Expert to Expert Webinar: Annual Updates Safe Use of Opioids - Concurrent Prescribing for 2025 implementation
Questions and Answers
July 17, 2025

Question	Answer
Where can we find a definitive list of Schedule II, III, IV opioid medications?	You can find the full list of Schedule II, III, and IV codes in the Schedule II, III and IV Opioid Medications (2.16.840.1.113762.1.4.1046.241) value set viewable on the Value Set Authority Center at https://vsac.nlm.nih.gov
So just to confirm a standalone cancer diagnosis alone is removed as an exclusion, there must be a cancer related pain diagnosis now instead is that correct?	Yes, this is correct. There must be a cancer related pain diagnosis in order to meet denominator exclusion criteria.
Does the diagnosis of sickle cell require an onset date?	Yes, and must be active (not abated) during the inpatient encounter period/interval. Both onset dateTime and abatement dateTime are required to calculate the prevalence period.
Just for clarification sickle cell disease is inherited and a lifelong illness. So, the onset date would potentially be date of birth. Not just the onset date of the visit.	While sickle cell disease is inherited and therefore present at birth, symptoms typically begin to appear around 5 or 6 months of age and may vary by individual. The measure logic requires that the Sickle Cell disease diagnosis prevalence period overlaps the inpatient encounter and therefore an "onset date" is required to confirm this.
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.
For the denominator exclusion regarding treatment of opioid use disorders: does the patient need all 3 criteria to be met 1. diagnosis or SNOMED code 2. Medication order 3. Medication active (given) during their hospitalization? please clarify	To meet the "Treatment for Opioid Use Disorders" exclusion, a patient must have a Medication for Opioid Use Disorder (MOUD) Medication Active (given) or Medication Order with a Medication Assisted Treatment (MAT) intervention performed (represented by a SNOMEDCT code) where the medication is during a day of the MAT. You can view these codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov
Is the same opioid medication at same dose, one given as given as scheduled dose and route, and same med dose with same route as PRN count as one or 2 discrete opioids	This would depend on whether they have the same or different RxNorm codes. If the form, medication components, dose and route are the same the RxNorm codes should be the same.
Any specific ICD-10 codes that are exclusions to the numerator and/or denominator of this measure (e.g., chronic methadone use)?	This measure does not have any numerator exclusions however, codes for denominator exclusions of this measure can be found on the National Library of Medicine (NLM) Value Set Authority Center (VSAC) (https://vsac.nlm.nih.gov/valueset/expansions?pr=ecqm&rel=eCQM%20Update%202024-05-02&q=CMS506v7).

Question	Answer
Currently, if the same med is dispensed but with a different dose, the reports are counting them as 2 different medications due to having different RxNorm codes but it is the same medication. How should these be handled?	This measure considers an opioid as unique based on the RxNorm code for the opioids. Because the same medication with different dosing would be captured under two different RXNorm codes, these will be considered unique opioids.
Is there a target or goal percentage to obtain for the Safe Use of Opioids metric?	There currently is no target or goal percentage to obtain for the Safe Use of Opioids measure. You can view performance results by hospital, state, or nationally on Care Compare by searching hospital data sets for Timely and Effective Care (https://data.cms.gov/provider-data/search?fulltext=timely%20and%20effective%20care&theme=Hospitals)
Looking for benchmarking information. Please share any benchmarks you have for this measure (i.e., is there a percentage institutions should strive for?).	There currently is 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).
Is there a goal for CY25 or one planned for the future and how does this new eCQM affect CMS Star Ratings	There currently is no goal for CY2025. 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. 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/
Will there be a CMS benchmark set for this measure? When can we expect a benchmark to be announced for this measure? And will sickle cell patients eventually be 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.
Can you please clarify when the new specifications will be effective?	The specifications being reviewed today are for patients discharged in the 2025 calendar year.
Does the measure consider z-drugs (e.g., zolpidem) as benzodiazepines?	The Schedule IV Benzodiazepines included in the measure are listed in the "Schedule IV Benzodiazepines" (2.16.840.1.113762.1.4.1125.1) value set. You can view the specific drugs in the list on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov.
Would you consider an exclusion the co-prescription of naloxone for surgical post op patients?	The opioid medication list for the measure, "Schedule II, III and IV Opioid Medications" (2.16.840.1.113762.1.4.1046.241) does not contain naloxone as a stand-alone medication. A patient discharged from an inpatient stay with naloxone and an opioid would be in the denominator due to the opioid but not the numerator.

