

## Questions and answers about HCA's opioid clinical policy for Apple Health (Medicaid) Updated November 6, 2017

This Q&A covers questions the Health Care Authority (HCA) received during webinars about the opioid clinical policy presented in September 2017 and through emails and calls from prescribers and pharmacists.

### FREQUENTLY ASKED QUESTIONS: What we're hearing from you most often

#### **Verbal "Exempt" orders:**

**Q: Can MA's, nurses, etc. give verbal "exempt" status for prescriptions under provider direction?**

If an MA or nurse specifically discusses this with the prescriber and is given a verbal order, and documents this discussion and verbal order in the chart, then transmission of the verbal order by the MA is acceptable. An MA cannot legally give a verbal order under any other circumstances.

**Q: If I am covering for someone and they did not write "exempt" can I give a verbal "exempt" for them?**

Yes. If you have prescribing authority and believe the dose is clinically justified, and reasons for the justification are documented in the chart, you can give a verbal exemption.

#### **Where to type "Exempt"/what about handwritten prescriptions?**

**Q: Where does "exempt" need to be typed in? Actual directions of the RX or in the note section that only the pharmacy sees?**

Exempt can be typed in either the notes section of prescriptions or in the directions of the prescription. Either is acceptable.

**Q: If we do not have a prescription printer and cannot type exempt, how is this handled?**

"Exempt" can be handwritten on a prescription if necessary, but this will likely result in a call from the pharmacy to verify verbally that it is not forged by the patient. For those who have the capability, typing "exempt" will prevent this extra step.

**Q: Will the "exempt" function still work with electronic submission of the prescription?**

Yes, as long as the "exempt" is typed on the prescription and visible to the pharmacy staff, it can be processed with the appropriate expedited authorization code.

#### **Post-operative and post-hospitalization issues:**

**Q: What about surgeons who need to provide opiates for short term post op care?**

A surgeon discharging a patient with needs above the limit should write "exempt" on the prescription to meet the patient's needs. The patient does not need to meet specific criteria for you to write "exempt;" rationale for use should be in the chart, but you simply have to write "exempt" on the prescription.

**Q: What about a hospitalist discharging a patient who has been on opioids during a long hospital stay?**

Likewise, a hospitalist discharging a patient on opioids after a long stay would typically use the “exempt” process if a supply above the limits is needed. The policy applies only to outpatient prescriptions, so a patient who was not taking opioids prior to admission will be seen as an acute user. If the patient stays on opioids for more than six weeks after discharge, the provider giving care at that point would need to fill out the attestation form.

**Exemption vs grandfathering vs attestation:**

**Q: Please clarify the "exemption" versus grandfathered patients and when the attestation is required. If you write “exempt,” do you also have to complete the attestation form.**

Patients are grandfathered if they are already on continuous opioids (more than 90 days in the previous 120 day period). The exemption process applies for acute users who have needs beyond the policy limits (42 doses for adults, 18 for children). The attestation form applies to patients who are transitioning from acute to chronic use (going beyond 6 weeks/42 days of treatment in a 90-day period).

## General

**Q: How is this new policy going to be communicated to patients?**

HCA has developed a handout that prescribers and pharmacists can give to patients this policy affects. The handout and the policy are posted on the HCA website. Our communications strategy also includes a news release and social media postings.

**Q: What is your expectation of reduction in opioid use?**

We will track impact of the policy closely over time. We anticipate a decrease in pill quantity in new prescriptions, and increased adherence to recommendations to minimize risks with chronic use.

**Q: Approximately how many Medicaid patients are currently on chronic opioid analgesic therapy?**

Approximately 40,000 Medicaid patients are currently on chronic opioid therapy, excluding buprenorphine therapy and patients with cancer or in hospice.

**Suboxone and Methadone:**

**Q: Does this policy apply to suboxone for chronic pain/opiate dependence?**

No. All buprenorphine products have been excluded from this policy regardless of intended use. This includes Belbuca, Butrans, Suboxone, etc. These will remain covered under their existing policies and are not subject to the limits in this policy.

**Q: With this policy, will there be an increase in recommendations for patients to be enrolled in a Suboxone Program? If so, will there be any changes in the Medicaid Guidelines for Suboxone use?**

Existing chronic opioid patients are grandfathered, and a primary focus of this policy is to decrease the likelihood of new users developing substance use disorder. Thus, we don't anticipate that this policy will increase Suboxone use.

