Expert to Expert Webinar: Annual Updates for Safe Use of Opioids – Concurrent Prescribing eCQM for 2026 Reporting Year

Questions and Answers *Broadcast March 26, 2026*

Question	Answer
What is the goal (%)?	There is currently no national benchmark for this measure. Hospitals can compare their performance results to the national average and national top 10% performance rates available on Care Compare in the downloadable Hospital Timely and Effective Care National file. (https://data.cms.gov/provider-data/search?fulltext=timely%20and%20effective%20care&theme=Hospitals)
What is the benchmark for this measure?	There is currently no national benchmark for this measure. Hospitals can compare their performance results to the national average and national top 10% performance rates available on Care Compare in the downloadable Hospital Timely and Effective Care National file. (https://data.cms.gov/provider-data/search?fulltext=timely%20and%20effective%20care&theme=Hospitals)
Where can I find national performance on eCQM measures?	National and state average performance rates are available on Care Compare under Timely and Effective Care. (https://data.cms.gov/provider-data/search?fulltext=timely%20and%20effective%20care&theme=Hospitals) Individual hospitals' performance results are available in the Timely and Effective Care - Hospital data download from the CMS Care Compare provider data sets for hospitals at https://data.cms.gov/provider-data/.
How often is this measured and submitted?	The measurement period for Safe Use of Opioids is January 1 through December 31. Data is submitted for this measure annually. Guidance for reporting can be found at https://qualitynet.cms.gov/inpatient/measures/ecqm/participation.
What is the difference between the QRDA I and QRDA III for submitting the Safe Use of Opioids measure?	QRDA I files are individual-patient-level data reports. It contains quality data for one patient for one or more eCQMs and are used for eligible hospital reporting. QRDA III files are aggregate summary-level performance data reports for a set of patients that contain quality data for a set of patients for one or more eCQMs and are primarily used for eligible clinician reporting. For additional information, the CMS QRDA I and QRDA III Implementation Guides can be found on the eCQI Resource Center at https://ecqi.healthit.gov/qrda/versions.
What EHR tools in Epic are currently available to help improve this eCQM metric?	We encourage you to work with your EHR vendor to determine what tools are available to improve on the Safe Use of Opioids eCQM.
To confirm - the patient encounter will still qualify for the measure even if they expire after discharge?	Encounters are excluded if the patient expires during the inpatient stay where their inpatient encounter has a discharge disposition or status on their day of discharge of “Patient Expired”; "Discharge To Acute Care Facility"; "Hospice Care Referral or Admission" or "Left Against Medical Advice".
Is there a goal for CY26 or one planned for the future and how does this new eCQM affect CMS Star Ratings?	There currently is no goal for CY2026. Safe Use of Opioids contributes to CMS Star Ratings because it is one of the 13 Timely and Effective Care measures along with up to 34 other measures whose performance is used in calculating the CMS Star Ratings. We are not able to comment on how it contributes or to what degree it contributes because this may vary based on numerous factors. For more information about Star Ratings you can go to the Overall hospital quality star rating page on the CMS provider data catalog at https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/.
When can we expect a benchmark to be announced for this measure? And will sickle cell patients be eventually excluded?	There are no plans to establish a benchmark for this measure at this time. Patients with Sickle Cell disease are excluded from this measure as of version 7 for the 2025 reporting period which can be found here: https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS506v7.html.

Question	Answer
Just to clarify- Safe Use of Opioids is required by CMS for 2026 correct? I thought I heard they weren't accepting but maybe that was TJC?	This is a required eCQM for CMS for reporting year 2026. Joint Commission is not accepting data for this eCQM for 2026.
Are patients discharged to inpatient psych or inpatient rehab excluded from the measure as 'discharged to acute care facility'?	No. Patients discharged to inpatient psychiatric or rehabilitation facilities are not excluded under "discharged to acute care facility." The Denominator Exclusion applies only to discharges captured in the value set "Discharge To Acute Care Facility" (OID: 2.16.840.1.113883.3.117.1.7.1.87), which includes acute care hospitals such as community or tertiary hospitals . This value set currently includes the following SNOMED codes: 306701001 (Discharge to community hospital), 306703003 (Discharge to tertiary referral hospital), and 434781000124105 (Discharge to acute care hospital). Inpatient Rehabilitation Facility and psychiatric hospitals are generally specialized, distinct facilities that do not fall under the CMS definition of acute care hospital.
