



Maine Osteopathic Association in Collaboration with Patient360
2018 QCDR Measures

MOA1: (Measure 1): Objectifying pain and/or functionality to determine manipulative medicine efficacy with correlative treatment adjustment.

NQS Domain: Effective Clinical Care

Measure Type: Outcomes

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: Patients not getting OMT

Denominator Exceptions: Cognitive impairment

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. Successful Reporting: Successful reporting would include a validated QVAS or similarly validated tool showing for pain and functionality show either:
 - a. A two (2) point pain improvement since last clinical encounter with the treating provider or maintenance of a functional improvement greater than or equal to a six (≥ 6).
 - b. If functionality 5 or less and/or pain 7 or more, medical record documentation of treatment change or diagnostic work up is present.
 - c. Failure to document these changes with continued treatment despite lessening functionality and/or increasing pain would result in measure failure.
2. Numerator & Denominator: Numerator data will equal total pain patients receiving manipulative medicine or therapy with a QVAS done with functionality less than or equal to a five (≤ 5) or pain scale greater than or equal to seven (≥ 7) points. Numerator quality data coding options for reporting satisfactorily are Measure #1 4.a. and 4.b. (immediately below) in measure explanation. Denominator will equal patients aged 18-75 years on date of encounter during the reporting period meeting the following ICD and HCPCS codes located in Measure #1.
3. Measure explanation:
 - a. Utilizes Quadruple Visual Analogue Scale (QVAS) or similarly validated tool for pain related patient encounters to assess and document efficacy, functional, clinical and/or pain improvement of at least two points (a two-point reduction to show improvement) or a functionality ≥ 6 to show functional improvement is maintained with current treatment. Pain scale maintained between 4-6 for good control with current treatment regimen and/or a two-point improvement in pain since last visit for treatment with or without treatment adjustments.

If this fails to occur provider changes technique or considers other intervention (i.e.: further diagnostics, referral, injections, prescription medication).

- b. If provider changes manipulative technique at the previous visit he/she uses QVAS at the subsequent visit to assess impact of change in technique or intervention on current pain state where patient's pain is above a 6 on a 0-10 scale with 0 being no pain and 10 greatest pain and/or functionality is < 6 on a 0-10 scale with 10 most and 0 least functional. Pain scale maintained between 4-6 for good control with current treatment regimen and/or a two-point improvement in pain since last visit for treatment with or without treatment adjustments. If this fails to occur provider changes technique or considers other intervention (i.e.: further diagnostics, referral, injections, prescription medication).

4. Treated Areas Assessed: Low Back (Lumbar Spine) and Neck (Cervical Spine)

a. Low Back

- i. P360X01a if done
- ii. P360X01a-1P if medical reason prevented exam
- iii. P360X01a-2P if patient refused or prevented exam
- iv. P360X01a-3P if medical system prevented exam
- v. P360X01a-8P if not done and/or not documented and reason not documented or otherwise specified performance not done.

-OR-

b. Neck

- i. P360X01b if done
- ii. P360X01b-1P if medical reason prevented exam
- iii. P360X01b-2P if patient refused or prevented exam
- iv. P360X01b-3P if medical system prevented exam
- v. P360X01b-8P if not done and/or not and reason not documented or otherwise specified performance not done.

5. ICD Codes:

- a. Biomechanical lesions NEC (M99)
- b. Cervical disc disorder (M50)
- c. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
- d. Dislocation & sprain of joints & ligaments of thorax (S23)
- e. Dorsopathies, deforming (M43)
- f. Enthesopathies, other (M77)
- g. Headache (R51)
- h. Hemarthrosis (M25)
- i. Injuries (S66-T88)
- j. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
- k. Migraine (G43)
- l. M25, Neurologic deficit (R29)
- m. Nerve root and plexus disorders (G54)
- n. Osteoarthritis (M15-M19)
- o. Other disorders of muscle (M62)
- p. Other headache syndromes (G44)
- q. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)

- r. Porphyria (E80)
 - s. Rheumatologic conditions (M05-M14)
 - t. Scoliosis (M41)
 - u. Shoulder lesions (M75)
 - v. Spinal muscular atrophy and related syndromes (G12)
 - w. Spinal stenosis (M99)
 - x. Spondylosis & Spondylopathies, other (M47-M48)
 - y. Strains/sprains: Back (S39), Cervical (S16)
 - z. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - aa. Vasculitis (I77.6)
 - bb. Headache (R51)
6. HCPCS (E.g., CPT): 98925-98929, 98940-98943, 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292 CPT: New/Established E&M; Initial/Subsequent Hospital, Critical Care E&M
7. Rationale:
- a. Pain is by definition subjective. In order to properly assess efficacy of pain treatment objectivity must be obtained in order to determine whether a treatment should be adjusted or maintained. There is no standard diagnostic or clinical test to determine pain severity or even the presence of pain. The utilization of QVAS is the only valid means to objectify pain's subjectivity and the medical literature supports its use and validity in clinical practice. Our related companies have done audits on >50,000 medical records in the last 20 years and QVAS are not standardly used in pain practices (best pain, worst pain, today's pain, sleep and functionality ratings). Determining efficacy of manipulative medicine is often challenging due to the subjectivity of pain improvement. Objectifying subjective experiences as to stability, worsening or improvement of pain and functionality are key to high quality care. Utilization of QVAS allows for objectivity in the determination of outcomes relative to clinical response.
 - i. Manual medicine is dosed and adjusted similarly to a prescription, but is not standardly measured. Pain improvement and/or functional improvement and/or maintenance are excellent measures of clinical efficacy. Studies have shown that appropriate utilization of manipulative medicine can reduce cost and improve functionality. Over-utilization in medicine is both a potential abuse and is expensive costing the US billions of dollars per the IOM. Cost effectiveness of the therapy or treatment is paramount in as much as failed treatment or therapy should not be continued indefinitely. It is expensive and arguably inappropriate. As such, noting and addressing techniques or treatment types that are lacking efficacy in individual patients will eliminate redundant, clinically ineffective methodologies addressing patients who are not responding to certain treatment types and subsequently lower costs by reducing unnecessary care lacking clinical efficacy. Musculoskeletal medical issues cost the United States nearly \$240B/annum. Manual medicine has proven itself effective, but it is not panacea and its clinical efficacy must be monitored, evaluated and re-evaluated.
 - ii. This ability to recognize that which is or is not working allows for better decision-making, improved outcomes and potential cost savings. Maintenance of functionality is equally as important and primary goal of pain treatment similar to insulin for a diabetic or blood pressure medicine for a hypertensive patient; treatment is necessary for disease management,

