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Maryland Medicaid

Opioid Prescribing Guidance & Policy 2017

WEBPMD-0076-17 May 2017

Housekeeping

Session Interaction

- Your microphones are on mute
- Type any questions into the comment/question box located on the right side of your screen
- We will respond to all questions at the end of the session

Overview

1) **Opioid Overdose Epidemic Overview**
2) **2016 CDC Guideline for Chronic Pain**
    - Supporting Evidence & Recommendations
3) **State Recommendations & Policies**
    - DHMH Policies
    - Prescribing Recommendations
    - Medicaid Policy Limits
4) **Resources**

Opioid Overdose Epidemic Overview

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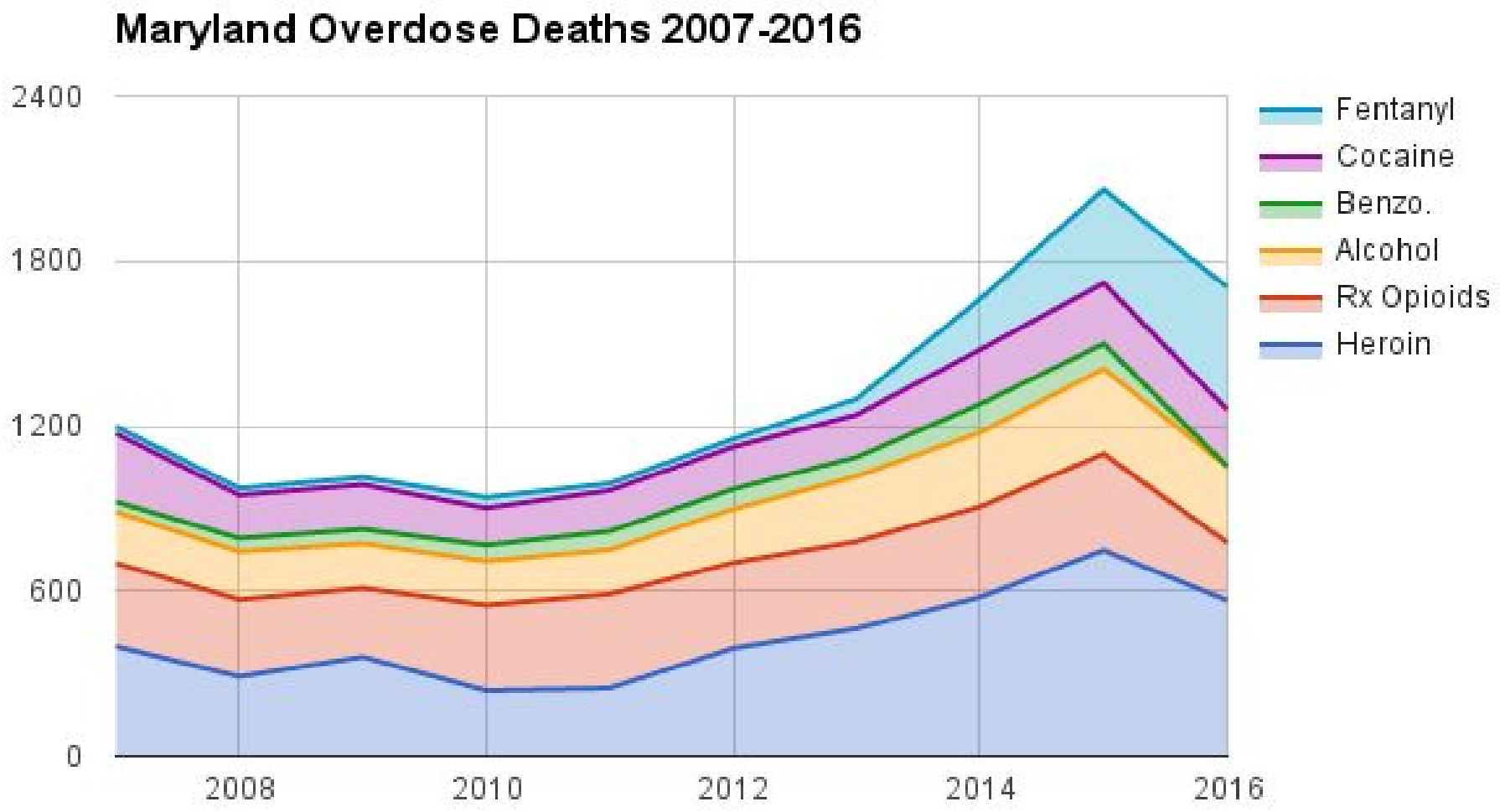
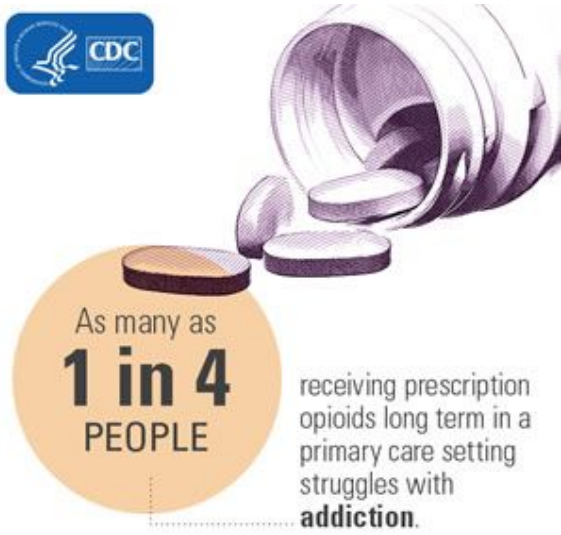
Maryland Overdose Deaths by Drug Class