The patient has to have a Cancer related pain diagnosis, not just a cancer diagnosis?	Yes. The Denominator Exclusion is specifically tied to Cancer Related Pain, not a cancer diagnosis alone. The measure requires documentation of a diagnosis from the "Cancer Related Pain" value set (OID: 2.16.840.1.113762.1.4.1111.180), and the logic looks for that diagnosis overlapping the inpatient encounter.
What constitutes as a patient receiving palliative or hospice care during the encounter?	A patient is considered to be receiving palliative or hospice care if there is documentation of an order or receipt of these services using the QDM datatypes "Intervention, Order" or "Intervention, Performed" with the value set "Palliative or Hospice Care" (OID: 2.16.840.1.113883.3.600.1.1579).
What are some examples of "Intervention, performed": MAT?	Examples of "Intervention, Performed: Opioid Medication Assisted Treatment (MAT)" are captured using the value set (Opioid Medication Assisted Treatment (MAT), OID: 2.16.840.1.113762.1.4.1111.177) and represent concepts that indicate an opioid medication assisted treatment. Currently, this value set includes SNOMEDCT codes such as: 310653000 (Drug addiction therapy using methadone), 792901003 (Drug addiction therapy using buprenorphine), and 792902005 (Drug addiction therapy using buprenorphine and naloxone).
What about chronic pain patients? Who is excluded in this measure?	Chronic pain patients are not excluded by this measure. The Denominator Exclusions are limited to specific conditions and scenarios defined in the measure specification and measure logic, including: • Inpatient hospitalizations where patients have cancer pain that begins prior to or during the encounter or are ordered or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the hospitalization or in an emergency department encounter or observation stay immediately prior to hospitalization • Patients receiving medication for opioid use disorder (OUD) with active OUD diagnosis or Opioid Medication Assisted Treatment (MAT) • Patients with sickle cell disease • Patients discharged to another inpatient care facility or left against medical advice • Patients who expire during the inpatient stay If a chronic pain patient does not meet one of these defined exclusions, they are included and may be counted in the numerator if discharged on concurrent opioids or an opioid and benzodiazepine.
Can a patient just have a diagnosis of opioid use disorder or are they required to start a medication to treat opioid use disorder?	The most recent version (version number 8.2.000) requires both Medications for Opioid Use Disorder (MOUD) and opioid use disorder (OUD) diagnosis during the inpatient encounter to be excluded from the denominator.

Question	Answer
If hydrocodone is documented twice on the dc summary, for example- take 1 tablet for moderate pain, then a separate instruction noting take 2 for severe pain. Does this count as 2 opioids prescribed at discharge?	The Hydrocodone RxNorm codes must be unique (distinct) and found in the Medication value sets "Schedule II, III and IV Opioid Medications' (OID 2.16.840.1.113762.1.4.1046.241) or "Schedule IV Benzodiazepines" (OID 2.16.840.1.113762.1.4.1125.1), and meet the "Medication, Discharge" QDM datatype. The measure does not consider the patient instructions in determining whether an opioid counts towards the measure.
Does this eCQM only pertain to Medicare or all payors?	No, this measure is ALL PAYOR. This measure does not evaluate by payor, all patients meeting measure criteria will be included. The results of the measure calculations are stratified by the supplemental data elements (SDE), including payor status. The payor type does not determine measure inclusion or exclusion.
Can you please explain the Denominator exclusion for MOUD with MAT? For a patient with an Active MOUD medication, buprenorphine patch, and no opioid use disorder diagnosis, does the patient need to have the patch given the same day the medication is identified in the chart? If the medication is captured on med rec on day of admission but withheld until the next day, the patient will not be excluded.	This is described within definition "Treatment For Opioid Use Disorders." An active MOUD medication or order must be during a day that the MAT intervention was performed, and both must occur during a day of the inpatient encounter. The medication codes are in the "Medications for Opioid Use Disorder (MOUD)" (2.16.840.1.113762.1.4.1046.269) . For MAT intervention, the codes that qualify are in the "Opioid Medication Assisted Treatment (MAT)" value set (OID 2.16.840.1.113762.1.4.1111.177).