**Q: Why is Methadone not covered under this policy?**

Methadone is covered under an existing HCA policy. Because methadone is rarely used for acute pain or in the transition from acute to chronic use, maintaining a separate methadone policy was felt to be more appropriate.

**Q: Is it reasonable to assume these restrictions will eventually be applied to most insurances? If yes, should we be applying this to all patients?**

The Health Care Authority manages Apple Health (Medicaid) program for Washington State and the Public Employees Benefits Board (PEBB) program. The policy effective November 1, 2017, applies to Apple Health. An opioid clinical policy for the Uniform Medical Plan, offered through the PEBB program and will be implemented for covered public employees in 2018. Similar opioid policies are being implemented some private plans. This will likely increase over time, though policy details will differ. There is statewide legislatively-mandated work going on around opioid prescribing, and HCA is participating in these discussions.

**Q: "in the old days' we used Tyl#3 if someone had significant pain; rarely used hydrocodone and almost never used oxycodone. For patients with good liver function, why is codeine never used as example—less potent but still effective for opiate naive patient?**

The lowest-potency effective medication should be used. We have revised our examples to include codeine in adults. In children, codeine is not recommended.

**Q: Do you have concerns that Oregon pharmacies will not be up to speed with new policies on November 1?**

Oregon pharmacies that dispense prescriptions to Medicaid patients have been included in our communications.

## **Provider-focused questions**

**Q: Are the UW TelePain service & UW Pain Hotline available for providers to use/access outside of Washington State, such as Idaho?**

The UW TelePain service and UW Pain Hotline are available to providers anywhere. However, questions and cases from Washington have priority in the discussions.

**Q: Will the AMDG guideline be modified to include this new guideline? Our internal medicine residents are required to take this training at the beginning of their residency so it would be good to incorporate this.**

Guidelines and policies differ somewhat in their approach and scope. Updates to the AMDG guideline are under consideration, but would likely not specifically reference HCA's opioid prescribing policy.

**Q: How are providers being made aware of this?**

HCA has send information to providers on the HCA listserv, and by the Medicaid MCOs to all their contracted providers. Partners including WSMA have sent out information to their members in their newsletters. Additionally, there is information on our website, and a news release will go out to general media.

**Q: Is the guideline 42 pills or 42 doses?**

The policy is #42 pills (tablets or capsules) or 5 mL doses of liquid formulation for adults, 18 pills or 5 mL doses for children.

**Q: Could this guideline encourage the prescribing of higher dose pills for patients that might not need them?**

If a supply is needed beyond the limits, providers should use the exempt process rather than adjusting pill strength. We believe that providers understand the urgency of the opioid crisis and we do not anticipate that they will use inappropriately strong pills, but we will monitor for this and change the policy if needed. Additionally, we are evaluating how to implement an MED limit.

**Q: Many prescribers give PRN short acting opioids q3h instead of q4h (which may allow lower doses to be given at each dose). 42 doses in such case is about 5 days.**

Prescribers can write Q3H for #42, which could be as short as a 5-day supply. If the patient is requesting additional opioids, another prescription can be prescribed. Connecting sig to days' supply is imperfect; many opioids are written PRN, so the expected use rarely matches the "max sig" written. (Many providers write "1-2 q 4-6 PRN," rarely intending that the patient take 12 pills daily throughout the course.) We selected 6/day as an approximation, but there will be exceptions. If you believe a patient needs 8 doses every day for 7 days, write for 56 pills and use "exempt."

**Q: We often see patients who are post-op and/or injured and are asking for pain relief at least 6 times daily. They have acute pain, but we often transition to long-acting opioids due to the frequency of their misery and need to have adequate pain control to participate in their treatment. NSAIDs don't seem to be a reasonable option for some. Are these what you'd consider a "special case"?**

Long-acting opioids are typically not used in the acute setting, but there are exceptions like the case you describe. If this is clinically needed, mark these prescriptions as "exempt."

**Q: What about surgeons who need to provide opiates for short term post op care?**

A surgeon discharging a patient with needs above the limit should write "exempt" on the prescription to meet the patient's needs.