Prescription Drug Sales

Opioid prescription sales increased fourfold between 1999-2014, with NO change in the amount of pain reported.

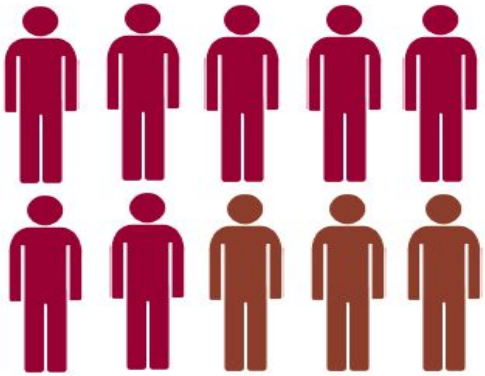
- Half of opioid prescriptions written for chronic, non-cancer pain
- 249 Million opioid prescriptions written in 2013
  - –US Population 242 Million Adults



Prescription Drugs and Heroin

Prescription opioid misuse is a major risk factor for heroin use

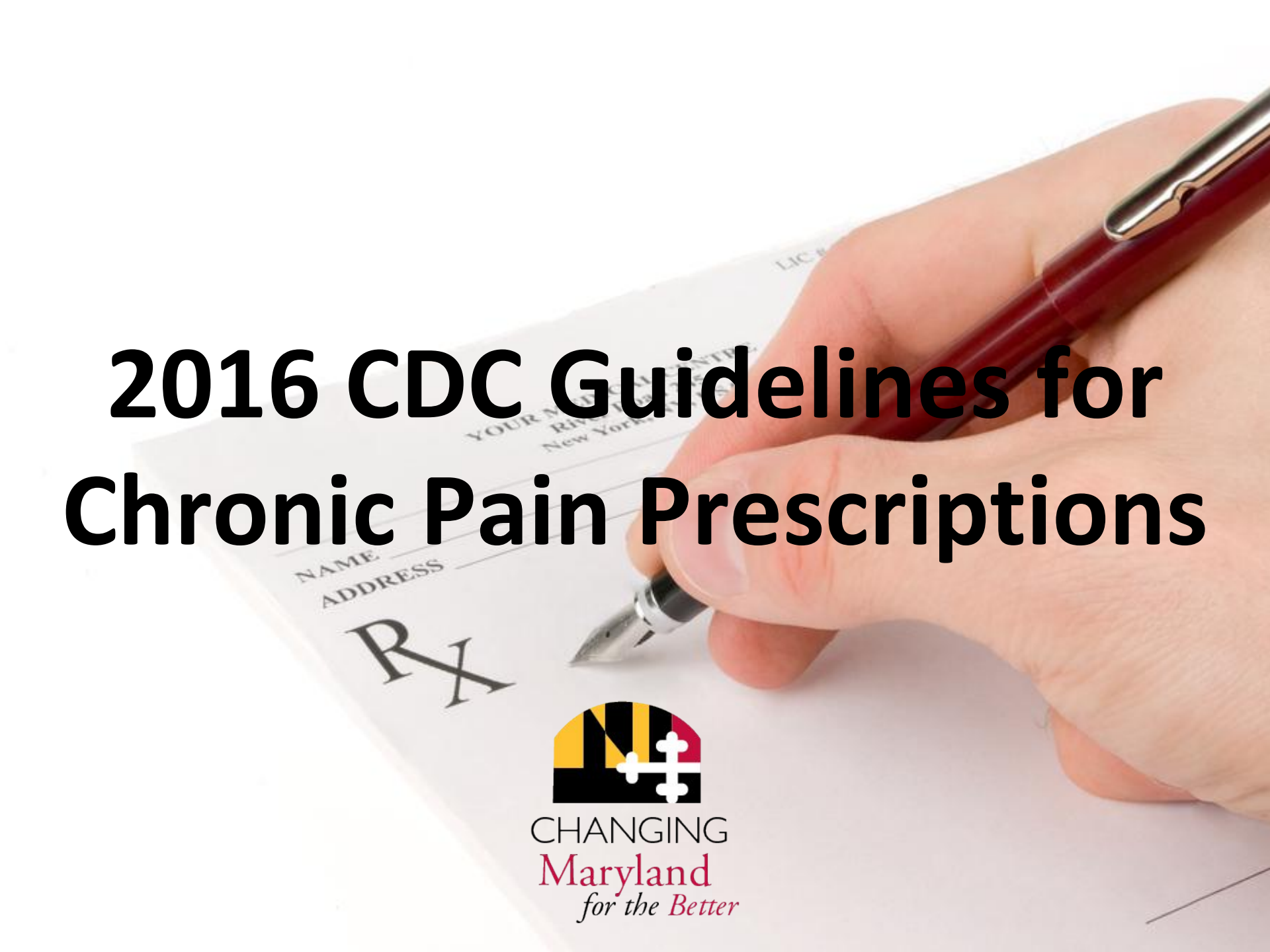
3 out of 4 people who used heroin in the past year misused opioids first