When you say "distinct" is there a list?	In the measure logic 'distinct' is a keyword used in statements to return unique rows, eliminating duplicate values from the result. For this measure, the numerator requires two distinct Opioid medication codes from the medication value sets. Therefore, a single medication (code) occurring twice or more will not qualify for the numerator.
For Opioid Use Disorder active diagnosis, is the logic meant to look at all previous encounters' diagnoses & Problem List, or do does the OUD diagnosis need to come from the current inpatient encounter? Our EHR logic excluded a case last year based on an OUD diagnosis documented during a 2017 ED encounter.	Version 8.2.000 had logic updates around this exclusion. The Opioid Use Disorder (OUD) diagnosis must be active the same day as the MOUD medication, and during a day of the inpatient encounter being evaluated.
The patient population includes only those observation patients that convert to inpatient status, correct? Straight OBS patients are not included in the denominator.	Patients with an observation encounter alone, not transitioning into inpatient status, will not be included. An observation encounter must end within 1 hour of the inpatient encounter start time to be included within the denominator.
Follow up question on OBS patients. If a patient is in OBS for 24 hours, then converts to inpatient, will they still be in the denominator? Thanks.	The length of the observation encounter makes no determinations of measure inclusion, however the time between the observation encounter end time and the inpatient encounter start time is used. An observation encounter must end within 1 hour of the inpatient encounter start time to be included within the denominator.
To clarify, a patient needs all 3 of the following for the patient to be excluded: 1. medication for opioid use disorder 2. a diagnosis of opioid use disorder AND 3. intervention perform, MAT ?	No, "Treatment For Opioid Use Disorders" has two paths: 1. MOUD medication with OUD diagnosis 2. MOUD medication with MAT intervention. Either path will qualify for the exclusion.

Question	Answer
Are there clear guidelines and descriptions as to how to map EMR fields to Value Sets for each measure? The ONC eCQM Issue Tracker has Q&A, but does not have clear, consistent, complete guidance. One example is how to map Discharge Dispo for this measure to the related Value Sets that exclude patients from the measure.	Unfortunately, we are unable to provide more specific guidance related to the mapping of codes, we recommend that you consult with your EHR vendor and clinical partners. If mapping is conducted, you should maintain documentation in case of a CMS audit.
I have a few situations in which the doctor would write a hold on a home chronic opioid. It shows up on discharge summary as on hold, but it counts as 2 opioids. is this correct? and is there a way out of this? Also, we have the doctor write for Ativan for outpatient MRI this is also being included as a numerator, is there a way out of this as well?	This measure does not distinguish between different medication scheduling or frequencies such as take twice daily, pause, start, or hold. If the patient was prescribed two opioids at discharge, the encounter would fall into the numerator regardless of the instructions.
Can you explain if there is an exclusion if a provider is continuing a discharge opioid and/or benzo, no new prescriptions? This is their current home prescriptions.	This measure looks at the "proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge." Inpatient hospitalizations with discharge medications of two or more opioids or an opioid and benzodiazepine resulting in concurrent therapy regardless of whether they are new or continuing at discharge should be included in the numerator. Although continuing home medications may be appropriate medical management for some patients, patients discharged to settings where they are not under direct close medical management and are on multiple opioids /combination opioid and benzodiazepine, are at risk for complications.. A score of 0% of patients being discharged on two or more opioids or an opioid and benzodiazepine is not expected for this measure. The intent is to capture patients who are prescribed either of these combinations because they increase patients risk for complications, comprising patient safety.