Question	Answer
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 is submitted annually. Guidance for reporting can be found at https://qualitynet.cms.gov/inpatient/measures/ecqm/participation.
If the same opioid was ordered at discharge twice, but ordered to be taken differently (such as 1 at 4-6 hours and the same opioid ordered to be taken at 6-12 hours), would that still be considered 2 unique opioids even though it was technically the same opioid ordered?	The measure considers an opioid as unique based upon the RxNorm code for the opioid. If there are two orders for the same opioid that have the same RxNorm code, the opioids are not considered unique. If the two opioids have different RxNorm codes, they are considered unique. If the drug components, form, dose, and route are all the same but the frequency instructions for taking them are different, they should have the same RxNorm codes.
What was the rationale for changing the denominator exclusion from a diagnosis of cancer to specifically cancer related pain?	The denominator exclusion was updated to cancer related pain to align with the clinical practice guidelines.
Will there be an upcoming webinar for PCM 02 &07?	That webinar was broadcast previously, and the recording is available. You can visit this site to see all the available recordings, slides, and follow-up documents from previous webinars that are presently available https://www.jointcommission.org/measurement/quality-measurement-webinars-and-videos/expert-to-expert-webinars/
The "Measure considerations" and "FAQ" slides are very insightful and helpful! Is it possible to make these an integration into all future presentations?	Thank you for this recommendation! We will consider including these slides in future presentations.
So, sickle cell is not identified by ICD10 codes?	Sickle cell disease is identified by SNOMEDCT and ICD-10CM codes listed in the sickle cell disease with and without Crisis (2.16.840.1.113762.1.4.1111.175) value set. You can view these codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov
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 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 quality reports that contain quality data for a set of patients for one or more eCQMs and are for eligible clinician reporting.
How do I log onto Value Set Authority Center? I do not see instructions posted on the website	To access VSAC and search value sets you will need a free Unified Medical Language System Metathesaurus License. If you do not have a UMLS License, you can request one at https://uts.nlm.nih.gov/uts/signup-login.
Are Swingbed patients included in measure	Patients who are admitted to an inpatient encounter and subsequently transferred to a skilled nursing level of service within the same facility (swing beds) should not be included in the measure. eCQMs are not able to differentiate patients based upon level of service. We encourage you to work with your EHR vendor to remove these patients from the measure for purposes of reporting.

