HEDIS®

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

PROVIDER GUIDE

An Independent Licensee of the Blue Cross and Blue Shield Association

HEDIS®/ STAR PROVIDER GUIDE – HEDIS MY 22 (Measurement Year 2022)

HEDIS® (**H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et) is a performance measurement tool developed by the National Committee for Quality Assurance (NCQA) to assess the quality of healthcare and improve patient health and outcomes, and is an important factor in our accreditation.

Select HEDIS® measures are also part of the Star Rating System managed by the federal Centers for Medicare & Medicaid Services (CMS), which evaluates health care plans based on a 5-Star rating system.

Adherence to these guidelines:

- Ensures health plans are offering quality preventive care and services.
- Provides a comparison to other plans.
- Identifies opportunities for quality improvement.
- Measures the plan's progress from year to year.

HEDIS® data collection is permitted under HIPAA and is performed three ways:

- Administrative: Pertaining to diagnosis codes (in our claims database) and medication fills, based on the NCQA Vol. 2 Technical Specifications & Value Sets (updated annually).
- Hybrid: A combination of Administrative, and medical chart review.
- Survey: Member and provider surveys.

Included within for your convenience are select HEDIS®/Star measures and their description and requirements. ***Star measures are designated with a star symbol*** (☆).

This guide does not include every clinical quality measure, but rather ones that are NCQA sensitive for accreditation.

If you would like the complete list of diagnosis codes or medication lists for any measure, or have questions, please call (386) 676-7100 Ext. 7258, or email QualityManagement@fhcp.com.

We hope you find this guide useful in your daily practice.

Sincerely,
FHCP Quality Management

TABLE OF CONTENTS (Ctrl-Click for Link)

ADULT

MENTAL / BEHAVIORAL HEALTH

ADULT / ELDERLY

RESPIRATORY

TABLE OF CONTENTS cont'd

Measure	Comments	More Tips
AAB **Avoidance of Antibiotic Treatment For Acute Bronchitis / Bronchiolitis** Members **3 months and older**, who were diagnosed with acute bronchitis or bronchiolitis, should **not** be dispensed an antibiotic prescription. Please explain to your patients that viruses are not treated with antibiotics. Promote symptom control instead. Antibiotics filled on day of visit or within 3 days from visit, count in the measure as non-compliant. If you prescribe an antibiotic, please consider using an alternate code other than acute bronchitis/ bronchiolitis if appropriate, such as the suggested examples listed in Column 3. **Note**: This measure now includes **both children and adults.**	Do **not** use the following acute bronchitis / bronchiolitis diagnoses with an antibiotic: • **J20.3** Acute bronchitis due to coxsackievirus • **J20.4** Acute bronchitis due to parainfluenza virus • **J20.5** Acute bronchitis due to respiratory syncytial virus • **J20.6** Acute bronchitis due to rhinovirus • **J20.7** Acute bronchitis due to echovirus • **J20.8** Acute bronchitis due to other specified organisms • **J20.9** Acute bronchitis, unspecified • **J21.0** Acute bronchiolitis due to respiratory syncytial virus • **J21.1** Acute bronchiolitis due to human metapneumovirus • **J21.8** Acute bronchiolitis due to other specified organisms • **J21.9** Acute bronchiolitis, unspecified Includes outpatient, Telephone, Telehealth, Urgent Care, and ED visits.	**Alternate Codes:** The following codes **are** acceptable with an antibiotic per the measure (not a complete list): • **H66.90**: Otitis media, unspec. • **J01.90:** Acute sinusitis, unspec. • **J02.9:** Acute pharyngitis (**perform strep test**) • **J03.90**: Acute tonsillitis (**perform strep test**) Also ok to give an antibiotic with acute bronchitis or bronchiolitis diagnosis if these **co-morbid conditions** are coded at the visit or up to a year prior (not a complete list)**:** • Cancer • COPD • Cystic fibrosis • HIV • Pulmonary edema • Respiratory failure • TB Members in hospice are excluded.