There were two opioids ordered before the patient's discharge. The provider discontinued one opioid after discharge. Will the numerator capture the two opioids ordered before discharge, or only the one opioid ordered after discharge?	Yes, the numerator would capture the two opioids ordered before discharge not just the one opioid ordered after discharge. This measure uses QDM datatype, "Medication, Discharge," that states "Data elements that meet criteria using this datatype should document that the medications indicated by the QDM category and its corresponding value set should be taken by or given to the patient after being discharged from an inpatient encounter," (source QDM v5.6). The measure does not intend to capture medications that are not on the discharge list or discontinued in another setting after the inpatient discharge. We encourage you to work with your EHR vendor to ensure medications that are canceled or discontinued before the patients discharge are not inappropriately captured by the measure.
How can we work around patients coming in for surgery already taking an opioid and benzo (have nothing to do with surgical procedure) and being discharged on already home medications?	Although continuing home medications may be appropriate medical management for some patients, patients discharged to settings where they are not under direct close medical management and are on multiple opioids are at risk for complications.. A score of 0% of patients being discharged on two or more opioids or an opioid and benzodiazepine is not expected for this measure. The intent is to capture patients who are prescribed either of these combinations because they increase patients risk for complications, comprising patient safety.

Question	Answer
Follow up on the MAT examples, do the SNOMEDCT codes indicate that those medications are "administered"?	For the Opioid Medication Assisted Treatment (MAT) the logic looks for an intervention performed. The codes that qualify are in the "Opioid Medication Assisted Treatment (MAT)" value set (OID 2.16.840.1.113762.1.4.1111.177) and consist of drug addiction therapy interventions.
Do you have a list of opioids and benzos?	The list of opioids can be found in value set "Schedule II, III and IV Opioid Medications" (OID 2.16.840.1.113762.1.4.1046.241) and the list of Benzodiazepines can be found in value set "Schedule IV Benzodiazepines" (OID 2.16.840.1.113762.1.4.1125.1). You can find the applicable codes for this measure on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/. Click on the "Search Value Sets" tab and enter the value set OIDs from the measure specifications to review codes included in the respective value set.
If a patient has a diagnosis code of Opioid Dependence, accompanied by a code F11.20 up to F11.29, does this exclude the patient from the measure?	The "Treatment for Opioid Use Disorders" logic looks for active or ordered "Medications for Opioid Use Disorder (MOUD)" then the measure logic looks for a diagnosis of "Opioid Use Disorder." Diagnosis codes for OUD can be found in the "Opioid Use Disorder" value set (OID 2.16.840.1.113762.1.4.1111.171). The patient in your example would be excluded from the measure because these diagnosis codes are in the "Opioid Use Disorder" value set, and remaining definition criteria are also met.
Will the measure steward change or has it changed recently?	The measure steward has not changed and at this time there are no plans to change the measure steward.
So, if a patient comes in on an opioid and a benzo and they are discharged on same PTA meds, they are no longer included in the numerator?	Patients who already had a prescription for an opioid and benzodiazepine and who are discharged on those same medications would be included in the numerator as this qualifies as a continuing medication.
If a patient is discharged with 2 rxs for the same opioid/dose but different frequency, is the patient included in the numerator? If the patient is discharged on 2 rxs with the same opioid, but different dose, is this patient included in the numerator?	This measure does not distinguish between different medication scheduling or frequencies (e.g., BID for twice daily, QID for four times a day). To be considered distinct, the medications must have different RXNorm codes, which do not distinguish based on frequency or instructions given to patients. The list of opioids can be found in value set "Schedule II, III and IV Opioid Medications" (OID 2.16.840.1.113762.1.4.1046.241) and the list of Benzodiazepines can be found in value set "Schedule IV Benzodiazepines" (OID 2.16.840.1.113762.1.4.1125.1). Two different medications from these value sets would be included in the numerator.
To clarify, this does not include outpatient, extended stay, or observation?	This measure does not include outpatient or extended stay. It includes an observation encounter that must end within 1 hour of the inpatient encounter start time to be included within the denominator.
For mapping purposes where to find the discharge medications. Sometimes the dc reconciliations happen many times during the stay and only the last day reconciliation is what the patient takes. Do we map DC summary medications or the whole medication history snapshot which sometimes include 2 opioids, but the DC reconciliation include only one?	Unfortunately, we are unable to provide more specific guidance related to the mapping of codes, we recommend that you consult with your EHR vendor and clinical partners. If mapping is conducted, you should maintain documentation in case of a CMS audit.

