

signed patients into one of two mutually exclusive classes, and (3) offered a benchmark for a comprehensive disease management strategy for more involved diabetic patients.

PGD6**A MANAGED CARE COST ANALYSIS OF THE TREATMENT OF PSORIASIS**

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There is little published on the relative costs of treatments in psoriasis.

OBJECTIVE: This study was designed to assess patterns of medication use, costs, and health care resource utilization among US managed care psoriasis patients.

METHODS: Members of 4 HMOs were identified using pharmacy outpatient and hospital claims data for a 1-year period. Patients were selected if they had (1) at least 2 claims for psoriasis (ICD-9 code 696, 696.1, and/or 696.8) or (2) 1 claim for psoriasis and 1 claim for a psoriasis drug or phototherapy. Descriptive data were collected to determine psoriasis drug and therapy use, and total and psoriasis-specific costs.

RESULTS: There were 2,868 members with psoriasis identified. The data showed that 47.4% of the patients were on monotherapy and 45% of the patients were on polytherapy, defined as two or more of the psoriasis-specific drugs or therapies. This coincides with recent market evaluations of psoriasis therapies. Topical corticosteroids were used by 82% of the patients. Claims for photochemotherapy were made by 9% of members. Eighty percent of patients received therapy from a dermatologist. There were psoriasis-related hospitalizations for 11% of the patients. The median costs for psoriasis-related hospitalizations/patient were \$252–\$1,383 (range: \$40–\$18,933). Median total psoriasis-related costs/patient were \$155–\$170 (range: \$0–\$24,334).

CONCLUSION: High potency topical corticosteroids remain the most commonly used medications for psoriasis. Even though few patients were hospitalized for psoriasis, the high costs of hospitalization made it one of the cost drivers of this condition. Phototherapy procedures, office visits for non-psoriasis-specific diagnoses, and total drug costs for psoriasis were additional cost drivers of psoriasis treatment.

PGD7**CONSEQUENCES OF HIGH HEMATOCRIT MAINTENANCE AMONG HEMODIALYSIS PATIENTS.**

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EPO was approved for the treatment of anemia in renal dialysis patients in 1989. In 1991, Medicare changed the way it reimbursed for EPO, and, in response, there was

an increase in average EPO dosages from 2,793 units to 3,200 units in the six-month period following the policy change. This change, while meant to improve apparently low EPO dosing, may have had the unintended consequence of maintaining some patients at unnecessarily high hematocrit levels. These patients may experience problems associated with relatively high hematocrits. Thus, while some patients may have received too little EPO prior to the policy change, now they may be receiving too much. Another recent change in EPO reimbursement policy indicates this may be the case. After July 1, 1997 Medicare will reimburse EPO based on a 90-day rolling average hematocrit measurement. If the average is above 36.5%, Medicare will not pay for the EPO. This policy implicitly assumes that high hematocrit levels are directly related to inappropriately high doses of EPO.

OBJECTIVE: The purpose of this study is to examine the incidence of complications resulting from abnormally high hematocrits, such as vascular shunt thrombosis, among patients with End-Stage Renal Disease (ESRD).

METHODS: This study uses data from the United States Renal Data System (USRDS) and logistic regression to model the incidence of adverse events as a function of hematocrit level while controlling for confounding factors such as age, gender, ethnicity, weight, comorbidities, facility characteristics, dialysis modality, and dialysis history.

RESULTS: Preliminary results suggest that the incidence of VST has increased since 1991.

CONCLUSION: This study provides Medicare with information concerning the appropriateness of the 36.5% cutoff and the projected impact of the change in reimbursement.

PGD8**COMPARISON OF PREVALENCE RATES OF LOW BACK DISORDERS OBTAINED FROM TWO LARGE NATIONAL CLAIMS DATABASES**

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Large national claims databases are sources of vital information concerning health care resource utilization. However, the comparability of data obtained from such databases has not yet been ascertained.

OBJECTIVE: To compare prevalence rates of low back disorders obtained from two large national inpatient claims databases and to study variations in length of stay and corresponding costs.

METHODS: Data were obtained from two independent databases with inpatient claims information including ICD-9 codes for specific diagnoses, demographics, length of stay (LOS), and payments or charges made. One of the databases is a 20% national inpatient sample of all community hospitals in the U.S. (HCUP). The other national database consists of data gathered for privately insured population (MarketScan). Claims for specific diagnoses of low back disorders (ICD-9 codes: 720.0–724.9) for 1994 were obtained. Using age, gender, and diagnosis-