Blue Advantage (HMO) Opioid Overutilization Monitoring Program

The Centers for Medicare and Medicaid Services (CMS) mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review programs to address overutilization of opioids. CMS defines opioid overutilization as use of opioids with morphine equivalent dose (MED) exceeding 120mg for at least 90 consecutive days with more than 3 prescribers and more than 3 pharmacies contributing to their opioid claims.

CMS expect plans to employ multiple levels of formulary management to prevent overutilization, including a cumulative MED safety edit, quantity limits, and retrospective claims review.

1. Blue Advantage (HMO) as implemented a cumulative MED point of sale safety edit that triggers when the MED meets or exceeds 200. This can only be overridden with an approved prior authorization exception request. In certain situations the cumulative MED will not trigger and claims will be allowed to process without prior authorization, including members with a hospice flag in the pharmacy claim system or the presence of cancer drug claims in the past 180 days. The cumulative MED point of sale edit was a new requirement in the CMS 2017 call letter.

2. The use of claim edits at the point of sale to detect early refills, therapeutic duplication, and doses exceeding the maximum FDA-approved doses. The plan’s pharmacy claims system is designed to detect and prevent utilization of combination opioid products where the dose of acetaminophen could exceed 4 grams per day.

3. Placing quantity limits on opioid medications. Quantity limits are based on FDA-approved prescribing recommendations when available, and are approved by CMS as part of the formulary approval process.

4. Retrospective drug utilization review and case management.

Retrospective drug utilization review and case management program

CMS provides Part D sponsors with quarterly reports identifying members with potential opioid overutilization, and also expects plans to develop and utilize internal reports on a monthly basis. The opioid overutilization management team at Blue Advantage (HMO) reviews the claims of members identified in the reports to determine whether there is a potential overutilization issue.
If a potential issue is identified, we will send a written inquiry to the prescribers involved and follow up with a phone call. The purpose of the communication is to make all prescribers aware of the member’s utilization pattern and to reach a consensus as to whether the current level of utilization is appropriate. If the consensus is reached that it is not appropriate, a beneficiary-level edit can be placed in the pharmacy claims system to limit utilization to a level agreed upon by the prescribers. Members would be given 30 days advance notice of the edit to give them time to submit a coverage determination request to us to cover a higher amount of opioids. If the request is denied, the member has the right to appeal the decision.

If your office receives an Opioid Overutilization Monitoring Program fax from Blue Advantage (HMO), please respond promptly to facilitate the case management process. We appreciate your cooperation!