7 out of 10 people who used heroin in the past year also misused opioids in the past year

Jones, C.M., Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002–2004 and 2008–2010. Drug Alcohol Depend. (2013).

2016 CDC Guidelines for Chronic Pain Prescriptions



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CDC Guidelines for Prescribing Opioids for Chronic Pain

CDC released a *Guideline for Prescribing Opioids for Chronic Pain* on April 16, 2016 with 12 recommendations

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use

CDC Recommendation 1 : Use First Line

Nonpharmacologic therapy and nonopioid pharmacologic therapy are first Line.

- Non-Opioid: NSAIDS, antidepressants, acetaminophen, anti-convulsants)
- Non-Pharmacologic: RICE (acute), exercise therapy, biofeedback, CBT, interventional treatments

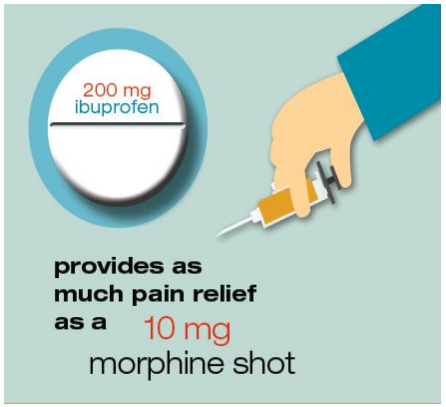


Image source: colorado.gov

NSAIDS, Acetaminophen and Opioids

NNT for 1 Patient to Have a 50% Reduction in Pain

HOW EFFECTIVE IS YOUR PAIN MEDICATION?	NNT SCORE
Ibuprofen 200mg + Acetaminophen 500mg	1.5
Diclofenac 200mg	1.7
Ibuprofen 200mg	2.5
Morphine 10mg IM	2.7
Oxycodone 10mg + Acetaminophen 1000mg	2.7
Acetaminophen 500mg	3.5
Oxycodone 15mg	4.6

Image source: colorado.gov

CDC Recommendation 2: Establish Expectations

Before starting opioid therapy:

1. Establish realistic treatment goals
   - Reduction in pain, Improvement in function
   - Use validated tools (PEG), 30% improvement is considered meaningful
   - Address psychological aspect

2. Determine when therapy will be stopped

Continue opioid therapy **only if** there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