Question	Answer
Does "inpatient" include patients in observation or Swingbed status?	Patients discharged from observation are not included in the patient population. Patients who are admitted to inpatient from observation with a transition time of one hour or less will have their time in observation included in their encounter, and will be included in the patient population. Patients who are admitted to an inpatient encounter and subsequently transferred to a skilled nursing level of service within the same facility (swing beds) should not be included in the measure. eCQMs are not able to differentiate patients based upon level of service. We encourage you to work with your EHR vendor to remove these patients from the measure for purposes of reporting.
Can Pain Management providers ordering opioids be treated as an exclusion, similar to Palliative/Hospice care? Or Post-Op Opioid?	Pain management and post-op opioids are not excluded by this measure.
When looking at our patients who are discharged with numerator criteria from an acute care settings, it is almost always a continuation of home medications which is appropriate, so is the intent to encourage acute care providers to discontinue medications managed by an outpatient provider?	No, the measure intent is not to encourage acute care providers to discontinue home medications managed by an outpatient provider. There are some patients for which it is appropriate to order an additional short term use opioid at discharge. CMS recognizes this, and does not expect a performance rate of zero for all patients. The intent of the measure is to minimize opioid coprescribing and opioid and benzodiazepine prescribing when there are alternatives that will meet patient needs.
Where can I find national performance on eCQM measures?	National and state average performance rates are available in Care Compare under Timely and Effective Care. 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/.
What will the documentation requirements be for the new exclusions?	Documentation required for the new exclusions for patients with sickle cell disease, patients receiving medication for opioid use disorder, and patients who left against medical advice can be found in the measure specifications on the eCQI resource Center at https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms0506v7. All value sets included in the measure specifications are viewable on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/.
If the pt is admitted to inpatient, then their status changes to observation, and they are eventually discharged in the observation status, would they be included in the measure?	If the patient meets the initial population criteria, requiring an inpatient encounter with an opioid or benzodiazepine at discharge, they would remain in the measure. The measure does not include logic that would exclude a patient who is admitted to inpatient, subsequently changed to outpatient status, and then discharged.
So just a diagnosis of opioid use disorder does NOT exclude from the denominator?	Diagnosis of opioid use disorder excludes a patient from the denominator for version 7 of this measure for the 2025 reporting period.

Question	Answer
Always hear from a few critical access hospitals that they are exempt due to the limited eCQMs that apply. Please clarify.	Critical Access Hospitals (CAHs) are required to report eCQMs through the Medicare Promoting Interoperability (PI) Program. The Safe Use of Opioids—Concurrent Prescribing eCQM is one of the mandatory eCQMs for CAHs to report on for the PI program. CAHs that do not have any patients who meet the Safe Use of Opioids initial patient population criteria during the reporting period may submit a zero denominator declaration. The case threshold exemption for hospitals with a low number of eligible cases cannot be applied for the Safe Use of Opioids measure.
Is there a way to recognize the continuation of chronic medications prescribed in ambulatory setting?	Continuation of chronic medications can be identified if they are documented in the EHR at admission.
How does this measure apply to Critical Access Hospitals under CMS Conditions of Participation?	CAHs are required to report on this measure through the Medicare Promoting Interoperability (PI) program.
(1) If patient is d/c AMA - does this still count as a fall out? (2) If opioid med is prescribed, but 2 different doses, does this still count?	Patients who left against medical advice as represented by a code in value set "Left Against Medical Advice" (2.16.840.1.113883.3.117.1.7.1.308), meet denominator exclusion criteria for the measure and are not included within the performance rate. Opioid RxNorm medication codes must be distinct to be considered different opioids. If any of the medication components, form, route of administration, or dose are different the medications will have different RxNorm codes. If the codes are different, they will be counted as two unique opioids
Can the intent of the measure be clarified for acute care providers that are continuing chronic medications?	Continuing medications are included in this measure. Please note we understand there may be clinically appropriate circumstances for a patient to be prescribed two unique opioids or an opioid and benzodiazepine. CMS does not expect this measure to have a numerator of zero
Can you enumerate again what the known issue is with the opioid use disorder and where can I find the list of "known issues"?	Please see issue EKI-31 on the ONC eCQM Known Issues Dashboard for details https://oncprojectracking.healthit.gov/support/browse/EKI-31. The denominator exclusion logic, specific to the diagnosis and treatment of opioid use disorder (OUD), contains two errors: Logic evaluates for patients who have ever had a diagnosis of OUD, when it should evaluate only for patients with an active diagnosis of OUD Logic evaluates for either a diagnosis of OUD or treatment of OUD, when it should evaluate for an active diagnosis of OUD and treatment of OUD This error leads to patients being excluded from the denominator, in error, and as a result, may result in undercounting patients that meet the denominator (and potentially the numerator).

