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| **Department:** | Pharmacy | **Original Approval:** | 01/23/2014 |
| **Policy #:** | PM564 | **Last Approval:** | 01/20/2021 |
| **Title:** | Medicare Opioid Overutilization Program | | |
| **Approved By:** | Medical Management Leadership Team | | |
| **Dependencies:** | None | | |

## Line(s) of Business

☐ WAH-IMC (HCA) ☐ BHSO ☒ Medicare Advantage (CMS)

☒ Medicare SNP (CMS) ☐ Cascade Select

## Purpose

This policy describes the program components of the Medicare Opioid Overutilization Program (MOOP) created by the Center for Medicare and Medicaid Services (CMS). The purpose of the MOOP is to identify Medicare beneficiaries who are potential opioid overutilizers and bring this to the attention of their prescribers. In some cases, CHPW may implement a beneficiary-level claim edit in accordance with the supplemental guidance regarding the section entitled "Improving Drug Utilization Review Controls in Part D", of the Medicare Final CY 2013 Call Letter. This process will comply with the drug utilization management (DUM) requirements of 42 C.F.R §423.153 et seq. to prevent overutilization of prescribed covered Part D drugs.

## Policy

The MOOP includes the following components:

**Identification of Potential Overutilizers**

- CMS has developed measures to monitor beneficiaries for the following three drug overutilization issues: 1) overutilization of Opioid drugs, 2) overutilization of Acetaminophen (APAP), 3) Center for Program Integrity (CPI) Referrals.
- Identification of potential opioid and APAP overutilizers is based on drug claims data. Members are included whose use clearly exceeds clinical thresholds and acceptable prescribing patterns. Beneficiaries who have medical diagnoses that may warrant legitimate high opioid use (e.g., cancer patients or others who need palliative care) will be excluded.
- At a minimum, a beneficiary may be identified as a potential opioid overutilizer when any of the following criteria (based on CMS guidance) are met:
    - The beneficiary exceeded 90 mg average daily MED for any duration in the most recent 6 months,

  - The beneficiary received those Opioid prescriptions from more than 3 prescribers and more than 3 pharmacies OR from more than 5 prescribers regardless of the number of opioid dispensing pharmacies.
  - The member has not been identified as a Hospice Patient
  - The member has not been identified as a cancer patient or in hospice
- Beneficiaries may be identified as an Opioid Overutilizer when the following additional criteria are met:
  - There is a consensus among the member's opioid prescribers that the beneficiary's level of opioid use is not medically necessary.
  - Opioid use is beyond the thresholds established in this policy and cannot be determined to be appropriate, medically necessary and safe, based on decision of the Plan Medical Director.
- At a minimum, a beneficiary may be identified as a potential APAP overutilizer when the following criteria (based on CMS guidance) are met:
  - The beneficiary exceeded 4 grams of APAP a day for at least 30 days
- CPI Referrals are beneficiaries whose cases were submitted for Fraud, Waste, and Abuse, but declined by the Office of the Inspector General. CMS reviews the cases and if deemed a potential misuse of medications, will be forwarded to CHPW to review and prevent continued inappropriate drug utilization.
- Members may also be internally identified who meet the CMS criteria and have not been previously identified by CMS via the quarterly Overutilization Monitor Package.

**Case Management**

The goal of Case Management in this program is to perform an intermediate assessment to identify whether a beneficiary identified as a potential opioid overutilizer: 1) meets the criteria for implementation of a Point of Sale (POS) claim edit, or 2) may benefit from medical or behavioral health case management and interventions.

The intermediate assessment may be provided by a nurse, pharmacist, physician assistant or medical doctor (e.g. Rph, Pharm.D, PA, MD, ARNP, RN & LPN).

- The intermediate assessment will include written inquiries to the prescribers of the Opioid medications about the appropriateness, medical necessity and safety of the apparent high dosage for their patient. Written inquiries will include a description of the beneficiary's recent Opioid utilization based on available information.

- The reviewer will make up to three (3) attempts to schedule telephone conversations with the prescribers (separately or together) within a 10 business day period from the issuance of the written inquiry notification.
- The reviewer may, at their discretion, choose not to call one-time prescribers such as emergency room physicians or dentists.
- When a prescriber is reached, communication includes information about the existence of multiple prescribers and the beneficiary's total opioid or APAP utilization. Additionally, the case manager elicits the information necessary to identify any relevant complicating factors in the beneficiary's treatment.
- The reviewer will document the following in the notes of the file of each beneficiary that has been identified as a potential opioid or APAP overutilizers and referred for an intermediate assessment:
    - Each phone call attempt to prescribers,
    - Content of telephone conversations with prescribers including a description of relevant complicating factors in the beneficiary's treatment,
    - A description of the beneficiary's utilization review, including the timeframe of claims reviewed; and the date, medication name, dosage, prescribers, and pharmacies used for each claim.
    - A description of the morphine equivalent dose (MED) or APAP daily dose for the time frame reviewed.
    - An assessment describing whether the beneficiary may meet the requirements for identification as an overutilizer.
    - A description of the consensus reached by the prescribers regarding the safety, medical necessity, and appropriateness of the opioid or APAP use.
- The intermediate assessor takes the following actions as appropriate:
    - Work with the Plan Medical Director when the beneficiary may warrant a claim edit or when the prescribers did not respond to the letter or phone calls.
    - A referral to Case management for care coordination for chemical dependency, substance abuse, unmet pain management needs, or other complex medical conditions.
    - A Compliance Report is completed when fraud, waste, or abuse is suspected in accordance with applicable policies.

