P-OCD patient was matched to ≥ 1 P-D patient on sex, race/ethnicity, medical illness severity (Charlson Comorbidity Index), and age and year at index diagnosis. P-OCD patients without a match were excluded from the analysis.
- Analysis:** We examined inpatient and outpatient primary diagnoses to classify medical versus psychiatric care, and NDC codes to classify pharmacy claims; we assumed amphetamines, antidepressants, antimanics, antipsychotics, anxiolytics, hypnotics, mood stabilizers, and stimulants were prescribed for psychiatric illness, and other medications were prescribed for medical illness. Numbers and costs of inpatient stays, outpatient visits, and pharmacy claims were calculated over the 2 years following each patient’s index claim. We then compared median per-patient total, medical, and psychiatric healthcare use and costs.

RESULTS

SAMPLE IDENTIFICATION



MEDIAN 2-YEAR HEALTHCARE UTILIZATION



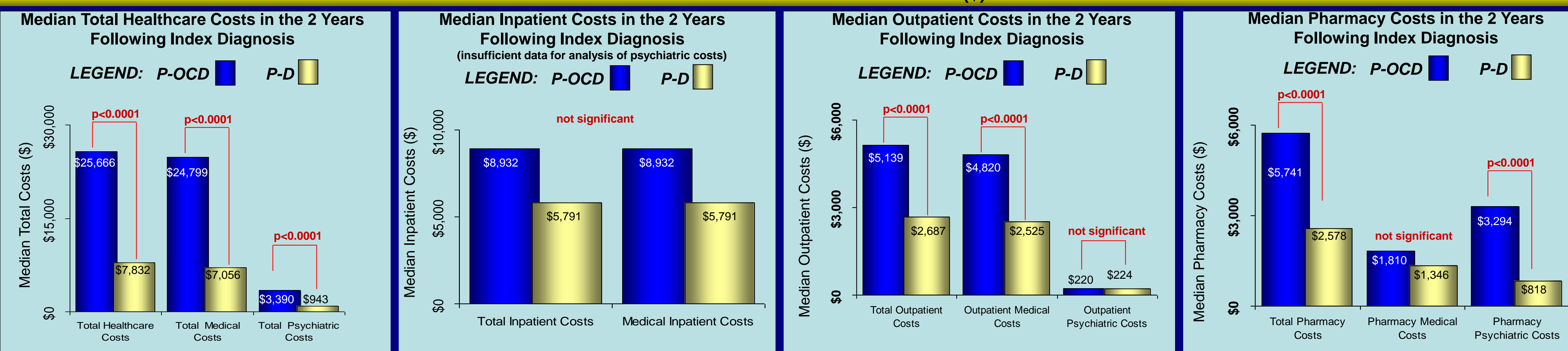
When matched on sex, race/ethnicity, medical illness comorbidity, and age and year of diagnosis, during the 2 years following diagnosis.

- Patients with P-OCD had significantly greater total median number of outpatient visits and costs than their P-D counterparts.
- Outpatient utilization differences extended across medical and psychiatric services. Outpatient costs were significantly different for medical health services but not psychiatric.
- Patients with P-OCD had significantly greater total median number of pharmacy claims and costs than patients with P-D.
- Number and costs of pharmacy claims were significantly different for psychiatric but not medical health services.

CONCLUSIONS

Although patients were matched on medical illness severity, those with P-OCD used significantly more outpatient medical services and had 2 times greater outpatient medical costs than those with P-D. Findings suggest that care for patients with OCD may occur in the outpatient medical setting. P-OCD patients had significantly greater psychiatric pharmacy claims and costs than those with P-D, perhaps due to higher doses of SSRIs required for the treatment of OCD versus depression⁴ or more frequent use of concomitant psychiatric medications in patients with P-OCD. For example, OCD patients who are nonresponsive to first-line therapy may be prescribed concomitant SSRIs and second-generation antipsychotics.⁵ Patients with P-OCD had fewer inpatient stays but higher inpatient costs than patients with P-D (although findings were not statistically significant). Two possible explanations are: 1) long-term and intermediate care were included in inpatient stays and claims for such costly care are entered into the Medicaid dataset once monthly, thereby confounding findings; 2) we did not exclude patients with developmental disorders (e.g., autism or mental retardation) who may require costly long- or intermediate-term care. Our future analyses will distinguish among types of inpatient care (e.g., acute hospitalization, long-term care, intermediate care) and exclude patients with developmental disorders from both the P-OCD and P-D groups.

MEDIAN 2-YEAR HEALTHCARE COSTS (\$)



REFERENCES

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DISCLOSURES

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