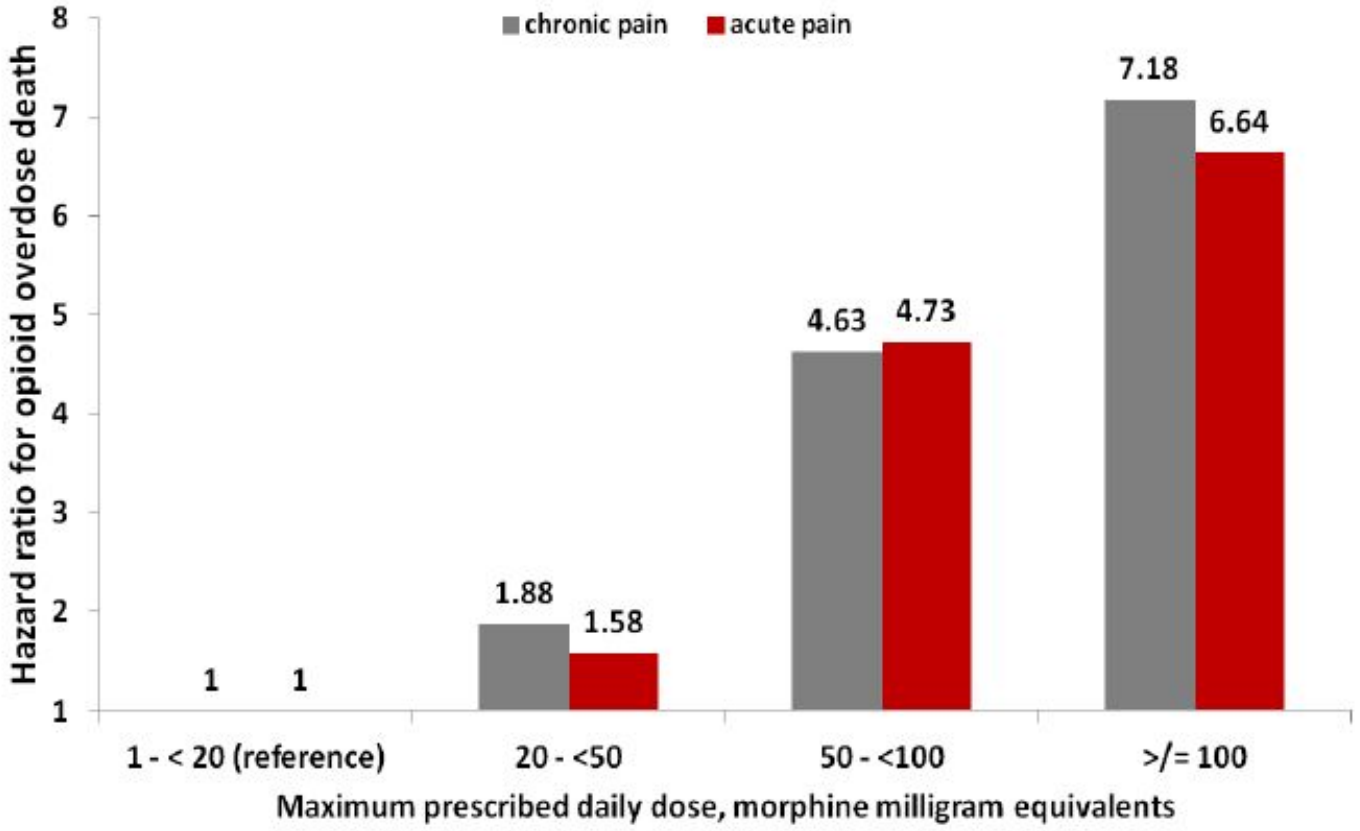
CDC Recommendation 3: Address Risk/Benefits with Patients

Before starting and periodically during opioid therapy, discuss:

1. **Risks**
   - Potentially fatal respiratory depression
   - Risk of addiction/dependence
   - Common side effects: constipation, nausea, dry mouth
   - Impaired ability to operate vehicle
   - Need to keep locked and not allow others access
2. **Realistic benefits**
   - Can reduce pain in short-term but no evidence on long-term
   - Complete pain relief is unlikely
   - Improving function is main goal
3. **Clinician responsibilities for managing therapy**
   - Monitoring compliance with urine drug testing, possible pill counting, electronic monitoring of prescriptions (PDMP)
   - Naloxone

