Pharmacotherapy
for Opioid Use Disorder (POD)

Why is the POD Measure Important?

Pharmacotherapy, the treatment of a disorder with medication, has been identified as a critical part of treatment for individuals challenged with opioid use disorder (OUD). Less than 40% of U.S. residents over age 12 with an OUD diagnosis receive pharmacotherapy.[1] Encouraging pharmacotherapy is critical because individuals with OUD who engage in treatment with pharmacotherapy are less likely to experience withdrawal symptoms or cravings and use illicit opioids and are more likely to remain in treatment and engage in mental health therapy.[2,3,4]

What is the POD Measure Looking For?

This measure captures the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 and older with an OUD diagnosis. Three requirements must be met for the measurement:

- Medicaid and Medicare members age 16+
- OUD dispensing event is captured between a 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year (Intake Period).
- Members must have a Negative Medication History (no OUD pharmacotherapy medications captured on pharmacy claims) as of 31 days prior to the new OUD pharmacotherapy.

How is Adherence/Compliance Met?

The measure is met when the member adheres to OUD pharmacotherapy for 180 days or more without a gap in treatment of more than eight days.

Who is Excluded?

- Members that had an acute or nonacute inpatient stay of eight or more days during the 180-day treatment period and members in hospice are excluded from the measure.
- Members receiving Methadone for the treatment of OUD are also excluded.

OUD ICD-10 CODES

F11.10

F11.120-122

F11.129

F11.13-14

F11.150-151

F11.159

F11.181-182

F11.188

F11.19-20

F11.220-222

F11.229

F11.23-24

F11.250-251

F11.259

F11.281-282

F11.288

F11.29

What Can You Do To Help?

- Consider Medication Assisted Treatment (MAT) options for patients with OUD and maintain appointment availability.
- Provide empathic listening and nonjudgmental discussions to engage the patient and caregivers in decision making and form a relapse prevention plan.
- Inform of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.
- Closely monitor medication prescriptions and do not allow any gap in treatment of eight or more consecutive days.
- Offer mutual help like peer recovery support, harm reduction, or 12-step fellowships (AA, NA, etc.).
- Reach out proactively within 24 hours if the patient does not keep a scheduled appointment to schedule another.
- Encourage coordination of care and communication between the physical and behavioral health providers, including transitions in care.
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.

Before prescribing opioids

- Given the substantial risk for serious side effects such as overdose and addiction with long-term opioid use, non-pharmacologic treatments and non-opioid medications are preferred for managing chronic pain, apart from terminal illnesses.
- Work with patients to learn more about alternative pain management benefits they might receive (i.e., acupuncture, physical therapy, massage therapy, etc.) and work with them to communicate with providers, especially if they are on long-term, high dosages of opioids.
- Consider these factors that may increase a patient's risk of opioid overdose:
  - History of past overdose
  - Personal or family history of substance use disorder
  - Opioid dosage of >50 Morphine Milligram Equivalents (MME) per day
  - Concurrent use of benzodiazepines
  - History of mental health conditions

If opioids are prescribed, the following guidelines should be followed

- For acute pain, immediate release (IR) opioids should be prescribed at the lowest effective dose with a reassessment completed no later than three to five days to determine if adjustments or continuation of opioid therapy is needed.
- Patients should be evaluated for benefits and harms within one to four weeks of starting opioid therapy, or after a dose increase, and opioids should be tapered off if benefits are not exceeding the risks.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Patients should have a urine drug test before opioid treatment is prescribed, and at least annually after, should use only one pharmacy to fill their medications, and should keep their medications in a locked or secure location.
- Discuss risks with patients and caregivers of using multiple prescribers.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Recommend a Naloxone prescription to reverse accidental overdose.

Treatment Medications for OUD:

Description	Prescription
Antagonist	Naltrexone (oral or injection)
Partial Antagonist	Buprenorphine (sublingual tablet, injection, or implant)
Partial Antagonist	Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)
Agonist	Methadone (oral)*

**Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Additional Support:

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov or MAT Webinars and Workshops

Provider Clinical Support Systems (PCSS)
www.pcssnow.org Answers from Clinicians in Real Time

We are committed to the care and wellbeing of our members. We are also committed to working with you as a partner to develop the best possible treatment plans for all patients.

Please view the Provider section of our website https://ambetter.arhealthwellness.com/ for additional tools and local resources or contact a Provider Relations or Quality Improvement Specialist for assistance.

References:

1. Wu, L.T., Zhu, H., & Swartz, M.S. (2016). Treatment utilization among persons with opioid use Disorder in the United States." Drug and Alcohol Dependence 169, 117–27.
2. NIDA. (2016). Effective treatments for opioid addiction. https://www.drugabuse.gov/effective-treatments-opioid-addiction-0
3. Connery, H.S. (2015). Medication-assisted treatment of opioid use disorder: Review of the evidence and future directions." Harvard Review of Psychiatry, 23(2):63–75. doi: 10.1097/HRP.0000000000000075.
4. NCQA: https://www.ncqa.org/hedis/measures/pharmacotherapy-for-opioid-use-disorder/