Opioid Prescribing Quality Measure Updates

According to the Centers for Disease Control and Prevention (CDC), there were 46,802 deaths involving opioids in 2018.[1] Various models using claims data and data studies have shown that high daily dosages of opioids, overlapping prescriptions from multiple providers and pharmacies, and continued use are risk factors for opioid abuse and overdose.[2-4] The National Committee for Quality Assurance (NCQA) issued two HEDIS measures in 2018 to assess the use of opioids at high doses and from multiple providers and/or pharmacies, and one measure in 2019 to evaluate the risk of continued opioid use, which was updated in 2020.

HEDIS Quality Measures

1. **Use of Opioids at High Dosage (HDO)[5]**
    a. Updates:
        i. Changed acronym from UOD to HDO.
        ii. Updated average daily morphine milligram equivalents (MME) from > 120 MME to ≥ 90 MME.
    b. Examines the proportion of patients 18 years and older who received prescription opioids (excluding buprenorphine) for 15 days or more at average doses of at least 90 (MME). The calculation and conversion table below are used to determine MME:

MME = (opioid strength) x (quantity / day supply) x conversion factor

Conversion Factors for Common Opioids:	
Codeine (mg)	0.15
Fentanyl oral transmucosal (mcg)	0.13
Fentanyl transdermal (mcg/hr)	7.2
Hydrocodone (mg)	1
Hydromorphone (mg)	4
Levorphanol tartrate (mg)	11
Methadone* (mg)	3
Morphine (mg)	1
Oxycodone (mg)	1.5
Oxymorphone (mg)	3
Tramadol (mg)	0.1

* Methadone for opioid use disorder is not included in the measure

2. **Use of Opioids from Multiple Providers (UOP).**[5] Three measures report the proportion of patients 18 years and older who received prescription opioids for 15 days or more from:
    a. Four or more different prescribers
    b. Four or more different pharmacies
    c. Four or more different prescribers and four or more different pharmacies.

3. **Risk of Continued Opioid Use (COU).[5]** Two measures report the percentage of patients 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use based on duration:
    a. 15 days or more in a 30-day period
    b. 31 days or more in a 62-day period.

How do I help improve performance?[7]

- Reassess benefits and risks of pain regimens with daily MME ≥ 90. Consider tapering or discontinuing opioid therapy if the patient does not have a clinically meaningful improvement in pain and function, shows signs of overdose risk, or demonstrates signs of substance use disorder.
- Evaluate continued opioid therapy with patients every 3 months or more frequently.
- Regularly consult CURES, California's prescription drug monitoring program, to ascertain whether a patient is receiving controlled substances from multiple providers and/or pharmacies.
- For opioid-naïve patients needing treatment for acute pain, prescribe the lowest effective dose of immediate-release opioids for only the expected duration of pain severe enough to require opioids. More than 7 days is rarely necessary.

References
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3. Peirce GL, Smith MJ, Abate MA, Halverson J. Doctor and Pharmacy Shopping for Controlled Substances. Med Care 2012 Jun;50(6):494-500.
4. NCQA Updates Quality Measures for HEDIS® 2019. NCQA; 2018. Available at https://www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2019. Accessed 10//7/2020.
5. HEDIS 2020, Volume 2. National Committee for Quality Assurance (NCQA).
6. Opioid Morphine Equivalent Conversion Factors. CMS. https://www cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-April-2017.pdf. Accessed 9/23/2020.
7. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

The CalOptima Approved Drug List is available on our website: www.caloptima.org
and for PDA download at www.epocrates.com