

<b>eMeasure title</b>	Potential Opioid Overuse		
<b>eMeasure identifier (measure authoring tool)</b>	460	<b>eMeasure version number</b>	0.0.006
<b>NQF number</b>	None	<b>GUID</b>	442edef2-7347-4080-988f-16c9d1998803
<b>Measurement period</b>	January 1, 20XX, through December 31, 20XX		
<b>Measure steward</b>	Centers for Medicare & Medicaid Services (CMS)		
<b>Measure developer</b>	The Lewin Group		
<b>Endorsed by</b>	None		
<b>Description</b>	Percentage of patients aged 18 years or older who receive opioid therapy for 90 days or longer and are prescribed an average daily dosage of 90 milligram morphine equivalents or greater		
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<b>Measure scoring</b>	Proportion		
<b>Measure type</b>	Process		
<b>Stratification</b>	None		
<b>Risk adjustment</b>	None		
<b>Rate aggregation</b>	None		
<b>Rationale</b>	More than 100 million people in the United States suffer from chronic pain (Institute of Medicine 2011). In 2010, more than 9 million adults in the United States were seen in primary care clinics with a diagnosis of nonmalignant chronic pain, and, of those, about 36 percent were prescribed an opioid (Prunuske et al. 2014). Emergency department visits for drug-related encounters doubled from 2004 to 2009, reaching more than 475,000 (Substance Abuse and Mental Health Services Administration 2014). Fatalities from prescription drug overdose reached 14,800 in 2008, more than tripling the death rate since 1990 (Centers for Disease Control and Prevention [CDC] 2011). Although all opioids can be dangerous, high doses and chronic use of opioids are more likely to result in fatalities and other adverse drug events (Edlund et al. 2014; Morasco et al. 2010; Atluri et al. 2012; Paulozzi et al. 2014). Recent guidelines recommend that (1) clinicians prescribe the lowest effective dose possible when initiating opioid therapy, (2) prescribers reexamine the patient’s individual benefits and risks when increasing doses above 50 milligram morphine equivalents (MME) per day, and (3) clinicians should carefully justify prescribing doses above 90 MME per day, weighing the benefits and harms of such a high dose (Dowell et al. 2016). In a large cohort study of almost 18 million commercially insured patients in the United States, about 15 percent of opioid recipients received a daily dose of 100 MME or higher, and 12 percent received more than a 90-day supply (Liu et al. 2013).		
<b>Clinical recommendation statement</b>	CDC’s Guideline for Prescribing Opioids for Chronic Pain—United States (2016) states, -“When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of		

