

Patient Safety: At the core of evidence-based guidelines for older adults

The Centers for Disease Control and Prevention (CDC) reported that opioids were associated with the most pharmaceutical-related overdose deaths in 2010 (75.2%), followed by benzodiazepines (29.4%). Moreover, benzodiazepine use was associated with 30.1% of opioid overdose deaths, and opioid use was associated with 77.2% of benzodiazepine overdose deaths.² CDC guidelines on opioid prescribing in chronic non-cancer pain advises clinicians to avoid coprescribing opioids and benzodiazepines whenever possible.³

In 2016, a U.S. Food and Drug Administration (FDA) review found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) resulted in serious side effects, including slowed or difficult breathing and death. To decrease the use of opioids and benzodiazepines, or opioids and other CNS depressants together, the FDA added boxed warnings—their strongest warnings—to the drug labeling of oral prescription opioid pain medicines, cough medicines and benzodiazepines.⁴

Based on this evidence, the Pharmacy Quality Alliance™ (PQA) developed and endorsed the Concurrent Use of Opioids and Benzodiazepines (COB) measure for adults.⁵

Prior authorization approval may be required for coverage of medications in this measure. However, a prior authorization does not prohibit a patient from failing the COB measure.

Concurrent Use of Opioids and Benzodiazepines

Risks of concurrent use	The Centers for Medicare & Medicaid Services (CMS) wants to ensure patients are not taking opioid and benzodiazepines together with overlapping days' supply for 30 or more cumulative days during the measurement period.
Description	Patients 18 years of age and older who are enrolled in a Part D plan, have had two or more fills for opioids on different dates of service (claims can be for same or different opioids), and with 15 or more cumulative days' supply during the measurement year, with no more than one gap in enrollment of up to 31 days during the measurement year. The earliest date of service can be no more than 30 days from the last day of the measurement year (Jan. 1–Dec. 2). Only paid, nonreversed prescription claims are included in the data set to calculate the measure.
Calculation (numerator/denominator) x 100% Lower rate is better	• A patient moves into the numerator if there are two or more claims of any benzodiazepine on different dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days. • The patient does not enter the numerator if the number of fills for each drug is less than two or the number of overlapping days' supply is less than 30 cumulative days.
Exclusions	• If there is at least one claim with a primary or secondary diagnosis of cancer, sickle cell disease or palliative care during the measurement year • Patients in hospice
Measurement period	Calendar year

COB medications

COB-A: opioids^{a,b}

Opioid medications

- | | | |
|-------------------|-----------------|---------------|
| • benzhydrocodone | • hydrocodone | • opium |
| • buprenorphine | • hydromorphone | • oxycodone |
| • butorphanol | • levorphanol | • oxymorphone |
| • codeine | • meperidine | • pentazocine |
| • dihydrocodeine | • methadone | • tapentadol |
| • fentanyl | • morphine | • tramadol |

a. Includes combination products and prescription opioid cough medications

b. Excludes the following: injectable formulations, sublingual sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (e.g., buprenorphine sublingual tablets, Probuphine®, implant kit subcutaneous implant and all buprenorphine/naloxone combination products)

COB-B: benzodiazepines^{a,b}

Benzodiazepine medications

- | | | |
|--------------------|--------------|-------------|
| • alprazolam | • diazepam | • oxazepam |
| • chlordiazepoxide | • estazolam | • quazepam |
| • clobazam | • flurazepam | • temazepam |
| • clonazepam | • lorazepam | • triazolam |
| • clorazepate | • midazolam | |

a. Includes combination products

b. Excludes injectable formulations

Recommendations

- Avoid COB medications unless safer drug alternatives and nonpharmacological interventions have been ineffective.
- Consider reducing use of other CNS-depressant medications and alcohol.
- Consider tapering to avoid symptom recurrence and discontinuation syndromes.
- Consider prescribing non-pharmacologic therapies, such as cognitive behavioral therapies, mindful meditation, acupuncture, chiropractic care, yoga and physical therapy/exercise, if appropriate.

Tapering regimens for COB medications

Drug class	Example of tapering regimen
Benzodiazepines	Taper 25% every week. Reduce to 10%–25% every 2–4 weeks if withdrawal symptoms occur. ⁶
Opioids	Taper 10% per week (or 10% per month if taking > 1 year). ⁷

Note: These tapering regimens are only provided as examples. Tapering may vary based on patient factors (e.g., duration of therapy, symptom recurrence) and the regimen should be adjusted based on patient monitoring.

Clinical best practices to reduce adverse events

- Review patient medications regularly, especially those who utilize specialists and receive care through other facilities, such as hospitals and urgent care clinics.
- Utilize standard criteria, such as the Beers Criteria, to identify medications that are not recommended to be taken together.
- Monitor the use of high-risk medications in patients and work with them to discontinue any that are inappropriate or should not to be taken together with other prescribed medications.
- Some medications in this measure may require a prior authorization approval to be covered by the patient's plan. Please note that even if the medications are deemed medically necessary and the prior authorization is approved, the patient **may still fail the COB measure**.
- Educate the patient on current plan for change, including the next follow-up call or appointment and when it is appropriate to contact a nurse, care manager or provider.
- Ensure patient records include clear documentation and that patients have a strong understanding of the directions given to them on discontinuing medications.
- Work with the patient's pharmacy to ensure no additional refills are available on discontinued medications.

COB measure exclusion codes

The following billing/reimbursement codes pertaining to cancer, sickle cell disease, palliative care and hospice care will be used to identify patients to be excluded from the COB measure.

Exclusion	Pertinent codes
Cancer	International Classification of Diseases, Tenth Revision (ICD-10): Any billable ICD-10 code from C00-C96
Sickle cell disease	ICD-10: Any billable ICD-10 code under D57
Palliative care	ICD-10: Z51.5
Hospice care	Current Procedural Terminology (CPT®): 99377, 99378 Healthcare Common Procedure Coding System (HCPCS): G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046 Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT): 170935008, 170936009, 183919006, 183920000, 183921001, 305336008, 305911006, 385763009, 385765002 UB-04 Revenue Code (UBREV): 115, 125, 135, 145, 155, 235, 650, 651, 652, 655, 656, 657, 658, 659

References

1. Maher RL, Hanlon JT, Hajjar ER. Clinical Consequences of Polypharmacy in Elderly. Expert opinion on drug safety. 2014; 13(1):57-65. doi: 10.1517/14740338.2013.827660.
2. Jones CM, Mack KM, Paulozzi LJ. Pharmaceutical Overdose Deaths, United States, 2010 JAMA. 2013; 309(7):657-659. doi:10.1001/jama.2013.272.
3. CDC Guideline for Prescribing Opioids for Chronic Pain. <https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/recommendations-and-principles.html>
4. FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning | FDA
5. Zint K, Haefeli WE, Glynn RJ, et al. Impact of drug interactions, dosage, and duration of therapy on the risk of hip fracture associated with benzodiazepine use in older adults. Pharmacoepidemiol Drug Saf. 2010; 19(12):1248-55. doi: 10.1002/pds.2031
6. https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Benzodiazepine_Provider_AD_%20Risk_Discussion_Guide.pdf
7. Centers for Disease Control and Prevention. Pocket guide: <https://stacks.cdc.gov/view/cdc/45237>

The information in this flyer reflects PQA specifications but is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider.

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.