Question	Answer
Can you please define inpatient hospitalization?	CMS506v7 defines this using the logic seen here, using codes found in the "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307) value set. You can view the encounter codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.666.5.307/expansion/eCQM%20Update%202024-05-02. Global.Inpatient Encounter ["Encounter, Performed": "Encounter Inpatient"] EncounterInpatient where EncounterInpatient.relevantPeriod ends during day of "Measurement Period"
Diagnosis sickle cell: ICD10 dx codes don't have a date. So how can the diagnosis of sickle cell require an onset date?	CMS506v7 specifies this denominator exclusion as follows: ["Diagnosis": "Sickle Cell Disease with and without Crisis"] SickleCellDisease where SickleCellDisease.prevalencePeriod overlaps InpatientEncounter.relevantPeriod The prevalencePeriod references the time from the onset date to the abatement date. The logic requires that the diagnosis of sickle cell disease overlaps the inpatient encounter. An onset date of the diagnosis is required for this calculation.
Does "End of Life Care" count as a denominator exclusion, equivalent to Hospice and Palliative care?	Denominator exclusions for CMS506v7 are captured using value set "Palliative or Hospice Care" (2.16.840.1.113883.3.600.1.1579). This value set includes codes for terminal and dying care. You can view specific codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.3.600.1.1579/expansion/eCQM%20Update%202024-05-02
Does continuation of chronic medications take the patient out of the numerator?	Continuation of chronic medications does not remove the patient from the numerator.
Does the cancer dx exclusion apply if the patient has an active dx of cancer during the encounter or dx = present on admission even if there is not dx of pain related to cancer?	Patients with active diagnosis of cancer are not excluded. Patients with cancer related pain diagnosis identified by presence of a code from the "Cancer Related Pain" (2.16.840.1.113762.1.4.1111.180) value set are excluded beginning with the 2025 reporting year. You can view codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov
Does the POA designation by ICD 10 codes count towards "prior to start of encounter"?	CMS506v7 does not include logic for the QDM presentOnAdmissionIndicator attribute.

Question	Answer
Hi. Still awaiting clarification on how signed and held orders and med orders with different doses should be handled. Signed and held orders do not get dispensed to the patient but are still being counted in the numerator. The same med is being counted multiple times because the doses have different RxNorm codes, but they are the same med.	Medications with unique RxNorm codes will be counted in the measure as distinct medications. Medications that have any of the following will have unique RxNorm codes: different medication components, different routes of administration, different forms (e.g., tablet, capsule, IV), or different doses. If all of these are the same and only the frequency of administration is different (e.g., every 4 hours, vs. PRN) the medication should have the same RxNorm code. We recommend working with your EHR vendor to differentiate non-discharge medications from the ones the patient is, or will be taking, at discharge.
I am concerned about patients with existing Rx of Benzo & Opioid prior to treatment flagging this measure. Is this a possible exclusion? and are the EHRs aware of this possible issue?	Patients discharged with an existing benzodiazepine and opioid would be included in the measure because they are continuing medications.
If a patient comes in on opioid and benzodiazepine but the physician does not send a script for refills, rather states in discharge to continue home medications does this affect the discharge physician's Safe Use of Opioids percentage??	Patients admitted with an opioid and benzodiazepine and subsequently discharged with the same medications would be included in the numerator because this measure includes continuing opioids and benzodiazepines.
If a patient comes to the ED and is on home hospice, does this count as "hospice care" prior to admit? If so, how is this captured to exclude?	In order to meet denominator exclusion criteria, the measure requires that palliative or hospice care be ordered or provided during the inpatient hospitalization. Hospice at home or prior to admission is not accounted for by the measure; it must be an inpatient order or provided as an inpatient. Please see measure logic below. "Intervention Palliative or Hospice Care" PalliativeOrHospiceCare where Coalesce(start of Global."NormalizeInterval"(PalliativeOrHospiceCare.relevantDatetime, PalliativeOrHospiceCare.relevantPeriod), PalliativeOrHospiceCare.authorDatetime) during Global."HospitalizationWithObservation" (InpatientEncounter)
Is there a specific reason for not excluding inpatient visits discharged to skilled nursing facilities? The majority of our numerator cases are for post-op pain due to joint fracture/replacement, with a benzodiazepine prescription for chronic anxiety.	CMS506 was originally tested and endorsed without excluding patients to rehab. We will consider testing this measure for this population in the future.

