SCG1 Evaluation of High Risk Pain Medications for MME

Percentage of patients aged 18 years and older prescribed and actively taking one or more high risk pain medications and evaluated for clinical appropriateness of morphine milligram equivalents (MME)

2018 OPTIONS FOR INDIVIDUAL MEASURES:
SCG Health, US Wound Registry

NATIONAL QUALITY STRATEGY DOMAIN: Patient Safety
MEASURE TYPE: Intermediate Outcome

INSTRUCTIONS:
This measure is to be reported at **each denominator eligible visit** during the 12 month performance period for patients prescribed a high risk pain medication. An accurate and complete medication list must be on file for each of the encounter date(s) of service. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

DENOMINATOR:

Denominator Criteria (Eligible Cases):
Patients 18 age and older on date of encounter
AND
All eligible instances when MIPS measure #130 (NQF 0419): Documentation of Current Medications is reported the same encounter
AND
Patient encounter during the performance period (CPT): 90791, 90792, 92002, 92004, 92012, 92014, 96116, 96118, 96150, 96151, 97532, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439
WITHOUT
Telehealth Modifier: GQ, GT

NUMERATOR:
Percentage of patients prescribed and actively taking one or more high risk pain medications

Numerator Instructions: The eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter.
Eligible clinicians reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. The MME must be documented in the medical record.

Definition:
Accurate and complete medication list – List of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration. MIPS measure #130 (NQF #0419) must be on file for the encounter to be eligible.

High risk pain medications – Patients prescribed certain high risk pain medications including:
Opiates: buprenorphine (Butrans not Suboxone), codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, tapentadol, tramadol
Benzodiazepines: alprazolam, diazepam, clonazepam, lorazepam Anti-spastics: baclofen, carisoprodol, cyclobenzaprine, metaxolone, methocarbamol, tizanidine
NSAIDs: ibuprofen, indomethacin, ketorolac, meloxicam, naproxen

Excluded: Transdermal lidocaine

Morphine milligram equivalents (MME) – Also called morphine equivalent daily dose, the conversion factors identified below were developed by the Centers for Disease Control and Prevention in May 2014. MME can be calculated using:

$$\text{MME} = \frac{\text{Drug Strength} \times \text{Drug Quantity} \times \text{MME Conversion Factor}}{\text{Days Supply}}$$

SOURCE: Centers for Disease Control and Prevention, Atlanta, GA, May 2014.

OPIOID (doses in mg/day except where noted)		**CONVERSION FACTOR**
Buprenorphine patch ‡		12.6
Buprenorphine tab or film		10
Butorphanol		7
Codeine		0.15
Dihydrocodeine		0.25
Fentanyl buccal or SL tablets, or lozenge/troche		0.13
Fentanyl film or oral spray§		0.18
Fentanyl nasal spray‖		0.16
Fentanyl patch¶		7.2
Fentanyl transdermal (in mcg/hr)†		2.4
Hydrocodone		1
Hydromorphone		4
Levorphanol tartrate		11
Meperidine hydrochloride		0.1
Methadone*	1-20 mg/day	4
	21-40 mg/day	8
	41-60 mg/day	10
	≥ 61-80 mg/day	12
Morphine		1
Oxycodone		1.5
Oxymorphone		3
Pentazocine		0.37
Tapentadol		0.4
Tramadol		0.1

* Methadone: the conversion factor increases at higher doses

† Fentanyl: dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

‡ The MME conversion factor for buprenorphine patches is based on the assumption that one milligram of parenteral buprenorphine is equivalent to 75 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 5 ug/hr buprenorphine patch * 24 hrs = 120 ug/day buprenorphine = 0.12 mg/day buprenorphine = 9 mg/day oral morphine milligram equivalent. In other