but cure is not and cannot be anticipated in chronic disease states for which there is no cure. For some patients, the underlying medical condition's chronicity may not warrant cessation or reduction of treatment, but in such instances the documentation of this rationale should be present. QVAS will prove efficacy in pain control and/or functional improvement if not, providers should then appropriately modify clinical care and decision-making.

8. References:

- a. Hawker, GA; Mian, S; Kendzerska, T; French, M; Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Constant Osteoarthritis Pain (ICOAP); *Arthritis Care & Research*; 63(S11). Article first published online: 7 NOV 2011. <http://onlinelibrary.wiley.com/doi/10.1002/acr.20543/pdf>
- b. Hooten, WM; Timming, R; Belgrade, M; Gaul, J; Goertz, M; Haake, B; Myers, C; Noonan, MP; Owens, J; Saeger, L; Schweim, K; Shteyman, G; Walker, N; Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. Updated November 2013. https://www.icsi.org/_asset/bw798b/ChronicPain.pdf
- c. Breivik, H; Borchgrevink, PC; Allen, SM; Rosseland, LA; Romundstad, L; Breivik Hals, EK; Kvarstein, G; Stubhaug, A; *Assessment of Pain*; Br J Anaesth. 2008;101(1): pp. 17-24. http://www.medscape.com/viewarticle/580952_7
- d. Jamison, RN; Serrailier, J; Michna, E; *Assessment and Treatment of Abuse Risk in Opioid Prescribing for Chronic Pain*; Pain Res and Treat; 2011; 2011:941808. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3200070/>
- e. Hass, M; Sharma, R; Stano, M; *Cost-effectiveness of medical and chiropractic care for acute and chronic low back pain*; J Manipulative Physiol Ther; 2005 Oct;28(8):555-63. <http://www.ncbi.nlm.nih.gov/pubmed/16226622>
- f. Hooten, WM; Timming, R; Belgrade, M; Gaul, J; Goertz, M; Haake, B; Myers, C; Noonan, MP; Owens, J; Saeger, L; Schweim, K; Shteyman, G; Walker, N; Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. Updated November 2013. https://www.icsi.org/_asset/bw798b/ChronicPain.pdf
- g. Cruser des, A; Maurer, D; Hensel, K; Brown, SK; White, K; Stoll, ST; *A randomized, controlled trial of osteopathic manipulative treatment for acute low back pain in active duty military personnel*; The Journal of Manual & Manipulative Therapy. 2012; 20(1):5-15. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267441/>
- h. Crow, WT; Willis, DR; *Estimating Cost of Care for Patients with Acute Low Back Pain: A Retrospective Review of Patient Records*; JAOA: Apr 2009; Vol 109; pp. 229-233. <http://jaoa.org/article.aspx?articleid=2093736>

MOA2: (Measure 2): Appropriate use of advanced imaging by ordering provider with glucocorticoid management to spare motor neuron loss when physical findings suggest neuropathic etiology.

NQS Domain: Efficiency & Cost Reduction

Measure Type: High Priority, Process

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: Those without imaging

Denominator Exceptions: Emergency surgery within 24 hours of a STAT advanced imaging study

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. **Successful Reporting:** Successful reporting would include >80% of encounters where advanced imaging was done only subsequent to an Evaluation and Management (E&M) encounter where the physical examination included appropriate and focal neurologic and/or musculoskeletal evaluations that support the imaging study(ies) being ordered. Correlative documentation of an oral corticosteroid (i.e.: prednisone) prescription given in the face of pending advanced diagnostic imaging (i.e.: CT or MRI) when documented symptoms or physical findings warrant utilization AND no contraindications to medications exist. Successful reporting of this measure would be the aforementioned medical record documentation with and at the time of the CPT/ICD combinations noted in the reporting year.
2. **Numerator & Denominator.** Numerator data are patients receiving advanced imaging in the reporting year ordered by the reporting provider. Numerator quality data coding options for reporting satisfactorily are a-e below in measure explanation. Denominator data are patients 18-75 years of age with advanced imaging ordered and diagnoses used in the reporting year under 4.f (ICD codes below) and the patient encounters during the reporting year (CPT or HCPCS) in 4.g below.
3. **Measure explanation:** Neurologic examination and/or focused musculoskeletal examination relative to symptomatic complaints documented prior to ordering MRI or CT Scan of neck or lumbar/lumbosacral spine for low back pain complaint. Corticosteroids/glucocorticoids given for symptomatic radicular pain and/or paresthesias with neurologic examination positive or equivocal, while advanced diagnostic imaging (i.e.: CT or MRI) is pending.
4. **Reporting:**
 - a. P360X02 if done
 - b. P360X02-1P if medical reason prevented exam
 - c. P360X02-2P if patient refused or prevented exam
 - d. P360X02-3P if medical system prevented exam