**Q: What is the window of time that the 42 doses applies to? Is that 42 doses in a 90-day period or 120 days? When does this reset?**

42 doses per script can be given to adult patient for multiple scripts, until the patient has had opioids for 6 weeks (42 days) in a 90-day period. At that time, the attestation form for chronic use is required prior to continuing on opioid therapy. Even if the intent is not to continue medications indefinitely, it is appropriate at this point to make sure that best practices are being followed.

**Q: How do you deal with serial opiate needs? For example, patient is having multiple dental procedures and needs opiates every month for 6 months, is there a limit to how many "acute" prescriptions are given?**

If the patient requires more than 42 days' supply in a 90-day period, the attestation would be required.

**Q: We're a group of "SNFists" that seem to have some "in between" status. A lot of our residents have CKD and peptic ulcer disease.**

Some patients will need acute and/or chronic opioids in SNFs as well as other settings. If use beyond 42 days in a 90-day period is needed, the attestation form would be required.

**Q: How would a pharmacy handle a prescription written by an ER physician who did not check the PMP and the patient needs a prior auth? Burden to PCPs?**

The prior auth/attestation occurs at 6 weeks of ongoing therapy, so this is likely to impact the provider giving ongoing care rather than acute care. ER docs are likely to see patients who are either chronic users and have an attestation in place, or new users subject to the acute limitations and “exempt” process rather than the attestation.

**Q: Could you discuss how providers should care for sickle cell anemia?**

Sickle cell patients with frequent opioid needs are likely to end up needing the attestation for chronic use. Recommendations for the general care of any medical condition are outside the scope of this policy.

**Q: A dental patient on chronic opioid pain management requiring a difficult extraction, and the patient requests another opioid Rx in case they need to take more than the prescribed dosage from their chronic pain physician. Is it appropriate to prescribe more than what they are already receiving?**

In terms of authorization, a patient in this case would likely already have an attestation in place, so the limits would not apply. The approach to clinical management in this situation is outside the scope of this policy. Refer to pain management guidelines and the TelePain service if needed. In general, communication between providers around care (in this case the dentist and pain specialist) is central to ensuring safe and appropriate care.

**Q: What happens if a provider, for whatever reason, doesn't do an attestation?**

If an attestation is needed, this would be required as a prior authorization step before the prescription can be dispensed.

**Q: What is the audit process?**

Charts are subject to audit per standard HCA/MCO rules. We do not currently have a specific plan for general audits, but these could be triggered by clinical circumstances. If an audit did occur, it would address whether the elements required in the attestation were documented in the chart as required. If these were not done, payment could be recouped or other disciplinary steps taken.

**Q: Is it correct that MED dose limits will not be implemented at this time?**

MED dose limits will not be implemented at this time. HCA will evaluate how best to implement dose limits in the future.

**Q: Will ALL Medicaid related plans accept/honor the HCA attestation form, or will they mandate that their specific health plan attestation form to be used?**

The health plans will require the same criteria and same process for the attestation. However, each plan will have an individual attestation form with its fax number and contact information.

**Q: We have a very robust chart note that providers use when transitioning patients from acute to chronic pain management. The note addresses all of the elements of the attestation form. Is that adequate?**

You will still need to sign and send the attestation form, but the note you describe would include all the documentation needed for the chart.

**Q: Does this policy apply to chronic pain specialists since this would apply to basically all of our patients?**

Chronic pain specialists are subject to this policy. Current patients who are on chronic opioid therapy will be grandfathered under the policy and will not require an attestation to continue opioids; this may apply for many existing chronic pain patients. Pain specialists who are initiating opioid therapy or transitioning a patient from acute to chronic opioid therapy will need to follow the processes described in the policy.

**Q: What are the implications of restrictions/exemptions being configured in the EMR system? Is it required that the policy be configured word for word or are we concerned with patients being in some grey area (grandfathering, legit chronic use, etc.)**

Implementation of the policy as stated is required for Medicaid patients. Each health system can determine how best to implement this including workflow and EMR systems.

**Q: What if a patient is going between different opioids? Are they all considered the same # of doses?**

**Ex. Pt gets #42 oxycodone then 'refill' #42 hydromorphone. Will this trigger a rejection?**

All of the opioids included in the policy would count toward the limits described. The two prescriptions described above would each be considered a 1 week supply. If 6 weeks' total supply is reached, then the attestation form would be required.