words, the conversion factor not accounting for days of use would be 9/5 or 1.8. However, since the buprenorphine patch remains in place for 7 days, we have multiplied the conversion factor by 7 (1.8 X 7 = 12.6). In this example, MME/day for four 5 µg/hr buprenorphine patches dispensed for use over 28 days would work out as follows: Example: 5 ug/hr buprenorphine patch * (4 patches/28 days)* 12.6 = 9 MME/day.
§ The MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given lozenge/troche.
" The MME conversion factor for fentanyl film and oral spray is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.
The MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.
The MME conversion factor for fentanyl patches is based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day. Example: 25 ug/hr fentanyl patch * 24 hrs = 600 ug/day fentanyl = 60 mg/day oral morphine milligram equivalent. In other words, the conversion factor not accounting for days of use would be 60/25 or 2.4. However, since the fentanyl patch remains in place for 3 days, we have multiplied the conversion factor by 3 (2.4 X 3 = 7.2). In this example, MME/day for ten 25 µg/hr fentanyl patches dispensed for use over 30 days would work out as follows: Example: 25 ug/hr fentanyl patch * (10 patches/30 days)* 7.2 = 60 MME/day.

Numerator Options:

***Performance Met 1*:** Patient evaluated and current high risk pain medication, current pharmacologic treatment regimen less than 20 MME per day

OR

***Performance Met 1*:** Patient evaluated and current high risk pain medication, current pharmacologic treatment regimen greater than or equal to 20 MME and less than 50 MME per day

OR

***Performance Met 1*:** Patient evaluated and current high risk pain medication, current pharmacologic treatment regimen greater than or equal to 26 MME and less than 50 MME per day

OR

***Performance Met 1*:** Patient evaluated and current high risk pain medication, current pharmacologic treatment regimen less than or equal to 50 MME and less than 90 MME per day

OR

***Performance Met 1*:** Patient evaluated and current high risk pain medication, current pharmacologic treatment regimen greater than or equal to 90 MME per day

AND

***Performance Met 2*:** Patient not prescribed an opioid and a benzodiazepine

OR

***Performance Exclusion*:** Patient not prescribed a high risk pain medication.

OR

***Performance Not Met*:** Patient not evaluated for the MME of their current high risk pain medication pharmacologic treatment regimen, reason not given

WHAT DATA SOURCES ARE USED FOR THE MEASURE? Administrative clinical data, Claims, Paper medical record, Prescription Drug Event Data Elements, Record review, Other

health information exchanges and Surescript pharmacy feeds

STEWARD: SCG Health

 # OF PERFORMANCE RATES TO BE SUBMITTED IN THE XML: 1
Indicate an Overall Performance Rate if more than 1 performance rate is to be submitted: NA

INVERSE MEASURE: No

PROPORTION MEASURE SCORING OR CONTINUOUS MEASURE SCORING

RISK ADJUSTED: Yes, by age, chronic conditions such as OA and hospice admission

RATIONALE:
The Institute of Medicine in their "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research" (2011) estimated that the yearly economic cost of chronic pain in the United States is $560-635 billion. Yet, the U.S. is facing an opioid crisis. A 2010 trend study estimates that 20 percent of patients presenting to physician offices with noncancer pain-related diagnoses (including acute and chronic pain) or pain symptoms receive an opioid prescription (Daubresse et al. 2013). These prescriptions have flooded the American market so much so that every American adult could have a bottle of opiates, with 259 million opioid prescriptions written in 2012 (Paulozzi et al. 2014). Prescribing rates are increasing.

Between 2007 and 2012 opioid prescriptions per capita increased 7.3 percent (Levy et al. 2015). Like other aspects of healthcare, there is significant prescribing variation across the country demonstrating the lack of consensus and/or education on how to appropriately prescribe and control opioid pain medication (Paulozzi et al. 2014).

The estimated annual direct and indirect cost for the abuse, dependence and misuse of prescription opioids to the United States is $55.1 billion (Hansen et al. 2011), with the broader category of abuse, dependence and misuse of opioids estimated at $55.7 billion (Birnbaum et al. 2011). An additional $20.4 billion is spent on the direct and indirect costs for opioid-related overdose (Inocencio et al. 2013).

Patients with chronic illnesses, including chronic pain, are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications (Nassaralla et al. 2007). In the outpatient setting, opioid prescriptions were estimated at $9.0 billion in total expenses in 2012 which is a 120 percent increase from a decade before (Stagnitti 2015)

Low dosages (20-50 MME per day) increase risk for opioid overdose with higher MME significantly increasing the patient risk of death. Higher MME have not been shown effective for long-term pain reduction (Dowell 2016).

CLINICAL RECOMMENDATION STATEMENTS:
This measure is based upon recommendations from Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (Dowell, et al. 2016).

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