- e. XP360X02-8P if examine and subsequent treatment not done and/or not documented before MRI/CT or other advanced imaging ordered and reason not documented or otherwise specified why exam not done.
5. ICD Codes:
- a. Biomechanical lesions NEC (M99)
 - b. Cervical disc disorder (M50)
 - c. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
 - d. Dislocation & sprain of joints & ligaments of thorax (S23)
 - e. Dorsopathies, deforming (M43)
 - f. Enthesopathies, other (M77)
 - g. Headache (R51)
 - h. Hemarthrosis (M25)
 - i. Injuries (S66-T88)
 - j. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - k. Migraine (G43)
 - l. Nerve root and plexus disorders (G54)
 - m. Neurologic deficit (R29)
 - n. Osteoarthritis (M15-M19)
 - o. Other disorders of muscle (M62)
 - p. Other headache syndromes (G44)
 - q. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - r. Porphyria (E80)
 - s. Rheumatologic conditions (M05-M14)
 - t. Scoliosis (M41)
 - u. Shoulder lesions (M75)
 - v. Spinal muscular atrophy and related syndromes (G12)
 - w. Spinal stenosis (M99)
 - x. Spondylosis & Spondylopathies, other (M47-M48)
 - y. Strains/sprains: Back (S39), Cervical (S16)
 - z. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - aa. Vasculitis (I77.6)
 - bb. Dislocation and sprain of joints and ligaments of thorax (S23)
6. HCPCS (e.g., CPT): 98925-98929, 98940-98943, 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292 CPT: New/Established E&M; Initial/Subsequent Hospital, Critical Care E&M
7. Rationale: Advanced imaging has been implicated in the escalating cost of care while not always improving quality. Appropriate clinical evaluations are key to knowing when and what areas may need advanced imaging to identify pathology and determine most appropriate treatment options. Poor decision-making or gestalt driven diagnostic testing increases cost, decreases quality and can negatively impact clinical outcomes. Corticosteroids provide excellent symptomatic relief in acute disc herniations and/or neuro-compressive pathology and can be motor neuron sparing while the most appropriate diagnostic and therapeutic interventions are being determined. This therapy, while inexpensive in and of itself, can have costly complications to patients necessitating potentially avoidable treatment (i.e.: GI complications, Permanent or Temporary Adrenal Dysfunction,

Osteoporosis/Osteopenia and related complications) and irreversible and potentially life threatening complications. Conservative and appropriate utilization of glucocorticoids is an important part of musculoskeletal and pain medicine.

8. References:

- a. Chou, R; Qaseem, A; Owens, DK; Shekelle, P; Diagnostic Imaging for Low Back Pain: Advice for High-Value Health Care From the American College of Physicians; Ann Intern Med. 2011;154:181-189. <http://annals.org/article.aspx?articleid=746774>
- b. Hollingsworth, W; Gray, DT; Martin, BI; Sullivan, SD; Deyo, RA; Jarvik, JG; Rapid Magnetic Resonance Imaging for Diagnosing Cancer Related Low Back Pain; J Gen Intern Med. 2003 Apr; 18(4): 303–312. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494841/>
- c. Arts, MP; Brand, R; van den Akker, E; Koes, BW; Peul, WC; The NEtherlands Cervical Kinematics (NECK) Trial. Cost-effectiveness of anterior cervical discectomy with or without interbody fusion and arthroplasty in the treatment of cervical disc herniation; a double-blind randomised multicenter study; BMC Musculoskeletal Disorders; 2010; 11:122; DOI: 10.1186/1471-2474-11-122. <http://bmcmsculoskeletdisord.biomedcentral.com/articles/10.1186/1471-2474-11-122>
- d. Holve, RL; Barkan, H; Oral Steroids in the Initial Treatment of Acute Sciatica; J Am Board Fam Med; September-October 2008 vol. 21 no. 5 469-474. <http://www.jabfm.org/content/21/5/469.full>
- e. Goldbirg, H *et al*; Oral Steroids for Acute Radiculopathy Due to a Herniated Lumbar Disc: a Randomized Clinical Trial; JAMA; 2015 May 19;313(19):1915-23. <http://www.ncbi.nlm.nih.gov/pubmed/25988461>
- f. Ghasemi, M; Masaeli, A; Rezvani, M; Shaygannejad, V; Golabchi, K; Norouzi, R; Oral prednisolone in the treatment of cervical radiculopathy: A randomized placebo controlled trial; Journal of Research in Medical Sciences : The Official Journal of Isfahan University of Medical Sciences. 2013;18(Suppl 1):S43-S46. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3743318/>
- g. Liu, D; Ahmet, A; Ward, L; Krishnamoorthy, P; Mandelcorn, EF; Leigh, R; Brown, JP; Cohen, A; Kim, H; A practical guide to the monitoring and management of the complications of systemic corticosteroid therapy; Allergy Asthma Clin Immunol. 2013 Aug 15;9(1):30. <https://www.ncbi.nlm.nih.gov/pubmed/23947590>

MOA7 (Measure 7): Appropriate controlled substance prescribing (definitive diagnosis(es)) via adherence to Controlled Substance Agreements (CSA) or (OA's) with corrective action taken for pain and/or substance use disorder patients when violations occur.

