Opioid Prescription Intervention™ (OPI) Program Prescriber Feedback Response Form

The information in your OPI mailing packet is based on paid Medical Claims, including diagnosis and prescription drug claims submitted by pharmacies. IF you believe the information is in error, please indicate on this form and use the fax or e-mail information below to contact us. **You must also contact the pharmacy directly to correct this information, as we cannot resolve this issue for you.**

Please use this form to facilitate your response to information contained in your OPI mailing packet. We want to understand the patient-specific reasons for the drug therapy you have prescribed that is hitting the Quality Indicators™. You may alternately use the **Prescriber Summary Report** or a specific **Patient Profile Report** contained within the mailing to send comments, advise us of your follow-up actions, or inform us of some other opioid-responsive plan. You may also use this form to request a peer-to-peer consultation. Because of confidentiality considerations, you should use a separate feedback form for each patient response and send communication via secure e-mail, fax, or by US Mail. Make as many copies of the form as needed. A fillable version of this form is available at the following website link:
https://dss.mo.gov/mhd/providers/files/provider-communication.pdf

Prescriber Name, NPI and address on record:

Primary Specialty:

Patient Name and MO HealthNet ID:

☐ Peer-to-Peer Consultation Requested

*Provider Contact # and preferred time of day for call: _____

Quality Indicator™(QI)	OPI Questions	Diagnoses/Therapies Dates and Results
QI 889 - TWO or more Dx Suggesting Somatization or Factitious Disorder (psychological cause)	1. List the **Indication** (i.e. Physical Basis) and **ICD-10 Diagnoses** for Chronic Opioid therapy.	
	2. List previous **Non-Opioid therapies** prescribed and the result (mark all that apply).	☐ Cognitive Behavior Therapy ☐ Anticonvulsants, Antidepressants ☐Physical Therapy/ Massage/Relaxation/Exercise ☐ Other _____
	3. What is the **ongoing opioid prescribing plan**? (mark all that apply)	☐ Taper/discontinue (may include adding non-opioid meds) ☐ Refer to pain management specialist ☐ Refer for opioid use disorder tx ☐ Other _____
QI 890/891 - Chronic Opioid Therapy > 60 days in the Absence of Active Cancer Diagnosis The other 3QIs can be discussed in comments below.	1. List **Descriptive Chronic Pain Diagnoses** related to physical and/or neuropathic cause (e.g. G89.4 Chronic Pain Syndrome is not a Dx that identifies a specific cause)	
	2. List **Previous non-opioid medications and/or therapies** prescribed and the result (mark all that apply)	☐ Surgery ☐ NSAIDs, Acetaminophen ☐ Anticonvulsants ☐ Antidepressants ☐ Physical Therapy/Massage/Relaxation/Exercise ☐ TENS or other neurostimulation ☐ Interventional (e.g. blocks, botox) ☐ Other _____
	3. What is the **ongoing opioid prescribing plan**? (mark all that apply)	☐ Taper/discontinue (may include adding non-opioid meds) ☐ Refer to pain management specialist ☐ Refer for opioid use disorder tx ☐ Other_____

Patient Name and

MO HealthNet ID:

Quality Indicator™ (QI) **use separate line for each*	**Comments and/or Explanation** ***(use additional pages as necessary)***

Send this form and any documentation via secure communication to:

Missouri Medicaid Audit and Compliance (MMAC) Unit
PO Box 6500
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E-Mail: MMAC.OPICompliance@dss.mo.gov