	individual benefits and risks when considering increasing dosage to $\geq 50$ morphine milligram equivalents (MME)/day, and should avoid increasing dosage to $\geq 90$ MME/day or carefully justify a decision to titrate dosage to $\geq 90$ MME/day.” -“Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.”
<b>Improvement notation</b>	A lower rate indicates better quality.
<b>Reference</b>	Atluri, S., H. Akbik, and G. Sudarshan. “Prevention of Opioid Abuse in Chronic Non-Cancer Pain: An Algorithmic, Evidence-Based Approach.” <i>Pain Physician</i> , vol. 15, suppl. 3, July 2012, pp. ES177–ES189.
<b>Reference</b>	CDC. “Vital Signs: Overdoses of Prescription Opioid Pain Relievers: United States, 1999–2008.” <i>Morbidity and Mortality Weekly Report</i> , vol. 60, no. 43, November 2011, pp. 1487–1492.
<b>Reference</b>	Dowell, D., T.M. Haegerich, and R. Chou. “CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016.” <i>Recommendations and Reports</i> , vol. 65, no. 1, March 2016, pp. 1–49.
<b>Reference</b>	Edlund, M.J., B.C. Martin, J.E. Russo, A. DeVries, J.B. Braden, and M.D. Sullivan. “The Role of Opioid Prescription in Incident Opioid Abuse and Dependence among Individuals with Chronic Noncancer Pain.” <i>Clinical Journal of Pain</i> , vol. 30, no. 7, July 2014, pp. 557–564.
<b>Reference</b>	Institute of Medicine. “Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.” 2011. Available at <a href="http://www.nationalacademies.org/hmd/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx">http://www.nationalacademies.org/hmd/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx</a> . Accessed September 21, 2017.
<b>Reference</b>	Liu, Y., J.E. Logan, L.J. Paulozzi, K. Zhang, and C.M. Jones. “Potential Misuse and Inappropriate Prescription Practices Involving Opioid Analgesics.” <i>American Journal of Managed Care</i> , vol. 19, no. 8, August 2013, pp. 648–658.
<b>Reference</b>	Morasco, B.J., J.P. Duckart, T.P. Car, R.A. Deyo, and S.K. Dobscha. “Clinical Characteristics of Veterans Prescribed High Doses of Opioid Medications for Chronic Non-Cancer Pain.” <i>Pain</i> , vol. 151, no. 3, December 2010, pp. 625–632.
<b>Reference</b>	Paulozzi, L.J., K. Zhang, C.M. Jones, and K.A. Mack. “Risk of Adverse Health Outcomes with Increasing Duration and Regularity of Opioid Therapy.” <i>Journal of the American Board of Family Medicine</i> , vol. 27, no. 3, May–June 2014, pp. 329–338.
<b>Reference</b>	Prunuske, J.P., C.A. St. Hill, K.D. Hager, A.M. Lemieux, M.T. Swanoski, G.W. Anderson, and M. Lutfiyya. “Opioid Prescribing Patterns for Non-Malignant Chronic Pain for Rural Versus Non-Rural U.S. Adults: A Population-Based Study Using 2010 NAMCS Data.” <i>BMC Health Services Research</i> , vol. 14, no. 563, November 2014.
<b>Reference</b>	Substance Abuse and Mental Health Services Administration. “Drug Abuse Warning Network: Selected Tables of National Estimates of Drug-Related Emergency Department Visits.” Rockville, MD: Center for Behavioral Health Statistics and Quality, 2014.
<b>Definition</b>	Long-term opioid therapy is defined as opioid use for more than 90 consecutive days (CDC 2016). High-dose usage is defined as at least 90 milligrams morphine equivalent dosage per day (CDC 2016).

<b>Guidance</b>	<p>For this measure, the numerator applies to patients in the initial population with a 90-day or longer supply of opioids at a 90 MME or larger daily dose.</p> <p>Please note that the numerator criteria of this measure are satisfied for all patients in the initial population with a 90-day or longer supply of the following specified opioids at 90 MME or larger:</p> <ul style="list-style-type: none"> <li>-Buprenorphine (for pain management)</li> <li>-Butorphanol</li> <li>-Codeine</li> <li>-Dihydrocodeine</li> <li>-Fentanyl</li> <li>-Hydrocodone</li> <li>-Hydromorphone</li> <li>-Levorphanol</li> <li>-Meperidine (Pethidine)</li> <li>-Methadone</li> <li>-Morphine</li> <li>-Nalbuphine</li> <li>-Opium</li> <li>-Oxycodone</li> <li>-Oxymorphone</li> <li>-Pentazocine</li> <li>-Tapentadol</li> <li>-Tramadol</li> </ul> <p>This measure allows for up to 7 days between prescriptions for long-term opioid users. If a patient has a gap between prescriptions of 7 days or fewer, but takes one or more opioids listed above for at least 90 days, he or she will still be included in the measure's denominator.</p>
<b>Initial population</b>	Patients aged 18 years or older who are prescribed an opioid for 90 days or longer and who have a visit during the measurement year
<b>Denominator</b>	Equals initial patient population
<b>Denominator exclusions</b>	<p>Patients receiving palliative or hospice treatment during the measurement period</p> <p>Patients with cancer during the measurement period</p> <p>Patients with sickle cell disease during the measurement period</p>
<b>Numerator</b>	Patients with an average daily dosage of 90 morphine milligram equivalents (MME) or greater, prescribed during the measurement year
<b>Numerator exclusions</b>	None
<b>Denominator exceptions</b>	None
<b>Supplemental data elements</b>	For every patient evaluated by this measure, it is essential to identify payer, race, ethnicity, and gender.