AAD 18: Avoidance of Opioid Prescriptions for Closures and Reconstruction After Skin Cancer Resection

- **National Quality Strategy Domain: Patient Safety**
- **Meaningful Measure Area: Medication Management**

2023 COLLECTION TYPE:
QCDR MEASURE

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of procedures in patients, aged 18 and older with a diagnosis of skin cancer, who had intermediate layer and/or complex linear closures OR reconstruction after skin cancer resection where opioid/narcotic therapy* was prescribed as first line therapy (as defined by a prescription in anticipation of or at time of surgery) for post-operative pain management by the reconstructing surgeon. (Inverse measure)

This measure is stratified by intermediate layer or complex linear closure or reconstructive procedures.

High Priority Measure: Yes
Meaningful Measure Area: Medication Management
Risk-Adjusted: No
Inverse Measure: Yes
Proportional Measure: Yes
Continuous Variable Measure: No
Ratio Measure: No
Number of performance rates required for measure: 3rd Performance Rate
Care Setting: Ambulatory Care: Clinician Office/Clinic; Hospital; Ambulatory Surgical Center; Hospital; Hospital Outpatient; Office Based Surgery Center

INSTRUCTIONS:
This measure may be reported by eligible physicians and allied professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All procedures in patients aged 18 and older with a diagnosis of skin cancer where intermediate layer and/or complex linear closures OR reconstruction after skin cancer resection were performed.

All procedures in patients with a diagnosis of skin cancer aged 18 and older who underwent:

Strata 1: Intermediate layer or complex linear closures after skin cancer resection

Strata 2: Reconstruction after skin cancer resection

Strata 3: Intermediate layer and complex linear closures AND reconstruction after skin cancerresection in the office-based setting (Weighted average of Strata 1 and 2)

Denominator Criteria (Eligible Cases):
Strata 1:
CPT for Encounter Intermediate layer and complex linear closures
12031, 12032, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13100, 13101, 13120, 13121, 13131, 13132, 13151, 13152

OR

Strata 2:
CPT® for Encounter Reconstruction
14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061; 15050, 15100,15120; 15200, 15220, 15240, 15260, 15570, 15572, 15574, 15576; 15730, 15740; 67971, 67973, 67974, 67975

and

ICD-10 Codes for most common skin cancers:
C43-C44
D03-D04

Strata 3: FOR REPORTING
Strata 1 + Strata 2; Calculate as (numerator 1 + numerator 2)/(denominator 1 + denominator 2),not the average of the performance rates

Denominator Exclusions:

1. Location exclusion due to high tension closure and anticipated exceptional postsurgical pain (lower extremity, scalp, ear, genitals, perineum, lip, and nail unit)
2. Surgical procedures associated with anticipated exceptional post-surgical pain
    a. Flaps greater than 30 square cm*
    b. Split thickness skin grafts greater than 10 square cm*
    c. Paramedian forehead flap*
    d. Composite graft*

*These exclusions only apply to strata 2 (Reconstruction)

Denominator Exceptions:

1. Medical reason exception for patients who cannot take non-opioid pain medications (patients with chronic kidney disease, COPD, allergy to non-steroidal anti-inflammatory medications and acetaminophen or documented contraindication to non-steroidal anti-inflammatory medicationsand acetaminophen, cirrhosis/liver disease)
2. Number of surgical sites – greater than 3 skin cancer sites treated or reconstructed in one day of service)

NUMERATOR:
Patients who were prescribed opioid/narcotic therapy* as first line treatment (as defined by a prescription in anticipation of or at time of surgery) for post-operative pain management by the reconstructing surgeon. (Inverse measure)

*List of narcotic/opioid medications included:
morphine, oxycodone, fentanyl, oxymorphone, hydromorphone, buprenorphine, meperidine, codeine, butorphanol, tramadol, levophanol, sufentanil, pentazocine, tapentadol, hydrocodone

CLINICAL RECOMMENDATION STATEMENT:
The Work Group recommends that clinicians should not routinely prescribe narcotic medication as first line treatment for pain in adult patients undergoing reconstruction after skin cancer resection.

Evidence Quality: Moderate
Recommendation Strength: Moderate

The Work Group recommends that clinicians should prescribe acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs) as first line therapy in adult patients undergoing reconstruction for skin cancer resection.

Evidence Quality: Moderate
Recommendation Strength: Moderate

RATIONALE:
There is increasing evidence that prescription narcotics, which surgical patients are 4 times as likely to receive upon discharge than non-surgical patients, are associated with increased risk of opioid diversion, addiction, unintentional injury, and death (Brat GA 2018). Patients who fill narcotic prescriptions after minor surgical procedures are more likely to exhibit persistent opioid use (Harbaugh CM 2018), and the duration of the prescribed use is a predictor of future misuse (Harris K 2014).

In the realm of reconstruction after skin cancer removal, a randomized clinical trial comparing oral postoperative pain management regimens has not shown narcotics to be more effective (Sniezek PJ 2018). Specifically, patients undergoing reconstruction of head and neck wounds were assigned to receive every 4 hours after surgery (up to 4 doses) one of the following: 1000 mg of acetaminophen, 1000 mg of acetaminophen plus 400 mg of ibuprofen, or 325 mg of acetaminophen plus 30 mg of codeine. Pain was assessed by patient self-report using a visual analog scale immediately after surgery, and at 2, 4, 8, and 12 hours postoperatively. Subgroups were compared based on the area of the reconstructed defect. At 2 and at 4 hours the acetaminophen plus codeine group reported more pain than the acetaminophen plus ibuprofen group. At other time points, no difference was seen in mean change in pain scores across the groups. At no time points was the regimen including the narcotic agent found to control pain better than either of the other two non-narcotic regimens. Overall patient satisfaction, measured at the end of the study, did not differ between the codeine group and either of the other two groups (Sniezek PJ 2018).

Retrospective and prospective case series (Parsa FD 2017; Kelley BP 2016) that compared narcotic and non-narcotic post-operative pain strategies found no difference in surgical outcomes.

This measure is specifically focused on not prescribing opioids and narcotics as first line treatment. Although it does not address other forms of pain management, the guideline on which the measure is based does. That recommendation is cited above. There is also flexibility to add a narcotic medication for breakthrough pain should the need arise.