Measure ASPS 23: Avoidance of Opioid Prescriptions for Reconstruction After Skin Cancer Resection

This measure may be used as an Accountability measure.

Measure Description

Percentage of patients aged 18 and older who underwent reconstruction after skin cancer resection who were prescribed opioid/narcotic therapy* as first line therapy (as defined by a prescription in anticipation of or at time of surgery) by the reconstructing surgeon for post-operative pain management. (Inverse measure)

Measure Components	
Numerator Statement	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 that should not be prescribed: morphine, oxycodone, fentanyl, oxymorphone, hydromorphone, buprenorphine, meperidine, codeine, butorphanol, levophanol, sufentanil, pentazocine, tapentadol, hydrocodone
Denominator Statement	All patients aged 18 and older who underwent reconstruction after skin cancer resection
Denominator Exclusions	None
Denominator Exceptions	Medical reason exception for patients who cannot take non-opioid pain medications (i.e. patients with chronic kidney disease, COPD, allergy to non-steroidal anti-inflammatory medications and acetaminophen or documented contraindication to non-steroidal anti-inflammatory medications and acetaminophen, cirrhosis/liver disease)
Supporting Guideline	**5a. 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** **5b. 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 Chen et al, ASPS, Reconstruction After Skin Cancer Resection Guideline 2019, in press
Measure Importance	
Rationale/ Opportunity for Improvement	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. Gap in care: All Mohs micrographic patients in a study by Limthongkul, Samie et al 2013) were given an opioid prescription to fill as needed, and more patients (16% vs 7.1%) used opioids for pain relief than in similar studies where the prescription was not given ahead of time. Another study comparing full-thickness skin grafts with second-intention wound healing for defects of the helix found the mean pain scores to be

	similar for both (2.8 and 2.5 of 10, respectively) (Hochwalt, Christensen et al 2015). Thirty-five percent of the patients in Harris et al 2104 received a postoperative opioid prescription, with a total of 851 opioid pills prescribed for 82 patients. In a survey of ASDS members regarding opioids prescribing, 36% reported prescribing opioids in > 10% of their cases, with 7% prescribing in more than 75% of cases. 59% reported prescribing >10 pills and 31% reported prescribing >15 pills after surgery (Harris et al 2014).
Harmonization with Existing Measures	There are currently no opioid measures for post-op acute pain in skin cancer patients, or even in general surgery, in MIPS or on the 2019 QCDR list.
Measure Designation	
Measure Purpose	Accountability Quality Improvement
Type of Measure	Process
Care Setting	Ambulatory care, ASC, Inpatient
Data Source	Medical record (paper or EHR), administrative data
Guidance	Reconstruction After Skin Cancer Resection: Reconstructive options may include tissue rearrangement, grafts, or flaps. Primary or complex linear closures are not included. See the specifications at the end of the document for exact codes included in each measure. Procedures of the forehead, lips, and other anatomical areas considered exceptionally painful are not included. As previously stated, this measure applies to first line prescriptions only. It is not expected that performance will be 100% on this measure.

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<table>
<tr><td>Denominator
(Eligible Population)</td><td>All patients aged 18 and older who underwent reconstruction after skin cancer resection

Age ≥ 18 years

AND

CPT® for Encounter:
14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061
14301, 14350
15050
15100, 15120
15200, 15220, 15240, 15260
15570, 15572, 15574, 15576
15730, 15740, 15760
67971, 67973, 67974, 67975

AND

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

Code descriptions - for reference only:
<table>
<tr><th>Code Range</th><th>Descriptors</th></tr>
<tr><td>14000 - 14061, 14301</td><td>Adjacent Tissue Transfer</td></tr>
<tr><td>14350</td><td>Filleted finger or toe flap, including preparation of recipient site</td></tr>
<tr><td>15050</td><td>Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter</td></tr>
<tr><td>15100 - 15120</td><td>Split Thickness Grafts</td></tr>
<tr><td>15200 - 15260</td><td>Full Thickness Grafts</td></tr>
<tr><td>15570 -15576</td><td>Formation of direct or tubed pedicle</td></tr>
<tr><td>15730</td><td>Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)</td></tr>
<tr><td>15740</td><td>Island Pedicle Flap</td></tr>
<tr><td>15760</td><td>Composite Skin Graft</td></tr>
<tr><td>67971 - 67975</td><td>Reconstruction of Eyelid</td></tr>
</table></td></tr>
<tr><td>Denominator Exclusions</td><td>none</td></tr>
<tr><td>Numerator</td><td>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

Captured by attestation in the work flow of the QCDR</td></tr>
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Denominator Exceptions	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 medications and acetaminophen, cirrhosis/liver disease)