Question	Answer
For 2026, if patient was not prescribed a new opioid/benzo at discharge, but medication is a continuation of therapy, "prescribed… at discharge" terminology may be argued, because technically discharging provider is not prescribing a med (sending rx to pharmacy). Is there a formal definition what "prescribed at discharge" is to show providers?	If continuing opioid or benzodiazepine medications are prescribed on the discharge list, they would be included in the measure. In terms of a formal definition, this measure uses QDM datatype, "Medication, Discharge," that states "Data elements that meet criteria using this datatype should document that the medications indicated by the QDM category and its corresponding value set should be taken by or given to the patient after being discharged from an inpatient encounter," (source QDM v5.6).
As a follow up: what about a psych patient on chronic GAD therapy (by Psychiatrist) who just had a surgery and was prescribed an short term opioid by a surgeon?	If the patient is receiving Benzodiazepines for treatment of chronic GAD therapy and also has an opioid prescription and both medications are on the discharge list, the patient will be in the numerator.
Do you have any links to resources for best practices or some sort of tool kit on how to manage this measure?	We recommend you review the guidance section of the header to learn more about this measure and also review the CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022.
Why are patients discharged to rehab still included in this measure? When sent to rehab on a differential dose of the same opioid, the numerator is met but doesn't meet the intent of the measure.	CMS506 was originally tested and endorsed without excluding patients discharged to rehab. We will consider this population in future measure testing.
Transfer medications are managed by a nurse, so why do you not exclude cases that are discharged to rehab, skilled care, and inpatient psych?	CMS506 was originally tested and endorsed without excluding patients to rehab, skilled care, and inpatient psych. A score of 0% of patients being discharged on two or more opioids or an opioid and benzodiazepine is not expected for this measure. The intent is to capture patients who are prescribed either of these combinations because they increase patients risk for complications, comprising patient safety in any setting.
Do all qualifying opioids fall under Class C?	The opioids in value set "Schedule II, III and IV Opioid Medications" (OID 2.16.840.1.113762.1.4.1046.241) are classified under the Drug Enforcement Administration (DEA) Controlled Substance Act (CSA) Scheduling which describe medications that fall under Schedule II, III, and IV substances.
So, the same medications, different MG qualify as separate medications?	To be considered distinct, medications must have different RXNorm codes. The same medication at different doses will most likely have different RXNorm codes and will therefore be distinct.
Is there any timing component to consider patient as inpatients if the patient admit in ED ?	Yes. Timing is relevant, but only in how the measure defines the inpatient encounter. The measure uses the QDM datatype "Encounter, Performed" with the value set "Encounter Inpatient" (OID 2.16.840.1.113883.3.666.5.307) to identify qualifying encounters. An emergency department (ED) visit alone does not qualify a patient for the measure. If a patient is admitted from the ED to inpatient status, the ED visit can be linked to the inpatient encounter using the Global.HospitalizationWithObservation function. This logic allows an ED visit (also observation, if applicable) to occur up to 1 hour prior to the start of the inpatient encounter and still be considered part of the same inpatient encounter or hospitalization.
Will Swing bed patients be included in the measure?	Currently there are no plans to include swing beds in this measure.

Question	Answer
Can you clarify what should be mapped to capture medication assisted treatment as an intervention? Patients on Subutex are flagging as numerator cases despite diagnosis of opioid dependence.	Unfortunately, we are unable to provide more specific guidance related to the mapping of codes, we recommend that you consult with your EHR vendor and clinical partners. If mapping is conducted, you should maintain documentation in case of a CMS audit. Medication assisted treatment (MAT) is considered an intervention and is defined in the value set "Opioid Medication Assisted Treatment (MAT)" (OID 2.16.840.1.113762.1.4.1111.177) which contains the following SNOMEDCT codes: 310653000 Drug addiction therapy using methadone (regime/therapy); 792901003 Drug addiction therapy using buprenorphine (regime/therapy); 792902005 Drug addiction therapy using buprenorphine and naloxone (regime/therapy). A patient being ordered buprenorphine or other MOUD would fall into value set "Medications for Opioid Use Disorder (MOUD)" (OID 2.16.840.1.113762.1.4.1046.269). Bupropion is listed in the Schedule II, III and IV Opioid Medications value set (OID 2.16.840.1.113762.1.4.1046.241) therefore it would fall into the numerator and denominator.
