Opioid Measures FY 2019* IPPS/LTCH PPS Final Rule		
FAQ Number	**Question**	**Answer**
Query of Prescription Drug Monitoring Program (PDMP) measure		
	For an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program, how frequently must the query of the PDMP be conducted?	As stated in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41653), the measure description is: for at least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law. Because the measure specifies a minimum of one Schedule II opioid electronically prescribed, an eligible hospital or CAH must perform a query at least once.
	For the Query of PDMP measure, is the expectation that eligible hospitals and CAHs have to include the capabilities and standards of CEHRT defined in § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation if they are not planning on reporting the Query of PDMP measure?	For an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability Program, if an eligible hospital or CAH is not planning on reporting the Query of PDMP measure they do not have to have to include the capabilities and standard of CEHRT defined § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation. Please refer to ONC's 2015 Edition test method** for the testing requirements for § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation.
	For an EHR reporting period in CY 2019, how is CMS expecting a Medicare eligible hospital or CAH to calculate the numerator and denominator for the Query of PDMP measure?	We understand not all EHRs are integrated with PDMPs and therefore are not able to automatically calculate the numerator and denominator for the Query of PDMP measure and may require manual calculations. Our intent is not to increase burden, but rather to take steps to combat the opioid crisis. We would like to stress the measure is optional for CY 2019.
	Regarding an EHR reporting period in CY 2019 for Medicare eligible hospitals and CAHs, does the person performing a query and/or reviewing the query data have to be the same person as the ordering user?	We have not limited the query to physicians or required that the same health care professionals in the eligible hospital or CAH be involved throughout the process. We believe that eligible hospitals and CAHs can determine what's most appropriate for the medical staff involved in running queries based on their own SOPs, guidelines, and preferences (in accordance with applicable law).
	Will there be an exclusion for the Query of PDMP measure if a state does not have a PDMP that can be queried?	The two new opioid measures are optional for EHR reporting periods in CY 2019 under the Medicare Promoting Interoperability program so we did not establish exclusions for 2019. We will consider whether additional exclusions would be appropriate in our 2020 rulemaking cycle.

*The information provided in this FAQ applies for an EHR reporting period in CY 2019 (83 FR 41634-41675)

**ONC's 2015 Edition test method

Verify Opioid Treatment Agreement measure		
	For the Verify Opioid Treatment Agreement measure, how is CMS expecting EHRs to calculate 30 cumulative days within a 6-month look-back period?	For an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program, we understand that calculating 30 cumulative days within a 6-month look-back period may be a manual process. The 30 cumulative days may be calculated using the medication history request/response transactions that are already part of the provider's workflow and may include use of a HIE, PDMP, or similar mechanism.
	For the Verify Opioid Treatment Agreement measure, is CMS expecting "as needed medications," also known as "PRN medications," to be included when calculating 30 cumulative days within a 6-month look-back period?	We believe the inclusion of PRN medications is important to create a more complete medication history that may help to identify cases of potential overutilization of opioids. PRN medications include a quantity and maximum dose that may be used to determine the minimum number of days supplied, which should be included in the calculation of the number of cumulative days a Schedule II opioid is prescribed. The maximum dose may be calculated by multiplying the dose by the maximum number of times per day that dose can be taken if taken at the maximum dose at the maximum frequency. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.
	If CMS is not defining an "opioid treatment agreement," how do health care providers know what constitutes an opioid treatment agreement for inclusion in the numerator?	CMS was purposefully broad with regard to what could constitute an opioid treatment agreement because we want to encourage clinicians to engage with patients in care planning and coordination of opioid use in the manner they believe is most appropriate. An opioid treatment agreement could include, but is not limited to, documentation such as patient centered goals, a care plan, shared decision making, record of a consultation with the patient, or documentation of the extended care team. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.
	Is the expectation that EHR vendors certify the Verify Opioid Treatment Agreement measure to the ONC 2015 Edition § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation certification criteria for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program if they do not plan to report on the measure?	For an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability Program, if an eligible hospital or CAH is not planning on reporting the Verify Opioid Treatment Agreement measure they do not have to have § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation CEHRT for the Verify Opioid Treatment Agreement measure. Please refer to ONC's 2015 Edition test method** for the testing requirements for § 170.315 (g)(1) Automated Numerator Recording and § 170.315 (g)(2) Automated Measure Calculation.
	For the Verify Opioid Treatment Agreement measure, please clarify the definition of incorporation. For example, is a PDF acceptable?	Although we do not specify all of the various options for incorporating a signed opioid treatment agreement in CEHRT, a PDF could be incorporated for purposes of this measure. As stated in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41654), the ''patient health data capture'' functionality, which is part of the 2015 Edition certification criteria (45 CFR 170.315(e)(3)), could be used to incorporate a treatment plan that is not a structured document with structured data elements. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.