**Q: I have a patient who has been on tramadol for a long time. To continue her treatment at the same dose, all I need to do is write exempt on her Rx?**

If patients have been using an opioid (including tramadol) for greater than 90 days in a 120-period, they will be grandfathered under the policy and no additional steps are needed.

**Q: Tolerance can take place in a lot less than 90 days. This probably pertains more to dosage rather than to doses. Still it might be ironic if patients were encouraged to wait for 90 days of therapy pre-op to be "grandfathered" to exempt them post-op.**

The "exempt" process should be used for post-operative patients who require medications above the limits. The "grandfathering" process is only to prevent disruption of care for patient already on continuous opioids.

## Prescriber and pharmacist questions

**Q: How will clients be prevented from being able to just write EXEMPT on prescription?**

Prescriptions with handwritten "exempt" will require the pharmacy to call the prescriber to verify verbally whether the prescription should be exempt from the policy or not.

**Q: What about patients who elect to cash pay but have MCA? Are patients allowed to pay cash/not on insurance for the amount over the limit?**

In nearly all cases, it is unlawful for patients with Medicaid to pay cash for opioid prescriptions.

**Q: Do these policies only pertain to Medicaid patients?**

At this time this policy will only impact Medicaid clients. HCA intends to implement this policy for public employees with the UMP plan in 2018.

**Q: Does this policy apply to Medicaid patients in other states or is it limited to Washington State?**

This policy only applies to Washington Medicaid. A number of Medicaid programs in other states have implemented or plan to implement similar policies.

**Q: How will patients be grandfathered? Do the authorizations for grandfathered patients happen automatically because the system knows they have been on it chronically or does the doctor or pharmacy have to do anything to indicate they should be a "grandfathered" patient?**

Patients will be identified and grandfathered automatically by the health plan computer systems.

**Q: Will "grandfathered" chronic use patients ever be reviewed and require an attestation or are they grandfathered for lifetime?**

The policy may change in the future to review grandfathered patients, but the process has not been developed at this time.

**Q: What do you see as the role of the MCOs in implementing this policy?**

All five MCOs will be implementing the HCA policy. They worked closely with HCA as the policy was developed, and are prepared for implementation.

**Q: Are all patients with Medicaid managed plans being notified before November 1, and if so, how?**

Since existing chronic opioid users are grandfathered, this policy will primarily impact future new users (who can't be identified in advance). Therefore, instead of sending materials to all Medicaid recipients, educational materials will be provided for providers and pharmacies to give to their patients. This applies to both FFS Medicaid and the Medicaid MCOs.

**Q: Where do we find this information on the HCA website?**

The web address is: [www.hca.wa.gov/billers-providers/programs-and-services/opioids](http://www.hca.wa.gov/billers-providers/programs-and-services/opioids)

**Q: Where do you get the attestation forms? Where do you send them?**

The attestation form will be available from each health plan, and will include the fax number for sending in the form. A direct link to the attestation form for Fee-for-Service Medicaid is here: [www.hca.wa.gov/assets/billers-and-providers/13-967-opioid-attestation.pdf](http://www.hca.wa.gov/assets/billers-and-providers/13-967-opioid-attestation.pdf)

**Q: Can the attestation be filled in online and be processed in real time or is it a document that we print out and fax off somewhere?**

Currently, the attestation form cannot be filled in online. It must be printed out, signed, and faxed to the health plan. Some health plans have the capacity to accept online forms and are working to build the attestation into their systems. We appreciate that this would be helpful across the board, but currently there are technical limitations on our ability to do this.

**Q: What if a patient is started on a long-acting opioid in the hospital setting due to an extended hospital stay. Will the hospitalist have to fill out the attestation form?**

These limits apply to prescriptions filled through the outpatient pharmacy system. The first pharmacy fill would also be the "start" of therapy for these purposes. At discharge in this case, the hospitalist would write "exempt" if these medications if long-acting opioids are needed (rather than filling out the attestation form). At six weeks after discharge if these are still needed, the provider giving continuing care would fill out the attestation.

