Department:	Pharmacy Management	**Original Approval:**	01/23/2014
Policy No:	PM564	**Last Approval:**	12/18/2025
Policy Title:	Medicare Opioid Overutilization Program Policy		
Approved By:	Clinical Services Leadership Team		
Dependencies:	N/A		

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 entitled "Contract Year 2022 Part D Drug Management Program Guidance". 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 overutilization of frequently abused drugs (FADs). FADs are defined by CMS to include opioids (except buprenorphine for medication-assisted treatment [MAT] and injectables) and benzodiazepines
- Identification of potential FAD 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 overutilizer when any of the following criteria (based on CMS guidance) are met:
    - Criteria 1: Level of opioid use

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        - The beneficiary's use of opioids exceeded 90 mg average daily MED for any duration in the most recent 6 months
        - The beneficiary received those Opioid prescriptions from 3 or more prescribers and 3 or more pharmacies OR from 5 or more prescribers regardless of the number of opioid dispensing pharmacies.
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    - Criteria 2: History of opioid overdose
        - The member had a medical claim with a primary diagnosis of opioid-related overdose within the most recent 12 months, and a pharmacy claim for an opioid prescription (not including MAT) within the most recent 6 months.
- Additionally, beneficiaries meeting the Supplemental OMS criteria may be reviewed for potential overutilization
    - Use of opioids (regardless of average daily MME) during the most recent 6 months
    - The beneficiary received those Opioid prescriptions from 7 or more prescribers OR from 7 or more pharmacies
- Beneficiaries meeting any of the following criteria are exempt from placement in a Drug Management Program
    - The beneficiary is in treatment for active cancer-related pain
    - The beneficiary is receiving hospice, palliative, or end-of-life care
    - The beneficiary is a resident of a long-term care (LTC) or other facility for which FADs are dispensed for residents through a contract with a single pharmacy
    - The beneficiary has sickle cell disease
- 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.
- 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.

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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 and/or benzodiazepine 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 and/or benzodiazepine 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 and/or benzodiazepine overutilizer 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, prescriber, and pharmacy used for each claim.
    - A description of the morphine equivalent dose (MED) for the time frame reviewed.
    - An assessment describing whether the beneficiary may meet the requirements for identification as an overutilizer.

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  - A description of the consensus reached by the prescribers regarding the safety, medical necessity, and appropriateness of the opioid and/or benzodiazepine 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 or more of the following types of edits may be 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, such as:
  - Limiting the beneficiary's coverage for FADs, including all, or certain specific, prescription opioid and/or benzodiazepine medications
  - Limiting the amount (i.e., quantity or MME) of prescription opioid and/or benzodiazepine medications that may be covered for the beneficiary

- Beneficiary-level claims edit limiting coverage for FADs to drugs obtained from one or more selected prescriber(s)
- Beneficiary-level claims edit limiting coverage for FADs to drugs obtained from one or more selected network pharmacy(ies)

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 FADs 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.

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

Edit information must also be submitted into the CMS MARx system. Access to MARx is managed by the Eligibility Department. Pharmacy Department staff administering the DMP will collaborate with Eligibility as needed to ensure that required information is submitted into the WiPro system within the timeframes required by CMS.

Quarterly Overutilization Monitoring Package

On a quarterly basis, CHPW is expected to indicate on a Sponsor Response Form (SRF) if CHPW does or does not have any sponsor identified cases to report. In addition to the SRF, CHPW also responds to CMS identified potential overutilization issues via the Overutilization Monitoring Response Form (ORF).

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 the purposes of care management or investigating fraud and abuse. Incoming notifications from other sponsors are also tracked, and CHPW will request records pertaining to overutilization assessments and actions from previous sponsors. CHPW will then implement case management and beneficiary-level claims edits as appropriate.

List of Appendices

A. Detailed Revision History

Citations & References

CFR	42 CFR 405, 42 CFR 417, 42 CFR 422, 42 CFR 423, 42 CFR § 423.120, 42 CFR § 423.153, 42 CFR 455, 42 CFR 460	
WAC	284-43-5642	
RCW		
LOB & Contract Citation	☐ **WAHIMC**	

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	☐ **BHSO** ☐ **Wraparound** ☐ **SMAC** ☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	Contract Year 2022 Part D Drug Management Program Guidance (09/30/2021), 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, CMS Final Rule CMS-4190-F2
	☐ **CS**	
Other Requirements		
NCQA Elements		

Revision History

SME Review:	01/17/2014; 03.04.2015; 03.10.2016; 03/01/2017; 03/02/2018; 11/19/2018; 12/06/2019; 02/27/2020; 11/29/2021; 01/31/2023; 02/19/2024; 01/22/2025; 12/16/2025
Approval:	03/18/2014; 04/23/2014; 04/07/2015; 03/18/2016; 03/14/2017; 03/13/2018; 12/03/2018; 12/12/2019; 01/20/2021; 03/01/2022; 02/13/2023; 02/21/2024; 01/24/2025; 12/18/2025

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Appendix A: Detailed 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
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
11/29/2021	Revised policy per Contract Year 2022 DMP guidance, updated citations table	Dustin Peskuric
02/28/2021	Departmental approval	Omar Daoud
03/01/2022	Approval	CMO Cabinet
01/31/2023	Reviewed, no changes	Omar Daoud
02/13/2023	Approval	Clinical Services Leadership Team
02/19/2024	No changes	Omar Daoud
02/21/2024	Approval	Clinical Services Leadership Team
01/22/2025	No changes	Omar Daoud
01/24/2025	Approval	Clinical Services Leadership Team
12/16/2025	No changes	Omar Daoud

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12/18/2025	Approval	Clinical Services Leadership Team

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