NQS Domain: Patient Safety

Measure Type: Outcomes

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: Not on controlled meds

Denominator Exceptions: No CSA or OA in place at time of UDS or no violations

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. Successful Reporting:
 - a. Documentation of definitive pathology (e.g., imaging, surgical report, serology, provider referral for addiction/substance use disorder, etc.) to warrant chronic pain and/or buprenorphine/naloxone medication chronically.
 - b. Provider must document signing of a Controlled Substance (CSA) or Opiate Agreement (OA) if more than two (2) Schedule II controlled substance prescriptions are provided to a patient in a 12-month period. Understandably, prescriptions may occur in the prior reporting year as well as in the current reporting year.
 - c. For all patients violating existing CSA/OA, such violations are documented with correlative adjustments in treatment (e.g.: shorter duration prescriptions (2 week to 4 week), increased frequency of urine drug screens (quarterly to monthly), random pill counts, more frequent visits, etc.).
2. Numerator & Denominator. Numerator data are patients aged 18 and above with documented definitive pathology of ICD data below. Denominator data are all patients aged 18 and above with any combination of the ICD and HCPCS data defined in this section 3, below.
3. Measure explanation: Chronic Pain medication prescribed (prescribed for greater than one week or more than twice a year) only after a diagnosis and medical or surgical plan has been implemented. CSA or OA followed and, if actionable violation (i.e.: Urine Drug Screen inappropriate, pill counts off, multiple providers prescribing, polypharmacy, etc.) corrective action taken (i.e.: probation, escalated use of Urine Drug Screens, shorter prescriptions intervals, termination of controlled prescribing or similar actions) as result of the CSA/OA violation.
 - a. P360X03 if done
 - b. P360X03-1P if medical reason prevented diagnostic findings, CSA/OA policy adherence
 - c. P360X03-2P if patient refused diagnostic work-up, CSA/OA
 - d. P360X03-3P if medical system prevented diagnostic findings, CSA/OA policy adherence

- e. P360X03-8P if not done and/or not documented what the patient's definitive diagnosis is, CSA/OA not in chart or reason not documented or otherwise specified why it was not documented.
4. ICD Codes: Biomechanical Lesions NEC (M99)
- a. Cervical disc disorder (M50)
 - b. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
 - c. Dislocation & sprain of joints & ligaments of thorax (S23)
 - d. Dorsopathies, deforming (M43)
 - e. Cervical disc disorder (M50)
 - f. Enthesopathies, other (M77)
 - g. Headache (R51)
 - h. Injuries (S66-T88)
 - i. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - j. Migraines (G43)
 - k. Nerve root and plexus disorders (G54)
 - l. Neurologic deficit (R29)
 - m. Osteoarthritis (M15-M19)
 - n. Other headache syndromes (G44)
 - o. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - p. Porphyria (E80)
 - q. Rheumatologic conditions (M05-M14)
 - r. Scoliosis (M41)
 - s. Spinal muscular atrophy and related syndromes (G12)
 - t. Spinal stenosis (M99)
 - u. Spondylosis & Spondylopathies, other (M47-M48)
 - v. Strains/sprains: Back (S39), Cervical (S16)
 - w. Shoulder lesions (M75)
 - x. Somatic dysfunction (M99)
 - y. Substance Use Disorders (F10-19)
 - z. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - aa. Vasculitis (I77.6)
5. HCPCS (e.g., CPT): 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292 CPT: New/Estab E&M; Initial/Subsequent
6. Rationale: *Primum non nocere*—first do no harm is a mantra echoed in virtually every medical school and medical training environment. In an effort to alleviate pain, many providers move to pain medication to acutely manage pain and before long this treatment becomes chronic. To well manage pain patients, clear diagnoses must be made, definitive treatment options considered and a comprehensive medical and/or surgical management plan considered. Patients should *not* be placed on chronic pain medication indefinitely without a clear diagnosis of what is being treated and, more importantly determine if the issue at hand could have a definitive treatment option. Unfortunately, many medical conditions are chronic. Like diabetes, hypertension, coronary disease and other chronic conditions, chronic pain conditions are also common.

Chronic pain conditions span the spectrum from porphyrias to osteoarthritis, from spinal stenosis to recurrent renal colic or even from rheumatoid arthritis to multiple sclerosis related pain. More

challenging is that each patient experiencing any of these disease states suffers from them and deals with the associated pain quite differently. Irrespective of how the pain is managed, a clear diagnosis(es) is paramount to determine appropriate treatment or, in some instances, discontinuation of treatment and what options are available to manage the medical conditions at hand.

Use of CSA/OA are paramount to full transparency on the part of patients and providers. There has been an increase in the prevalence of controlled substance diversion and untoward medical outcomes escalating the last fifteen years. As political, medical and media focus on opiate/opioid and other controlled substance utilization state and federal authorities as well as local, state, regional and national medical societies are working to better manage and attempt to control and regulate controlled substances. Toward this end having controlled substance agreements (CSA) or opiate agreements (OA) necessitate patient and provider compliance with them. Actionable consequences to violations are paramount to impacting the number of prescriptions and amount of controlled substances making it out of a practice where potential illicit activity.

By adhering to and implementing the penal components for CSA/OA violations, legitimate, therapeutic prescribing should be achieved. To not do so will put their patients and their practices in jeopardy as well put their communities at risk for increased levels of illicit activity and/or diversion directly stemming from their practices not following the protocols and rules outlined within these agreements. While these agreements are not full proof at halting diversion, they are very much part of front line medicine in pain and psychiatric care utilizing any number of controlled substances for therapeutic purposes.