To follow up about MAT intervention, how does "drug addiction therapy using buprenorphine or other MOUD" differ from patient being ordered buprenorphine or other MOUD?	MAT is considered an intervention and is defined in the value set "Opioid Medication Assisted Treatment (MAT)" (OID 2.16.840.1.113762.1.4.1111.177) which contains the following SNOMEDCT codes: 310653000 Drug addiction therapy using methadone (regime/therapy); 792901003 Drug addiction therapy using buprenorphine (regime/therapy); 792902005 Drug addiction therapy using buprenorphine and naloxone (regime/therapy). A patient being ordered buprenorphine or other MOUD would fall into value set "Medications for Opioid Use Disorder (MOUD)" (OID 2.16.840.1.113762.1.4.1046.269).
Can you clarify how MOUD medication differs from MAT intervention? And what interventions are included in MAT other than just medication use?	MAT is considered an intervention and is defined in the value set "Opioid Medication Assisted Treatment (MAT)" (OID 2.16.840.1.113762.1.4.1111.177) which contains the following SNOMEDCT codes: 310653000 Drug addiction therapy using methadone (regime/therapy); 792901003 Drug addiction therapy using buprenorphine (regime/therapy); 792902005 Drug addiction therapy using buprenorphine and naloxone (regime/therapy). MOUD medications can be found in value set "Medications for Opioid Use Disorder (MOUD)" (OID 2.16.840.1.113762.1.4.1046.269).
If the patient has an active OUD diagnosis from the value set and is on an MOUD from the value set, do they also need a diagnosis of MAT to be considered for the exclusion?	If the patient has an active OUD diagnosis from the value set "Opioid Use Disorder" (OID 2.16.840.1.113762.1.4.1111.171) and is on an MOUD from the value set "Medications for Opioid Use Disorder (MOUD)" (OID 2.16.840.1.113762.1.4.1046.269), they DO NOT also need MAT to be considered to be excluded from the measure.
If a patient who is transferred to an acute care facility has a home medication opioid or benzodiazepine noted on the Admission Note, but the Discharge Summary states No Discharge Medications available and there are no medications populating the Discharge Med List or the eCQM measure, would that case count as a measure outcome mismatch since it will be missing from the IPP vs being Excluded due to the acute care facility discharge?	The measure does not intend to capture medications that are not on the discharge list. In the example provided, this medications would be considered a continuing medication and should result in the patient ending up in the denominator. We encourage you to work with your EHR vendor to ensure the correct patients are being captured by the measure.

Question	Answer
Are opioid or benzodiazepine medications that are listed as “ask your provider” after discharge, or noted as “hold and resume at a certain date,” counted toward the numerator, or do they need to be actively prescribed?	If the medications in your example are included in the discharge list, they will be included in the measure. This measure does not distinguish between different medication scheduling or frequencies such as take twice daily, pause, start, or hold. We encourage you to work with your EHR vendor to ensure the correct patients are being captured by the measure.
Epic has a functionality that allows for medications to be 'paused' at discharge. Epic has a functionality that allows for medications to be 'paused' at discharge. Our providers consider this medication when paused, NOT concurrently prescribed either with an opioid or with a benzo, whatever the case may be. We seem to still be falling out when this functionality is being used, even though technically, the two medications are not being prescribed together. This is confusing as the eCQM definition of the prescribed states “Continued” and the guidance uses “continued” throughout the description. Even though paused, the medication is still being included on the discharge list and then is counting in the numerator. Can we please get clarification around the use of the EPIC paused functionality - does CMS still consider the medication 'prescribed' and therefore active even though it is 'paused' (and not continued at the time of discharge) on our end?	This measure does not distinguish between different medication scheduling or frequencies such as take twice daily, pause, start, or hold. If the patient was prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge, the encounter would fall into the numerator regardless of the instructions. We encourage you to work with your EHR vendor to ensure the correct patients are being captured by the measure.