**Beneficiary-level claim edit**

A licensed Physician, or Pharmacist, will review the information gathered by the case manager and determine whether the beneficiary meets criteria to establish a beneficiary- level edit. If so, one of the following is implemented 30 days after the beneficiary is notified:

- Beneficiary-level claims edit allowing only the appropriate level of opioid use, based on the consensus reached by the prescribers, or
- Beneficiary-level claims edit preventing coverage of an unsafe level of drugs, in cases where prescribers have been unresponsive.

**Notification of beneficiaries and prescribers**

- The beneficiary and prescribers are notified in writing of the results of the case management activities and plans for implementing the claims edit.
- If the current level of opioids is determined to be medically necessary for the beneficiary, the prescribers who asked for such information for treatment purposes should also be promptly notified in writing.

**Notification of the Center for Medicare and Medicaid Services (CMS)**

When a decision is made to implement a beneficiary-level claim edit, a copy of the notice is sent to the CMS account manager for CMS's audit purposes in a secure manner with the subject line "Notice of Pending Beneficiary POS Opioid Claim Edit." This e-mail should include the beneficiary's name, address, date of birth, and HICN number, as well as a description of the action taken by the sponsor. Any non-opioid POS edit notices should be sent to the CMS account manager as well as the CMS email PartD_OM@cms.hhs.gov.

Edit information must also be submitted into the CMS MARx system. The Pharmacy Operations Tech will submit required information into the WiPro system.

**Quarterly Overutilization Monitoring Package**

CHPW is expected to indicate on a Sponsored Identified (SPI) Reporting Form if CHPW does or does not have any SPI to report. In addition to the SPI report, CHPW also reports CMS identified potential APAP, opioid, CPI and closed overutilization issues to CMS on a quarterly basis.

The deadline for the quarterly submission of the two Reporting Forms is generally 30 (thirty) days after the release of the Overutilization Monitoring Packages on the Patient Safety Analysis website.

**Transfer of Information**

The beneficiaries who voluntarily disenroll from CHPW with an Opioid claim edit are tracked. CHPW will transfer those beneficiaries' case management files to the new sponsor within 2 weeks if the new sponsor asks for such information for care management or investigating fraud and abuse. Incoming

notifications from other sponsors are also tracked, and CHPW will request overutilization records and actions from previous sponsors. CHPW will then implement case management and pharmacy edits as appropriate.

## List of Appendices

None

## Citations & References

| | | |
|---|---|---|
| **CFR** | 42 CFR § 423.120, 42 CFR § 423.153 | |
| **WAC** | | |
| **RCW** | | |
| **Contract Citation** | ☐ WAH - IMC | |
| | ☐ BHSO | |
| | ☒ MA | Medicare Prescription Drug Manual Chapter 6 § 30.2.2 Formulary Benefit Management Tools, Chapter 7 § 60: Drug Utilization Management Program |
| | ☐ Cascade Select | WAC 284-43-5642 Essential health benefit categories |
| **Other Requirements** | Part D Drug Management Program Policy Guidance (11/20/2018), Comprehensive Addiction and Recovery Act (CARA) § 704: Programs to prevent prescription drug abuse under Medicare parts C and D, CMS Final Rule CMS-4182-F | |
| **NCQA Elements** | | |
| **References** | | |

## Revision History

| Revision Date | Revision Description | Revision Made By |
|---|---|---|
| 01/17/2014 | Original | Mary Eckhart |
| 03/18/2014 | Approval | P&T |
| 04/23/2014 | Approval | MMLT |
| 03/4/2015 | Minor text revisions. Moved to new template. | Mary Eckhart |
| 04/7/2015 | Approval | MMLT |
| 03/10/2016 | Updated clinician reviewers | Fran McGaugh |
| 03/18/2016 | Approval | MMLT |
| 03/01/2017 | Moved to new template | Mary Eckhart |
| 03/14/2017 | Approval | MMLT |
| 03/02/2018 | Moved to new template. Updated the CMS criteria per 2018 Call Letter | Mary Eckhart |
| 03/13/2018 | Approval | MMLT |

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| 11/19/2018 | Revised to reflect expansion of program | Mary Eckhart |
| 12/03/2018 | Approval | MMLT |
| 12/06/2019 | Annual review | Ivan Figueira, PharmD |
| 12/12/2019 | Approval | CMO Cabinet |
| 02/27/2020 | Updated Citations Table | Dustin Peskuric |
| 01/19/2021 | Approval | Yusuf Rashid |
| 01/20/2021 | Approval | CMO Cabinet |