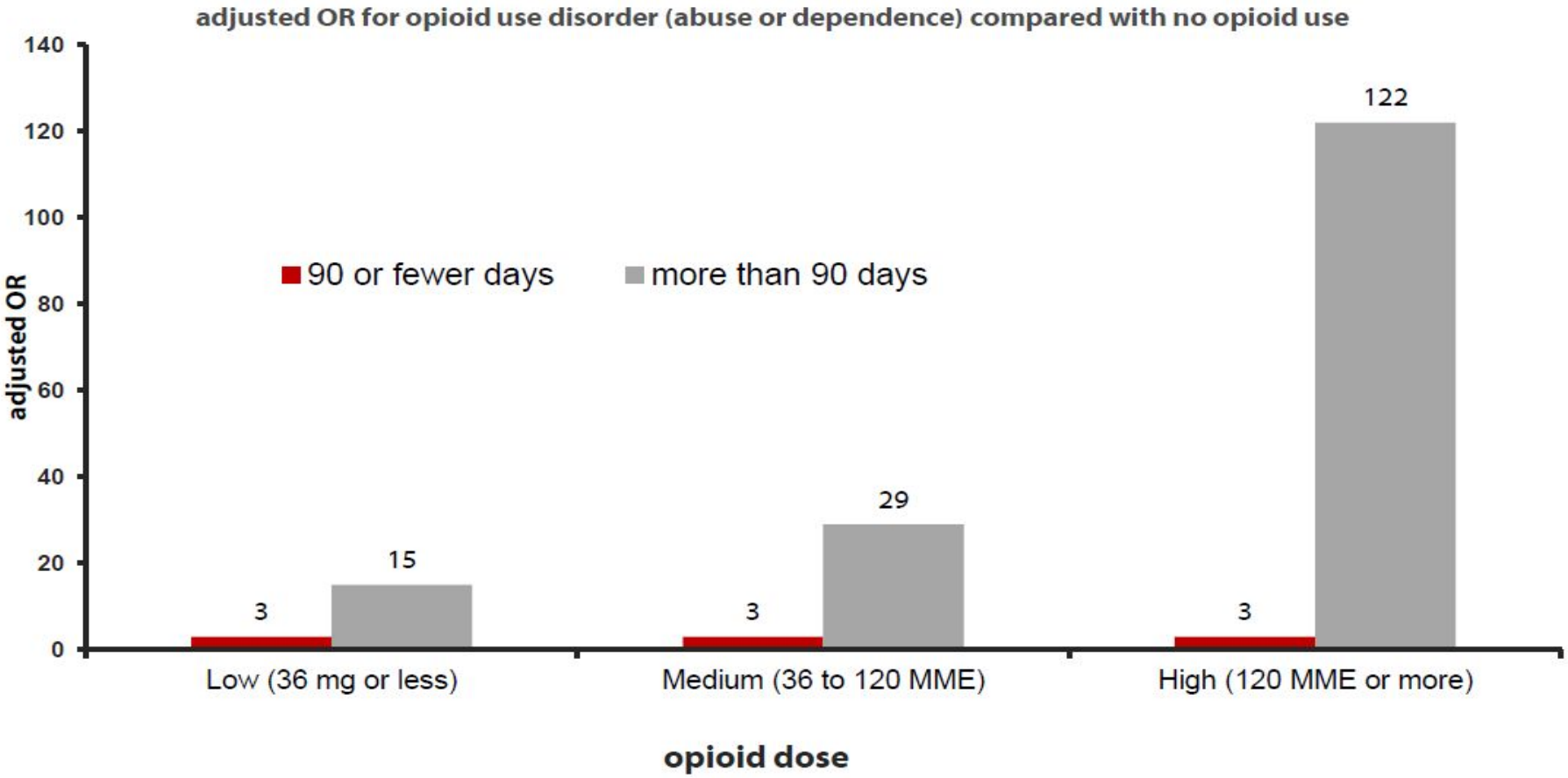
CDC Recommendation 4 : Lowest Effective Dose

As Dose Goes Up Risk Goes Up



Source: Bohnert, Amy SB, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. Jama 305.13 (2011): 1315-1321.

CDC Recommendation 5: Shortest Duration



Edlund, MJ et al. The role of opioid prescription in incident opioid abuse & dependence among individuals with chronic noncancer pain. *Clin J Pain* 2014; 30: 557-564.