Measure	Comments	More Tips
ADD **Follow-Up Care for Children Prescribed ADHD Medication** Ages 6 to 12 with ***newly prescribed** attention-deficit/hyperactivity disorder (ADHD) medication should have: • At least 3 follow-up care visits within a 10-month period. • One of the visits should be within 30 days of when the first ADHD medication was dispensed. **Two rates are tracked:** 1. **Initiation Phase:** One follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. (*Telehealth and Telephone visits added)* 2. **Continuation and Maintenance (C&M) Phase.** Remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. *(One E-visit or virtual check-in encounter allowed)* ***Newly prescribed-** no ADHD Rx for 120 days prior* <u>Intake period:</u> 12-month window starting March 1st of the prior year to February 28th of the current year.	**<u>ADHD Medications</u>:** **CNS Stimulants:** • Dextroamphetamine • Dexmethylphenidate • Lisdexamfetamine • Methylphenidate • Methamphetamine **Alpha-2 receptor agonists**: • Clonidine • Guanfacine **Miscellaneous ADHD Medication:** • Atomoxetine **Telephone/Telehealth Visits:** • CPT 98966-68, 99441-99443 *Acceptable for both phases of the measure* **Online Assessments/E-visit/Virtual Check-in:** • CPT 98969–98972, 99421–99423, 99444 *Can be used for 1 of the 2 C&M Phase visits* Exclusions: • Hospice • Filled an ADHD prescription 120 days prior to the index prescription start date (IPSD). • Have a diagnosis of narcolepsy. • Had an acute inpatient encounter for mental, behavioral, or neurodevelopmental disorder: ✓ 30 days after IPSD (Initiation Phase only) ✓ 300 days after the IPSD (C&M phase only)	• Use an e-visit or virtual check-in for one of the visits after the first 30 days. *Only one online assessment is allowed during the C&M phase.* • Schedule the first follow-up visit within 21 days of the initial prescription while the patient is still in the office. This will allow time to reschedule missed appointments within the 30-day initiation phase compliance timeframe. • Encourage compliance with follow-up appointments to evaluate medication effectiveness and adverse events. • Consider prescribing the first ADHD medication for a 21- or 30-day supply to promote timely follow-up. • Schedule at least two additional appointments while the patient is in the office for the first follow-up visit - the first in 3 months and the second in 6 months following the 30-day initial visit. Again, this will allow time to reschedule missed appointments within the 31 to 300-day C&M Phase compliance timeframe. • Refer to Behavioral Health for further treatment as indicated.

AMM

Antidepressant Medication Management

Age 18 and older who had a diagnosis of Major Depression and who were treated with an antidepressant medication, are monitored for how long they remained on the medication.

Two rates are tracked for remaining on the antidepressant medication:

1. **Effective Acute Phase Treatment:**
   - At least 84 days (12 weeks)
2. **Effective Continuation Phase Treatment:**
   - At least 180 days (6 months)

Intake Period: 12-month window starting May 1st of the prior year and ending on April 30th of the current measurement year.

See Appendix 1 for Antidepressant Medications.

Major Depression ICD-10 codes:
F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

Consider using the **Patient Health Questionnaire (PHQ-9)** to assess depressive symptoms, measure severity, develop a provisional diagnosis, and monitor treatment outcome.

Scoring and Interpretation:

PHQ-9 Score	Provisional Diagnosis	Proposed Treatment
5-9	Minimal Symptoms*	Support; educate to call in if worsens; repeat PHQ-9 at follow-up in 1 month
10-14	Minor Depression Dysthymia* Major Depression, Mild	Support; watchful waiting; antidepressant and/or psychotherapy
15-19	Major Depression, Moderate	Antidepressant and/or psychotherapy
20-27	Major Depression, Severe	Antidepressant with psychotherapy; collaborative management.