7. References:

- a. Thorson, B; Biewen, P *et al*; Institute for Clinical Systems Improvement. Acute Pain Assessment and Opioid Prescribing Protocol. Published January 2014.
<https://www.icsi.org/asset/dyp5wm/Opioids.pdf>
- b. Kaye AD, Baluch A, Scott JT; Pain Management in the Elderly Population: A Review; The Ochsner Journal; 2010;10(3):179-187. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096211/>
- c. Smith, BH; Hopton, JL; Chambers, WA; Chronic pain in primary care; Family Practice; 1999; 16:475–482. <http://fampra.oxfordjournals.org/content/16/5/475.full>
- d. Rosenblum, A; Marsch, LA; Joseph, H; Portenoy, RK; Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions; Experimental and clinical psychopharmacology; 2008;16(5):405-416. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711509/>
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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3200070/> Willis, DR; Eaton, G; MacKie, P; Using the recurring-calendar-event function in Microsoft Outlook, this practice created a systematic approach that ensures patient refills on the day they're due; Fam Pract Manag. 2010 Nov-Dec;17(6):22-27.
<http://www.aafp.org/fpm/2010/1100/p22.html>
- f. Dhalla, IA; Mamdani, MM; Sivilotti, MLA; Kopp, A; Qureshi, O; Juurlink, DN; Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone; CMAJ; 2009;181(12):891-896. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2789126/>
- g. Drug Enforcement Agency's (DEA) CSA/OA for provider use speaking to their position on its importance: <http://www.deacom.gov/prints/abagr.html>

- h. Jamison, RN; Serrailier, J; Michna, E; *Assessment and Treatment of Abuse Risk in Opioid Prescribing for Chronic Pain*; Pain Res and Treat; 2011; 2011:941808.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3200070/>

MOA12 (Measure 12): Treatment of spinal stenosis with manipulative medicine and alternative medicine modalities.

NQS Domain: Patient Safety

Measure Type: Outcomes

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: No spinal stenosis, no acupuncture

Denominator Exceptions: None

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. **Successful Reporting:** Successful reporting would include a validated QVAS or similarly validated tool showing for pain and functionality show a two (2) point pain improvement since last clinical encounter with the treating provider or maintenance of a functional improvement greater than or equal to a six (>6). If functionality 5 or less and/or pain 7 or more, medical record documentation of treatment change or diagnostic work up is present. Failure to document these changes with continued treatment despite lessening functionality and/or increasing pain would result in measure failure. Providers would be providing manual medicine in addition to non-traditional, but literature proven alternative medicine modalities (i.e.: acupuncture) with patients who have imaging confirmed spinal stenosis (M99 ICD-10 Code).
2. **Numerator & Denominator:** Numerator data will equal total imaging confirmed spinal stenosis (M99) patients receiving manipulative medicine or therapy for this complaint that was inadequate at providing pain relief and necessitated the addition of an alternative medicine therapy (i.e.: acupuncture) during the reporting period. As such patients with a QVAS done with functionality less than or equal to a five (≤ 5) or pain scale greater than or equal to seven (≥ 7) points would be candidates for this measure. Numerator quality data coding options for reporting satisfactorily are below. Denominator will equal patients aged 18-75 years with date of encounter during the reporting period meeting the following ICD (must contain M99) and HCPCS codes located below.
3. **Measure explanation:** Spinal stenosis typically is conservatively managed until surgical fusion or foraminotomy is necessitated based upon pain or neuropathic progression necessitating spinal fusion and/or foraminotomy. These surgeries carry risk to the patient and major expense to the system. Moreover, once a spinal fusion occurs, typically the areas above and/or below this area are fused in another 5-10 years. Avoiding the initial surgery is the only means to avoid subsequent surgeries and the associated risks and costs. Manipulative medicine combined with alternative medical therapies have been shown to improve pain and avoid surgical intervention, thus, this measure is designed to report such treatment.
 - a. P360X09 if done
 - b. P360X09-1P if medical reason prevented exam
 - c. P360X09-2P if patient refused or prevented exam
 - d. P360X09-3P if medical system prevented exam
 - e. P360X09-8P if not done and/or not documented and reason not documented or otherwise specified why an opiate agreement or controlled substance agreement was not done.

4. ICD Codes:
 - a. Biomechanical lesions NEC (M99)
 - b. Cervical disc disorder (M50)
 - c. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
 - d. Dislocation & sprain of joints & ligaments of thorax (S23)
 - e. Dorsopathies, deforming (M43)
 - f. Enthesopathies, other (M77)
 - g. Headache (R51)
 - h. Injuries (S66-T88)
 - i. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - j. Migraines (G43)
 - k. Nerve root and plexus disorders (G54)
 - l. Neurologic deficit (R29)
 - m. Osteoarthritis (M15-M19)
 - n. Other headache syndromes (G44)
 - o. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - p. Porphyria (E80)
 - q. Rheumatologic conditions (M05-M14)
 - r. Scoliosis (M41)
 - s. Shoulder lesions (M75)
 - t. Spinal muscular atrophy and related syndromes (G12)
 - u. Spinal stenosis (M99)
 - v. Spondylosis & Spondylopathies, other (M47-M48)
 - w. Strains/sprains: Back (S39), Cervical (S16)
 - x. Somatic dysfunction (M99)
 - y. Substance Use Disorders (F10-19)
 - z. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - aa. Vasculitis (I77.6)
 - bb. Weakness of muscle (M62)

5. HCPCS (E.g., CPT): 97140, 99201-99205, 99211-99215, 99221-99223, 99231-99233, 98925-98929, 98940-98943 and 99291-99292

6. Rationale: Spinal stenosis is challenging and costly to treat. A recent study looking at 3,900 spinal stenosis patients concluded costs on a quality adjusted life year (QALY) to be \$77,000 for a spinal laminectomy and \$115,000 for spinal fusion. In the United States, cost effectiveness caps at \$100,000 QALY and each surgery can cost upwards of \$70,000. Pharmaceutical management coupled with other conservative treatment including interventional injections and manipulative medicine are often effective at controlling pain and improving functionality while avoiding surgery. Some alternative medicine therapies when added to manipulative medicine and other conventional treatment options have successfully treated these patients such that surgery is no longer their only option to attempt to achieve pain control and improved functionality. Moreover, most patients who have spinal fusion often are candidates for repeat procedures in a relatively short time frame after the initial procedure as spinal mechanics simply erode the vertebral facets above and below the surgical site due to compromised biomechanics. Manual medicine, pharmacologic treatment with alternative medicine modalities (i.e.: acupuncture) have been shown to improve outcomes, reduce surgical intervention subsequently avoiding surgical risk and associated costs. By measuring a provider's ability to utilize all the tools at his/her hands, optimal outcomes may be achieved and surgical intervention avoided.

