# Minimum standards for DUR programs

The Oregon Health Authority (OHA) and contracted managed care entities (MCEs) must follow these standards on and after July 1, 2021, for most Oregon Health Plan members. These standards are pursuant to 42 CFR § 456.703(h) and the SUPPORT Act.

**Exempt populations:** Individuals receiving hospice, palliative care, or cancer treatment; residents of long-term care facilities described in 42 USC 1396a(oo)(3)(A)(ii); and individuals with sickle cell disease are exempt from these requirements. MCEs must ensure individuals in these categories continue to have appropriate access to opioid treatment.

## 1. Prospective "safety edit" limitations and[1] and "claims review automated process"[2] for opioid fills above state-defined limitations for day supply and early refill

7-day supply limits for at least new starts of short acting opioids, and early refill thresholds to identify potential misuse or abuse.

- Thresholds must be equal to or more restrictive than general refill thresholds.
- Supply limits and early refill thresholds must be enforced by prior authorization (PA), quantity limits, or "soft edits" at point-of-sale.

Periodic claims review to look for concerning treatment (could include multiple prescribers, long courses of treatment, patients prescribed duplicate therapy, multiple early refills, or other indicators) and apply interventions *as deemed appropriate* (PA for further fills, patient or prescriber letters, "lock in," continued monitoring, etc.).

## 2. Prospective safety edits and claims review automated process on quantity dispensed for initial and subsequent fills to minimize potential for inappropriate use and diversion

CCOs must apply prospective safety edits (such as PA review) to limit quantities of dispensed pills and to dose optimize when clinically appropriate to minimize the risk of inappropriate use and diversion. For example, dose optimization may be required for patients receiving long-acting opioids, and this requirement may be applied through prior authorization review.

Periodic claims review to look for concerning treatment (could include claims with quantities larger than typical FDA-labeled doses, quantities in excess of expected use for the probable indication, or quantities that are statistical outliers compared to similar patients prescribed opioids) and apply interventions *as deemed appropriate.*

## 3. Prospective safety edits and claims review automated process for therapeutically-duplicative initial and subsequent opioid prescription fills

CCOs must apply a point-of-sale alert ("soft edit" or "hard edit") that requires pharmacist or prescriber review when the claims system detects clinically significant overlapping opioid

treatment. Alert must be overridable so there is minimal interference with appropriate therapy, such as through NCPDP DUR/PPS codes or through MCE or PBM review and authorization.

Periodic claims review to look for concerning treatment (could include patients with concurrent prescriptions for more than one type of opioid [short and long-acting opioids or use of multiple molecular entities] or patients with concurrent opioid prescriptions from multiple providers) and apply interventions *as deemed appropriate*.

## 4. Prospective safety edits and claims review automated process for a state-defined maximum daily morphine equivalent for treatment of chronic pain

90 morphine equivalents daily (MED) for at least short acting opioids, applied at least to individual prescriptions and enforced by prior authorization, quantity limits, or "soft edits" at point-of-sale. Edits must apply to initial refills and refills, though method of enforcement may differ.

Periodic claims review to look for concerning treatment (could include high cumulative MED, rapid recent increase in MED, or other indicators) and apply interventions *as deemed appropriate* (patient or prescriber letters, "lock in," continued monitoring, etc.).

## 5. Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines or antipsychotics

MCEs must use the "push" list of mental health carve out drug claims to identify concerning concomitant opioid/benzo or opioid/antipsychotic treatment, and apply interventions *as deemed appropriate* (PA further fills, patient or prescriber letters, "lock in," continued monitoring, etc.).

## 6. Prospective safety edits and claims review automated processes to identify when a patient is prescribed an opioid after a recent diagnosis of opioid use disorder (OUD) or a prescription used to treat OUD

MCEs must apply an automated point-of-sale edit or a manual opioid PA review process to assess appropriate opioid use for patients being treated for OUD or who have a known recent diagnosis of OUD. This process must not interfere with OUD treatment and must not interfere with appropriate pain management for individuals with OUD.

Periodic claims review to look for concerning treatment (could include concomitant long-term opioid use in patients prescribed MAT, opioid prescriptions from multiple prescribers or in excess of state defined limits for patients with a diagnosis of OUD, multiple denied opioid prescriptions in patients with OUD) and apply interventions *as deemed appropriate*.

## 7. Edits or processes to identify when a patient may be at high risk of opioid overdose and should be considered for co-prescription or co-dispensing of an FDA-approved opioid antagonist/reversal agent (naloxone)

MCEs must apply either an automated point-of-sale pharmacy messaging edit or a regular retrospective review (at least quarterly) to identify members at high risk for opioid overdose who do not have a recent naloxone prescription. "High risk" must at least include patients receiving chronic high-dose opioid treatment and patients receiving high-risk concurrent treatment (such

as concurrent long- and short-acting opioid, concurrent opioid a benzodiazepine, or concurrent buprenorphine for MAT and a controlled substance). Apply interventions to mitigate overdose risk, ensure access to naloxone, and increase care coordination between the member, pharmacy, and prescriber as clinically indicated.

[1] CMS Guidance defines “safety edits” as prospective drug review, such as is defined in § 1927(g)(2)(A) of the Social Security Act.

[2] CMS Guidance defines “claims review automated process” as retrospective drug use review, such as is defined in § 1927(g)(2)(B) of the Social Security Act.

8. **Program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children. [Handled by OHA, no additional CCO action required]**

   Handled by OHA as follows:

   - **Non-foster care:** Periodic claims review with referral for specialist consultation when concerning treatment is identified (e.g., long-term antipsychotic use in patients < 10 years of age).
   - **Foster care:** Yearly review of foster-care children prescribed mental health medications. If concerning treatment is identified, providers are referred for consultation with a specialist. Examples of concerning treatment may include patients <18 years of age prescribed antipsychotics, prescription of an antipsychotic without diabetic screening, prescription of three or more psychotropics, patients with no documented age-appropriate indication for therapy, or children prescribed a psychotropic not FDA-indicated for children.

9. **Process that "identifies potential fraud or abuse of controlled substances" by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies**

   Periodic claims review to look for potential fraud or abuse of controlled substances by clients, prescribers and pharmacies (could include clients filling prescriptions at multiple pharmacies, prescribers or pharmacies filling high volumes of controlled substances, or other indicators) and interventions *as deemed appropriate* (lock-in, PDMP assessment, peer-to-peer consultation, etc.).