**Q: Will an attestation form be required at every refill for chronic pain patients?**

No, the signed attestation form is good for six months.

**Q: If a prescriber is unaware of other prescribers and the patient has had prescriptions greater than six weeks, will the pharmacy notify the prescriber and not fill?**

Yes, the pharmacy will notify the prescriber that the patient is transitioning to chronic opioid use and will require an attestation form to be signed.

**Q: How is the diagnosis of "metastatic cancer" or "hospice care" indicated on the prescription so that the patient does not have the frustration of having to come back to the pharmacy if a full prescription is not dispensed?**

Many pharmacy systems have access to diagnoses and maintain a list in a patient profile, but some do not. To be certain the exemption will be applied, type "for cancer pain" or "hospice" on the prescription.

**Q: What if "hospice" or "cancer" is handwritten on the prescription, or the patient or family states these are present?**

If the pharmacist has concern about the veracity of information provided, they should contact the prescriber to verify.

**Q: Regarding "malignancy" or "cancer:" What about basal cell carcinomas or thyroid cancers or other cancers that are not generally painful?**

The exception applies to treatment of pain from active cancer. Patients with pain unrelated to the active cancer would not be eligible under the cancer exception.



**Q: Is it a HIPAA violation if the pharmacist knows a patient's diagnosis?**

It is not a HIPAA violation for pharmacies to know a patient's diagnosis. Pharmacists are participants in a patient's care and as such have the right to access relevant clinical information. For instance, pharmacies use this information during drug utilization review to ensure there are no drug-disease interactions. It can be used in this situation to allow expedited authorization for patients.

**Q: For acute pain, what is the purpose of implementing this when providers can easily write exempt on the prescription; would it have been easier to make this a guideline vs a policy change?**

HCA understands that there are certain situations where patients will need more than 18 or 42 units depending on their unique situation. This exempt process will allow prescribers to address these patient needs with appropriate therapeutic care without requiring additional administrative burden. There will be a hard-stop as a patient transitions from acute to chronic opioid treatment that will ensure that the patient is having a safe transition and that best practices are being followed.

**Q: What is the expected turnaround time for the attestation process?**

The attestation turn-around time should be no more than 24-hours. Prescribers are encouraged to be preemptive and submit an attestation form early if they know that more than six weeks of therapy will be required.

**Q: A patient is treated for an acute injury and within the first week returns because the prescribed dose is inadequate. Additional prescription of slightly higher dosing would put the patient over the week limit. How is this handled?**

The limits apply to the number of pills per prescription. A second prescription can be written and filled even if a week has not elapsed; the second prescription would not need to be marked "exempt" if it were under 42 pills for an adult, 18 for a child. If the new prescription required more than 42 pills (for an adult patient), it would be allowed if "exempt" were typed on the prescription.

## Pharmacist questions

**Q: How do pharmacies submit the EPA codes for "cancer pain" or "exempt" prescriptions when there is no NCPDP standard override code? Where do we get the EPA codes? Will the EPA codes be available in the rejected claim info? Are there limits on the amount of times these EPA codes can be used?**

Pharmacies will adjudicate claims using expedited authorization codes that are specific to the patient's condition. EPA codes will be provided by the plans, and EPA codes will be displayed in reject messages to pharmacies. For example if the prescriber indicates the prescription is for "cancer pain" on the prescription, then you would use that expedited authorization code when you transmit the claim. If the prescriber does not type "Exempt", "cancer pain", "hospice care", or "palliative care" on the prescription, you may call the prescriber and get an oral verification. There are no limits on the number of times EPA codes can be used—except the "exempt" EPA code cannot override the requirement of an attestation form for the chronic phase.

**Q: How will pharmacy staff know if the appropriate forms have been completed?**

Pharmacy staff will know what forms need to be completed through point-of-sale rejections and messages. If the prescription requires an attestation form, the rejection will mention that it will require prior authorization.

**Q: Under what authority may the pharmacy dispense less than the prescribed amount per the laws outside of Medicaid? Can you please point to the relevant state and federal laws that permit a pharmacy to dispense less than the prescribed amount without FIRST getting the prescriber's authorization?**

The claim will reject saying that the prescription is above the quantity level limit and note the amount that can be dispensed. It is against the law for pharmacies to knowingly accept cash payment from Medicaid clients if patients were to request that the remainder be dispensed outside of Medicaid billing.