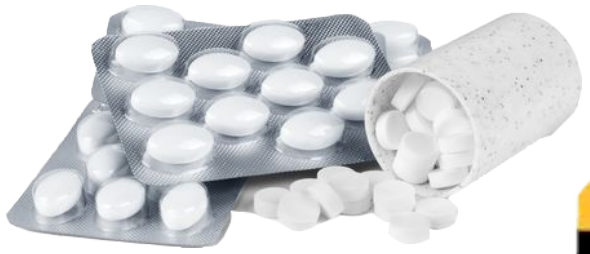
CDC Recommendation 6 & 7: Acute Pain and Re-evaluate

Long-term opioid use often begins with treatment of acute pain. If treating acute pain with opioids:

- Use lowest effective dose of immediate-release opioids
- Limit quantity, 3 days is usually sufficient
- More than 7 days rarely needed

Evaluate benefits and harms:

- Within one to four weeks of starting or dose escalation
- At least every three months



CDC Recommendation 8 : Reduce Risk

Mitigate risk of opioid-related harms:

- Avoid in high risk patient when possible including those with:
  - Sleep disordered-breathing, pregnancy, hepatic or renal insufficiency, age >65, depression or anxiety

- Considering offering naloxone if a risk for overdose present:
  - History of overdose, history of substance use disorder, higher opioid dosages (≥50MME/d), or concurrent benzodiazepine use, other high risk behaviors

CDC Recommendations 9 & 10: Monitor

Use data, calculation, and testing to monitor opioid therapy

- Check PDMP (Prescription Drug Monitoring Program) data
  - When starting opioid therapy
  - During opioid therapy (every prescription to every 3 months).
- Calculate total MME dose
- Use urine drug testing
  - Before starting opioid therapy and,
  - At least annually

CDC Recommendation 11: Avoid Benzodiazepines

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Image Source: wixtastic.com

CDC Recommendation 12: Opioid Use Disorder Treatment

Evaluate your patients for opioid use disorder and arrange for evidence-based treatment for patients who have SUD:

- Treatment is often medication-assisted with buprenorphine or methadone in combination with behavioral therapies

Maryland Medicaid Recommendations and Policies

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Maryland's Efforts

Addressing the opioid epidemic is a key priority in Maryland.

- The State and providers alike are committed to finding ways to monitor and reduce the effects of the epidemic using a multi-faceted approach.
- One approach is changing the way opioids are prescribed in Maryland.

Maryland Medicaid's Opioid Prescribing Policy

Starting Spring 2016, the ***Opioid Drug Utilization Review (DUR) Workgroup*** consisting of DHMH and the 8 HealthChoice MCOs representatives met to deliberate on and build consensus around minimum opioid prescribing rules and an implementation timeline.

DHMH:

- Supports full adoption of CDC Guideline
- Promoted through provider education and policy
- Asked all Medicaid insurers to align policies with CDC Guideline

Full implementation by July 1, 2017

Maryland Medicaid's Revised Prescription Policies

Maryland Medicaid's revised opioid prescription policies are informed by the Center for Disease Control and Prevention's *Guidelines for Chronic Pain Prescriptions*.

The policies aim to:

- Prevent medical and non-medical opioid use, abuse, and substance use disorder from developing;
- Identify and treat opioid dependence early in the course of the disease;
- Prevent overdose deaths, medical complications, psychosocial deterioration, transition to injection drug use, and injection-related disease; and
- Identify and outreach to providers who do not follow standard practice.

Maryland Medicaid Policy 1: Improve Coverage for 1st Line Treatments

Improved coverage for non-opioid medication options:

- Duloxetine, venlafaxine, and TCA covered for chronic pain
- Diclofenac topical covered

Encourage use of non-pharmacologic options:

- Options include physical therapy, home exercise program, etc.
- Work with behavioral health side to support treatment of patients with concomitant chronic pain and depression or anxiety with evidence-based CBT or Biofeedback, when appropriate

Continue to monitor for evidence supporting non-pharmacologic options not currently covered

*Aligns with CDC Recommendation 1

Maryland Medicaid Policy 2: Obtain Prior Authorization for Opioids

Prior Authorization Required *Every 6 Months* For:

- High dose >90 MME, or
- High quantity, or
- Long Acting Opioids, Fentanyl, or Methadone for pain

A standard 30-day quantity limit for all opioids <90 MME/day.