**ONC's 2015 Edition test method

Questions applicable to Query of PDMP and Verify Opioid Treatment Agreement measures		
	For the Query of PDMP and Verify Opioid Treatment agreement measures, what does CMS mean by Schedule II opioids electronically prescribed using CEHRT?	We understand that electronic prescribing of controlled substances, including Schedule II opioids, may not always be conducted through electronic prescribing functionality that is integrated with CEHRT. In the event this functionality is not integrated with a hospital's CEHRT, for purposes of satisfying the requirements of these measures, the hospital may use data from CEHRT, such as patient demographics, to electronically prescribe a Schedule II opioid.
	The FY 2019 IPPS/LTCH PPS final rule defines opioids as "Schedule II controlled substances under 21 CFR 1308.12, as they are recognized as having a high potential for abuse with potential for severe psychological or physical dependence." Does this definition include non-opioid Schedule II medications listed at 21 CFR 1308.12?	In the FY 2019 IPPS/LTCH PPS final rule (83 FR 41649),*** we defined opioids as Schedule II controlled substances under 21 CFR 1308.12.**** We understand the list of Schedule II drugs under 21 CFR 1308.12 includes opioids and other controlled substances. For these measures, we are including Schedule II opiate drugs only and not the other Schedule II controlled substances under 21 CFR 1308.12. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.
	Will CMS provide an RxNorm value set for the Schedule II opioids for the Query of PDMP and Verify Opioid Treatment Agreement measures?	CMS declines to provide an RxNorm value set for these measures. RxNorm is a standardized nomenclature for clinical drugs that is produced by the United States National Library of Medicine, and it is already part of the required standards for the e-Prescribing measure. Therefore, certified EHR technology is expected to be up to date as changes are made to the RxNorm value set. We are looking into the possible development of a value set for these measures, and we will take this into consideration in future rule making. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.
	What if the e-prescribing of opioids is not allowed under state law?	As we stated in the FY 2019 IPPS/LTCH PPS final rule at 83 FR 41649, eligible hospitals and CAHs must include Schedule II opioid prescriptions in the numerator and denominator of these measures if they choose to report on them. Both of the measures are optional for EHR reporting periods in CY 2019 under the Medicare Promoting Interoperability program and we established an exclusion for the Query of PDMP measure beginning in CY 2020 for providers that are not able to report on this measure in accordance with applicable law. We will consider whether additional exclusions would be appropriate in our 2020 rulemaking cycle. This information is intended to be applicable for an EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program.

***83 FR 41649

****21 CFR 1308.12

	For the EHR reporting period in CY 2019 under the Medicare Promoting Interoperability program, would an eligible hospital or CAH earn "up to 5" bonus points based on their performance on either the Query of PDMP or Verify Opioid Treatment Agreement measure(s), or would they earn 5 bonus points regardless of their performance as long as they satisfy the minimum requirements of the measure?	Although we stated in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41644) that both of the measure are optional in CY 2019 and each worth "up to 5 bonus points," our intent was to refer to 5 bonus points. In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20522-20523), we provided tables illustrating the proposed new scoring methodology and a numerical example of how that scoring methodology would be applied for CY 2019. We referred to these tables again in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41642). The table containing the numerical example demonstrates our intent to award 5 bonus points for each of the measures regardless of the eligible hospital or CAH's performance rate. To avoid potential confusion, in rulemaking next year, we expect to explain what our intention was for scoring the measure for CY 2019 and to propose to amend the regulation text for CY 2019 to better reflect our intended scoring policy. As we stated in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41644), the PDMP measure is a required measure beginning in CY 2020, worth up to 5 points. Beginning with the EHR reporting period in CY 2020, the measure will be scored based on performance, and an eligible hospital or CAH may earn up to 5 points for the measure based on their performance rate.