**Q: How do pharmacies handle a partial fill of a CII prescription?**

A: We are currently seeking guidance from the DEA on how pharmacies can process partial fills of CII prescriptions. In 2016, the Comprehensive Addiction and Recovery Act was signed into law, allowing for partial fills of CII prescriptions. However, the DEA has not updated its guidance on this practice. We have reached out to the DEA for more clarification on that status of partial fills for CII prescriptions. Until we receive more information, we recommend dispensing the allowed amount or calling the prescriber to notify that a partial fill is being dispensed under the HCA opioid policy.

**Q: Is there any guidance for pharmacies/pharmacists who receive prescriptions for high-dose opioids or dangerous combinations of medications (i.e. high-dose opioid, muscle relaxer, and benzodiazepine) or when a prescriber continues to authorize these concerning prescriptions?**

Pharmacies should exercise sound clinical judgement when dispensing prescriptions. This policy will not supersede a pharmacist's clinical judgement on the safety or appropriateness of the prescriptions dispensed. If you are unsure about a prescription, call the prescriber or the patient's primary care provider prior to dispensing the prescription.

**Q: How will the pharmacy know if the prescriber has completed the attestation form? If the attestation is required and the prescriber has not completed the form, does the pharmacy reject the fill? How should a pharmacy document that the attestation is made by the prescriber?**

Pharmacies will receive a reject message when patients reach chronic opioid use (42 days of opioids in the previous 90 day period) and that an attestation form from the provider must be completed. If the attestation is not complete and the patient is being prescribed beyond 42 days in the 90-day period, the pharmacy must reject the claim. The pharmacy will not need to document that the attestation is made by the prescriber since the attestation form is sent to the health plan, either to the patient's managed care plan or to Fee-For-Service.

**Q: We are located a drive-able distance from several states. How do we determine if patients are going to other states to get opioids?**

All prescription claims should be tracked by the health plan's PBM, so the health plan will be responsible for tracking opioid use if the patient is receiving them outside of Washington.

**Q: Does the pharmacy receive two dispensing fees if it dispenses the lower acute dose for which the remainder can later be dispensed subject to a prescriber exemption?**

Pharmacies would receive two dispensing fees if it fills the opioid prescription as two separate fills.

**Q: What specific requirements are stated by this policy toward the community pharmacist?**

Pharmacies will be expected to adjudicate claims in accordance with this policy. This means that pharmacies will need to identify whether an exemption applies to the patient and to enter the appropriate EA code or whether the provider needs to sign an attestation form.

**Q: Can pharmacist write exempt on hard copy after verbally verify with prescriber?**

Yes, it will be expected that the pharmacist document on the physical copy of the prescription that they spoke with the prescriber and the prescriber said to exempt the prescription.

**Q: We do prior authorizations for our primary care providers, in this instance a PCP would need to complete the attestation form, correct? We couldn't complete it on their behalf?**

Yes, the prescribing provider must sign the attestation form.

**Q: Do pharmacies need to keep something in their records reflecting that a patient is receiving above the limits due to a palliative/cancer care exception. What documentation are you referring to and who is responsible for getting that documentation to the pharmacy?**

A: Pharmacies can track chronic care conditions for patients in their pharmacy claims system. This information can be typed on the prescription presented to the pharmacy. It will be the responsibility of the prescriber to note if the opioid is being prescribed for any cancer pain, hospice, palliative care, end-of-life care, or if the patient requires an exemption to the acute opioid limits.

**Q: How will pharmacies be able to track grandfathered chronic pain patients?**

The Health Care Authority and the managed care organizations (MCOs) will track grandfathered status.

**Q: Does the pharmacy have to verify "exempt" with the doctor for every handwritten exempt and does this have to come from doctor only?**

Yes. The pharmacy must verify a hand written "EXEMPT" order from the prescriber.

**Q: How will a pharmacy know a patient has been grandfathered?**

Patients that are grandfathered will have an authorization in place to allow for the opioid prescriptions to be covered.

**Q: Will an override exemption allow oxycodone 5mg 1 to 4 tablets q3h prn #150 for acute trauma pain?**

Yes, this prescription would be filled for the full amount with an "exempt."