7. References:

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- c. Stuber K, Sajko S, Kristmanson K. Chiropractic treatment of lumbar spinal stenosis: a review of the literature. *Journal of Chiropractic Medicine.* 2009;8(2):77-85. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2780929/>
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MOA13 (Measure 13): Urine Drug Screen Utilization in Pain Management and Substance Use Disorders; no less than quarterly for pain and no less than monthly for substance use disorders.

NQS Domain: Patient Safety

Measure Type: Process, High Priority

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: No OA/CSA in place

Denominator Exceptions: None

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. **Successful Reporting:** Provider must document signing of a Controlled Substance Agreement (CSA) or Opiate Agreement (OA) if more than two (2) Schedule II controlled substance prescriptions are provided to a patient in a 12-month period. Understandably, prescriptions may occur in the prior reporting year as well as in the current reporting year. Documented urine drug screens (UDS) performed no less than quarterly on all pain patients and monthly for all substance use disorder patients with documented evidence of additional UDS if suspected diversion, illicit activity, or other red flags noted during the reporting year. Failure to perform the above frequency of UDS at a minimum, results in failure of this measure. Additionally, failure to increase regulatory scrutiny for red flags, diversion and/or illicit behavior (i.e.: problematic urines or pill counts) in the form of increased performance of urine drug screens via probationary periods and/or shorter prescribing periods and/or pill counts will result in measure failure.
2. **Numerator & Denominator.** Numerator data are patients aged 18 and above with a documented Controlled Substance or Opiate Agreement. Denominator data are all patients having received two (2) or more Schedule II controlled substances in (or around) the reporting period with the combination of HCPCS and ICD data detailed below.
3. **Measure explanation:** Controlled substance agreement (CSA) or opiate agreement (OA) utilized on all patients received greater than two Schedule II controlled substance prescriptions in a 12-month period.
 - a. P360X04 if done
 - b. P360X04-1P if medical reason prevented exam
 - c. P360X04-2P if patient refused or prevented exam
 - d. P360X04-3P if medical system prevented exam
 - e. P360X04-8P if not done and/or not documented and reason not documented or otherwise specified why an opiate agreement or controlled substance agreement was not done.

4. ICD Codes:
 - a. Biomechanical lesions (M99)
 - b. Cervical disc disorder (M50)
 - c. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
 - d. Dislocation & sprain of joints & ligaments of thorax (S23)
 - e. Dorsopathies, deforming (M43)
 - f. Enthesopathies, other (M77)
 - g. Headache (R51)
 - h. Injuries (S66-T88)
 - i. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - j. Migraines (G43)
 - k. Nerve root and plexus disorders (G54)
 - l. Neurologic deficit (R29)
 - m. Osteoarthritis (M15-M19)
 - n. Other headache syndromes (G44)
 - o. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - p. Porphyria (E80)
 - q. Rheumatologic conditions (M05-M14)
 - r. Scoliosis (M41)
 - s. Shoulder lesions (M75)
 - t. Spinal muscular atrophy and related syndromes (G12)
 - u. Spinal stenosis (M99)
 - v. Spondylosis & Spondylopathies, other (M47-M48)
 - w. Strains/sprains: Back (S39), Cervical (S16)
 - x. Somatic dysfunction (M99)
 - y. Substance Use Disorders (F10-19)
 - z. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - aa. Vasculitis (I77.6)
 - bb. Weakness of muscle (M62)
5. HCPCS (E.g., CPT): 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292

6. Rationale: Unarguably there has been an increase in the prevalence of controlled substance diversion and untoward medical outcomes over the last fifteen years. With the political, medical and media focus on opiate/opioid and other controlled substance utilization state and federal authorities as well as local, state, regional and national medical societies are working to better manage and attempt to control and regulate controlled substances. One tool in this process is a controlled substance agreement (CSA) or opiate agreement (OA) to make clear the patient's responsibilities, the provider's responsibilities and the rules governing the overall relationship.

In order to protect the patient and the providers working with controlled substances and to preserve the availability of these medications for those legitimately needing these therapeutic agents, CSAs and OAs are critical in this relationship as is adherence to them by patients and providers. Providers writing controlled substances on a chronic basis while not utilizing and adhering to CSA/OA are not practicing contemporary medicine. Furthermore, they put their patients and practices in jeopardy as well put their communities at risk for increased levels of illicit activity and/or diversion directly stemming from their

practices not following the protocols and rules outlined within these agreements. While these agreements are not full proof at halting diversion, they are very much part of front line medicine in pain and psychiatric care utilizing any number of controlled substances for therapeutic purposes.

Urine drug screens (UDS) are an integral part of any practice providing pain and/or substance use disorder treatment and management with buprenorphine or buprenorphine like and/or related products. While not uniformly used to detect diversion and other potential illicit activity until the last several years, they are now part of a multidisciplinary approach to patient care along with opiate agreements, controlled substance agreements, random pill counts and prescription monitoring programs. These multifaceted approaches are designed prevent illicit utilization and diversion, but equally if not more importantly prove adherence and appropriate utilization by patients needing controlled substances to manage substance use disorders and other psychiatric conditions. As such, practices must use regular and random screening methods to detect and verify medication compliance and screen for potential illicit behavior as part of a multifaceted approach to prevent diversion and prove licit behavior.