Question	Answer
Is there a way to ensure that outdated Opioids or Benzo—such as those with no remaining refills—are excluded from the measure when a patient receives a new prescription on Discharge?	We encourage you to work with your EHR vendor and internal team to ensure these medications are removed from discharge medication lists in your EHR.
Is version 7 the most recent version of this eCQM?	No, CMS506v8 was published in May 2025 for 2026 reporting.
Population Criteria - It mentions that exclusions include "emergency department encounter for observation stay immediately prior to hospitalization" But are observation stays included in the measure when the patients have an OBS stay and then are NOT admitted for hospitalization after the OBS stay but instead discharged home or elsewhere?	The inpatient hospitalization period assessed by CMS506 includes time in the emergency department and/or observation when the transition between discharge from these encounters and admission to the inpatient encounter is one hour or less. This is accounted for in the Global."HospitalizationWithObservation" function which determines the interval of the entire inpatient hospitalization encounter. If the patient never transitions to inpatient the observation stay is not included.
Regarding the Denominator Exclusion "...patients discharged to another inpatient care facility..." is there any intent here to also exclude those discharged to a care facility such as Nursing Home, Group Home, or Psych hospital?	Patients discharged to other acute inpatient facilities, as defined in the value set "Discharge To Acute Care Facility" meet denominator exclusion criteria. This value set includes community hospitals, tertiary referral hospitals, and acute care hospitals. Patients transferred to nursing homes, group homes or psych hospitals do not meet this denominator exclusion criteria. Please review the value set on the Value Set Authority Center for a complete list of codes (https://vsac.nlm.nih.gov).
Since the zero numerator is not expected in this measure, is there a percentage or number of numerators vs denominators that is acceptable, considering the risk discussed? thank you!	There currently is no target goal percentage or performance rate for the Safe Use of Opioids measure. You can view performance results by hospital, state, or nationally on Care Compare to which you can compare your hospitals performance by searching hospital data sets for Timely and Effective Care (https://data.cms.gov/provider-data/search?fulltext=timely%20and%20effective%20care&theme=Hospitals)
So, for Opioid Use Disorder (OUD), besides the known issue EKI-31, only patients with an OUD diagnosis and administered an opioid for Medication Assisted Treatment (MAT) during hospital stay are excluded from denominator?	In order to meet denominator exclusion criteria for patients receiving medications for OUD, patients must have either active medications for OUD, or medication orders for OUD in conjunction with an intervention performed for opioid MAT.
So, to clarify the first FAQ, if the RXNORM code does not distinguish an opioid based on different instructions, then that opioid is counted as one, correct?	Correct, if the RXNORM codes are the same, medications will be counted as one opioid.

Question	Answer
What does it take for a provider to use the Cancer related pain diagnosis? Any cancer patient who is admitted with an opioid home med?	A cancer related pain diagnosis involves identifying the source and characteristics of pain in individuals with cancer. Determining whether a patient has cancer related pain is a clinical decision beyond the scope of the measure specifications. The codes used by the measure to identify presence of a cancer related pain diagnosis are listed in the "Cancer Related Pain" (2.16.840.1.113762.1.4.1111.180) value set. You can view these codes on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov
Why are discharge dispositions to Swingbed or Inpatient Rehab facility not exclusions? If the intent is to decrease the prescription when transitioning to the outpatient setting, these two discharge dispositions should be included in the denominator exclusions.	Patients who are admitted to swing beds are not excluded because eCQMs are not able to differentiate patients based upon level of service. Facilities should work with their EHR vendor to remove these patients from the measure for purposes of reporting. Regarding Inpatient Rehab Facilities, CMS506 was originally tested and endorsed without excluding patients to rehab. We will consider testing this measure for this population in the future.
Would the new 2025 exclusions be the reason that my Jan-April report numbers are now looking different?	We recommend reviewing measure results with your quality improvement team.