*Aligns with CDC Recommendations 2, 8, 9, and 10

Prior Authorization Exemptions

Prior authorization is *NOT* needed for patients with cancer, sickle cell anemia, or in hospice.

- However, the State encourages they be kept on the ***lowest effective dose*** of opioids for the ***shortest required duration*** to minimize risk

* Aligns with CDC Recommendation 5 & 6

Medicaid's New Prior Authorization Form for Opioids

A standardized prior authorization (PA) form was developed for all opioids that fall within this policy.

- Prior Authorization Requires ***At Minimum***:
  - Checking PDMP
  - Using urine drug screens
  - Offering Naloxone
  - Signing prescriber-patient agreement
  - Attesting to benefit outweighing risk

- MCOs may establish more stringent PA policies and use a MCO-specific PA form

Maryland Medicaid Policy 3: Screen for Substance Use Disorder (SUD)

***Before* prescribing opioids or any controlled substance, providers should use a standardized tool(s) to screen to substance use disorders.**

- One option is ***Screening, Brief Intervention and Referral to Treatment (SBIRT)***
  - *SBIRT* is an evidence-based practice used to identify, reduce and prevent problematic use, abuse, and dependence on alcohol and drugs.
  - SBIRT is billable under Medicaid.

*Aligns with CDC Recommendation 8 and 12

Maryland Medicaid Policy 4: Refer Patients with SUD to Treatment

Patients identified with a SUD should be referred to a SUD treatment program.

- Medicaid offers speciality behavioral health services through Beacon Health Options.
- For Beacon information:
  - Phone: 800-888-1965
  - Website: http://maryland.beaconhealthoptions.com/med_hc_professionals.html

*Aligns with CDC Recommendation 12

Maryland Medicaid Policy 5: Prescribe Naloxone to High Risk Patients

The State encourages providers to prescribe naloxone for patients or household members with *any* of the following risk factors:

- History of SUD
- Daily dose > 50 MME
- Combination of opioids and benzodiazepine / non-benzodiazepine sedative hypnotics
- Other risk factors (EG: drug using friends/family, use of ETOH, etc)

Narcan / Naloxone does not need prior authorization: **When giving Rx clearly tell patient/household member that 911 is still needed as effect wears off**

*Aligns with CDC Recommendation 8

Maryland Medicaid Policy 6: Check PDMP Prior to Prescribing

Providers should use PDMP to review a patient's Controlled Dangerous Substance (CDS) prescription profile and utilization prior to writing a new prescription each time.

- Providers may have access to the PDMP portal free of charge by registering via CRISP.
- Providers ***highly-encouraged*** to use the PDMP; will be legally mandatory for CDS prescribers start July 1, 2018
- Links:
  - PDMP: http://bha.dhmh.maryland.gov/pdmp/Pages/Home.aspx
  - CRISP: https://crisphealth.force.com/crisp2_login

*Aligns with CDC Recommendation 9

Maryland Medicaid's Policy: Provider Outreach

DHMH and MCOs will send letters to providers who are:

- Providing part (or all) of a high risk combination
- Prescribing part (or all) of a high dose opioid regime
- Have patients with non-fatal overdose

Public Health:

- Alerts providers when they have patient with fatal overdose

Resources

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Resources: Websites

CDC

http://www.cdc.gov/drugoverdose/prescribing/providers.htm

- Provider and patient materials, including prescribing checklists, flyers, and posters

SAMHSA

http://www.samhsa.gov/atod/opioids

DHMH Opioid

http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Pages/Index.aspx

Resources: Training

General Training

CDC Webinars:

http://www.cdc.gov/drugoverdose/prescribing/resources.html

SCOPE of Pain:

https://www.scopeofpain.com/online-training/

Buprenorphine Training:

- Baltimore Providers (BHS Baltimore)
  http://www.bhsbaltimore.org/for-individuals-and-families/bbi/physicians/
- Other Providers:
  http://www.aaap.org/education-training/buprenorphine/
  http://www.asam.org/education/live-online-cme/buprenorphine-course

Resources: Mobile Apps

Over 200 pain related apps exist, many are pain trackers, some help manage symptoms, some for providers

Calculators:

- Opioid Australia/New Zealand College of Anaesthetists
- Opioid Calculator from NYC DHMH

Cognitive Behavioral Therapy:

- Pain Management Plan
- CBT-i Coach from VA

Questions?

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Visit

dhmh.maryland.gov/medicaid-opioid-dur