The urine drug screens should include enzyme immunoassay (EIA) point of care testing at the time of visit, EIA screening and subsequent gas and/or liquid chromatographic analytics (LCMS/GCMS) to confirm compliance as well as detect potential illicit activity via metabolite concentration levels of prescribed and illicit utilization. The incidence of false positive and false negatives make each level of testing (E.g.: point of care, EIA chemistry and LCMS/GCMS) necessary to have immediate results that are actionable along with more accurate and detailed results from subsequent to confirm compliance as well as detect and correct noncompliance and/or illicit utilization. Substance use disorder population is by definition high risk making hyper-vigilant risk management paramount. However, diversion happens in pain practices as well so standard risk mitigation strategies including CSA/OA, pill counts and UDS are equally as important in these groups of patients.

7. References:

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MOA14 (Measure 14): Addressing anxiety in pain patients with SNRI and SSRIs and reducing/eliminating benzodiazepines for chronic anxiety.

NQS Domain: Patient Safety

Measure Type: Outcomes

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: No anxiety dx or symptoms

Denominator Exceptions: Psychiatrist documentation of medical necessity for benzodiazepine over SNRI/SSRI

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psychiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. Successful Reporting: Chronic pain patients with anxiety symptoms will be provided an SNRI/SSRI prescription and not acutely given benzodiazepines as documented in the medical record and medication list. Patients with chronic pain on benzodiazepines will have those drugs serially weaned and replaced by SNRI/SSRI agents unless a defined anxiety syndrome exists, is documented by a psychiatric provider and this comorbid state is verified.
2. Numerator & Denominator. Numerator data are patients aged 18 and above with a documented complaint of or diagnosis of anxiety or sleep disorder and be provided SSRI/SNRI agents in lieu of benzodiazepines. If on benzodiazepines, these will be serially weaned unless a documented diagnosis of an anxiety syndrome exists from a psychiatric provider, and treated with SNRI/SSRI agents.
3. Measure explanation: Benzodiazepines are implicated in polypharmacy overdose deaths and are often prescribed for sleep or anxiety symptoms. Pain patients typically have deficits in serotonin (5-HT) and norepinephrine (NE) secondary to pain chronicity and physiologic response. NE and 5-HT block pain in the ascending spine and deficiencies are associated with increased pain and the primary presenting symptom of 5-HT deficiency is anxiety. As such, appropriate management warrants utilization of SNRI/SSRI agents in this setting in lieu of benzodiazepines.
 - a. P360X07 if done
 - b. P360X07-1P if medical reason prevented exam
 - c. P360X07-2P if patient refused or prevented exam
 - d. P360X07-3P if medical system prevented exam
 - e. P360X07-8P if not done and/or not documented and reason not documented or otherwise specified why an opiate agreement or controlled substance agreement was not done.
4. ICD Codes:
 - a. Anxiety (F41)
 - b. Biomechanical Lesions NEC (M99)
 - c. Cervical disc disorder (M50)
 - d. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)

- e. Dislocation & sprain of joints & ligaments of thorax (S23)
 - f. Dorsopathies, deforming (M43)
 - g. Enthesopathies, other (M77)
 - h. Headache (R51)
 - i. Injuries (S66-T88)
 - j. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - k. Migraines (G43)
 - l. Nerve root and plexus disorders (G54)
 - m. Neurologic deficit (R29)
 - n. Osteoarthritis (M15-M19)
 - o. Other headache syndromes (G44)
 - p. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - q. Porphyria (E80)
 - r. Rheumatologic conditions (M05-M14)
 - s. Scoliosis (M41)
 - t. Shoulder lesions (M75)
 - u. Sleep Disorder (G47)
 - v. Spinal muscular atrophy and related syndromes (G12)
 - w. Spinal stenosis (M99)
 - x. Spondylosis & Spondylopathies, other (M47-M48)
 - y. Strains/sprains: Back (S39), Cervical (S16)
 - z. Somatic dysfunction (M99)
 - aa. Substance Use Disorders (F10-19)
 - bb. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - cc. Vasculitis (I77.6)
 - dd. Weakness of muscle (M62)
5. HCPCS (E.g., CPT): 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292
6. Rationale: Escalation of controlled substances has led to increasing numbers of deaths nationally due to suppression of the central nervous systems by multiple agents including, but not limited to opiates/opioids, benzodiazepines, and ethanol, to name the more notable chemicals involved. Benzodiazepines are excellent skeletal muscle relaxants and can help in acute anxiety situations, but they can lead to rapid physical dependence and tolerance if chronically used. Well-meaning providers often give these agents for anxiety symptoms, when in fact the majority of anxiety symptomatology is secondary to 5-HT deficiency. In chronic pain patients, the reduction of systemic 5-HT and NE is well established and several FDA approved products are not even approved for depression or anxiety, but for pain. This speaks to the clear pattern in the medical community that these agents can help pain, but they can also help anxiety as several SSRI agents are specifically indicated for generalized anxiety disorder (GAD). As such, 5-HT agents, rather than benzodiazepines, should be a first line option for chronic pain patients who develop or are currently being treated for anxiety. Benzodiazepines cannot be abruptly stopped as that can be life threatening as this can precipitate epileptic cerebral activity. Thus, weaning doses must be done. In some instances and in patients with authenticated diagnostic evidence of GAD or similar diagnoses by a psychiatric provider benzodiazepines may be medically appropriate and necessary. Verification by a psychiatric provider is imperative both to improve patient care via a second opinion and to explore the possibility that other, safer agents may be a consideration for these patients.

7. References:

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- c. Jones JD, Mogali S, Comer SD; Polydrug abuse: A review of opioid and benzodiazepine combination use; *Drug and alcohol dependence*. 2012;125(1-2):8-18. doi:10.1016/j.drugalcdep.2012.07.004. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3454351/>
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MOA15 (Measure 15): Weight loss in pain patients with BMI \geq 30 with opiate utilization for weight related pain conditions rather than opiate dose escalation for improved pain control.

NQS Domain: Patient Safety

Measure Type: Outcomes

Inverse Measure: No

Proportional Measure: Yes

Continuous Variable Measure: No

Ratio Measure: No

Denominator Exclusions: No CSA or CSA & BMI \geq 30

Denominator Exceptions: None

Numerator Exclusions: None

Data Source: PM, EHR or EMR, other

Applicable Specialty/Specialties: Osteopathy, psysiatry, physical medicine & rehabilitation (PM&R), pain, orthopedics, anesthesia, chiropractic, occupational/physical therapy, and podiatry.

1. Successful Reporting: In chronic pain patients with weight related or weight exacerbated pain conditions (i.e.: DJD, DDD, Hip Pain/OA, Knee Pain/OA, Foot/Ankle Pain/OA, Pes Planus related plantar fasciitis) BMI will be documented and monitored at scheduled visits with serial reduction in BMI over the reporting period with correlative dose reduction (24 hour MME) of opiate/opioid therapy.
2. Numerator & Denominator. Numerator data are patients aged 18 and above with a BMI \geq 30 on opiates/opioids for chronic pain related to weight related pain conditions or pain conditions exacerbated by obesity with documented weight loss and BMI reduction AND dose reduction (24 hour MME) documented. Denominator data are patients who 18 age and older on chronic opiate therapy with BMI \geq 30 with weight related or weight exacerbated pain conditions.
3. Measure explanation: Pain conditions that can be treated definitively to avoid or cease opiate/opioid utilization should engage such treatment. Obesity, if causally related to pain, disease progression, and/or the major etiologic event must be addressed. Dose escalation for BMI escalation or maintenance is harmful and potentially dangerous to patients categorized as obese due to respiratory suppression and opiate/opioid related systemic endocrine dysfunction. Obesity is treatable. Pain medication may be needed initially help patients exercise and function to address pain in both weight bearing and non-weight bearing joints affected by obesity. However, weight reduction should eventually reduce opiate need and dosing if monitored, addressed and treated as part of comprehensive pain management.
 - a. P360X08 if done
 - b. P360X08-1P if medical reason prevented exam
 - c. P360X08-2P if patient refused or prevented exam
 - d. P360X08-3P if medical system prevented exam
 - e. P360X08-8P if not done and/or not documented and reason not documented or otherwise specified why an opiate agreement or controlled substance agreement was not done.
4. ICD Codes:
 - a. Biomechanical lesions NEC (M99)
 - b. Cervical disc disorder (M50)
 - c. Dislocation & sprain of joints & ligaments of shoulder girdle (S43)
 - d. Dislocation & sprain of joints & ligaments of thorax (S23)

- e. Dorsopathies, deforming (M43)
 - f. Enthesopathies, other (M77)
 - g. Headache (R51)
 - h. Injuries (S66-T88)
 - i. Injury of muscle, fascia, & tendon at shoulder & upper arm level (S46)
 - j. Migraines (G43)
 - k. Nerve root and plexus disorders (G54)
 - l. Neurologic deficit (R29)
 - m. Obesity (E66)
 - n. Osteoarthritis (M15-M19)
 - o. Other headache syndromes (G44)
 - p. Pain: Back & Radiculopathy (M54), Chronic (including Cancer; G89), Joint (M25), & Limb (M79)
 - q. Porphyria (E80)
 - r. Rheumatologic conditions (M05-M14)
 - s. Scoliosis (M41)
 - t. Shoulder lesions (M75)
 - u. Sleep apnea (G47 & P28)
 - v. Spinal muscular atrophy and related syndromes (G12)
 - w. Spinal stenosis (M99)
 - x. Spondylosis & Spondylopathies, other (M47-M48)
 - y. Strains/sprains: Back (S39), Cervical (S16)
 - z. Somatic dysfunction (M99)
 - aa. Substance Use Disorders (F10-19)
 - bb. Thoracic, thoracolumbar, & lumbosacral intervertebral disc disorders (M51)
 - cc. Vasculitis (I77.6)
 - dd. Weakness of muscle (M62)
5. HCPCS (E.g., CPT): 99201-99205, 99211-99215, 99221-99223, 99231-99233, and 99291-99292
6. Rationale: Obesity is a significant medical condition in the United States, such that the ICD-CM coding system published new BMI codes for utilization in the United States. Many pain conditions are worsened due to gravitational compression from excess weight and possibly an emerging neuroendocrine relationship. These conditions are often symptomatically improved with normalization of weight to a BMI that is less than thirty (≤ 30) or below the obese threshold. However, osteoarthritis and degenerative disc disease are overtly worsened with BMI greater than or equal to thirty (≥ 30); particular pathologic focus for these disease states with weight related causation and exacerbation can be found in the lumbosacral region and the lower extremities and hands. NSAIDS, due to their massive side effect profile, are not well tolerated for extended periods. Subsequently, many chronic pain patients with obesity related pain conditions are placed on opiate therapy despite evidence that some elements of their pain could be addressed with weight loss that would improve pain and functionality. More concerning is the risk to obese patients on opiate therapy that sleep apnea, coupled with the central nervous system suppression of chronic opiate therapy could be damaging to their nighttime oxygenation with systemic sequelae and ramifications. Toward this end, reducing weight rather than escalating doses of pain medicine makes the most medical sense for these patients.

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