Rule out other depressive disorders:

- F34.1: *Dysthymia-symptoms present ≥ 2 years
- F43.21: Adjustment disorder w/ depressed mood symptoms following an adverse life event
- F06.31: Mood disorder due to physiological condition, symptoms resulting from systemic diseases

- Educate patients on medication compliance for optimum effectiveness.
- Explain medication regimen, benefits, and expected duration of treatment.
- Discuss potential side effects.
- Make follow-up calls to check on patients and remind them of upcoming visits.
- Reiterate the importance of attending follow-up visits.
- Refer patients to Behavioral Health as indicated.
- Contact Case Management/Coordination of Care when barriers to medication compliance are identified: unable to afford medication/follow-up appointment co-pay, lack of transportation, education, community resource, or home care needs.
- Emphasize the importance of continuing treatment even after they begin to feel better.

If no significant signs/symptoms of Major Depressive Disorder (MDD) are present for 2 months, with or without medication, please consider replacing active MDD diagnosis with:

- **F33.42 Major depressive disorder, recurrent, in FULL remission.**

DSM-5 (psychiatry.org)
https://www.pcpcc.org

Measure	Comments	More Tips
AMR **Asthma Medication Ratio** For ages 5 to 64 with persistent asthma, the ratio of controller medications to total asthma medications is 0.50 or greater during the measurement year. Adjust dosage so patient is well-controlled on Asthma Controller Medications (see Column 2) without frequent use of Asthma Reliever Medications (rescue inhalers). (Rescue inhalers include **short-acting, inhaled beta-2 agonists** albuterol and levalbuterol).	**Asthma Controllers:** • **Antiasthmatic combinations**: dyphylline- guaifenesin • **Antibody inhibitors**: omalizumab • **Anti-interleukin-4**: dupilumab • **Anti-interleukin-5**: benralizumab, mepolizumab, reslizumab • **Inhaled steroid combinations**: budesonide-formoterol, fluticasone-salmeterol, fluticasone-vilanterol, formoterol-mometasone • **Inhaled corticosteroids**: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, mometasone • **Leukotriene modifiers**: montelukast, zafirlukast, zileuton • **Methylxanthines**: theophylline	Members are excluded from the measure if they have: • COPD • Chronic respiratory conditions due to chemicals, gases, fumes, vapors • Cystic fibrosis • Acute respiratory failure Also exclude members in hospice.
APM **Metabolic Monitoring for Children and Adolescents on Antipsychotics** Ages 1–17 who had two or more antipsychotic prescriptions should have metabolic testing.	Three rates are reported: The percentage of children and adolescents on antipsychotics who: 1. Received blood glucose testing. 2. Received cholesterol testing. 3. Received blood glucose and cholesterol testing.	**See Appendix 2** for the following medications which pertain to this measure: • Antipsychotic medications • Antipsychotic combination medications • Prochlorperazine medications Members in hospice are excluded.

Measure	Comments	More Tips
APP **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics** Ages 1–17 that had a new prescription for an antipsychotic medication should have documentation of psychosocial care as first-line treatment. Should have documentation of psychosocial care in the 121-day period from 90 days prior to the earliest prescription dispensing date (between 1/1-12/1), through 30 days after this prescription.	Exclude members for whom first-line antipsychotic medications may be clinically appropriate, such as those diagnosed with: • schizophrenia • schizoaffective disorder • bipolar disorder • other psychotic disorder • autism, or • other developmental disorder. The above from at least 1 acute inpatient encounter, or at least 2 visits in an outpatient, intensive outpatient, or partial hospitalization setting in the measurement year.	**See Appendix 2** for the following medications which pertain to this measure: • Antipsychotic medications • Antipsychotic combination medications. **Psychosocial Care CPT Codes:** 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875-90876, 90880 Members in hospice are excluded.
BCS ☆ **Breast Cancer Screening** Women ages 50 to 74 should have a mammogram at least every two years. A note with the screening year is compliant provided it is within the two-year time frame. All types of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for compliance.	MRIs, ultrasounds, or biopsies do not count for the measure. Women who have had a bilateral mastectomy, or unilateral mastectomy with a bilateral modifier are excluded from the measure population. Documented evidence should be present. Please document in chart and/or notify Quality Management if bilateral mastectomy occurred outside of FHCP, including where done.	Members in hospice are excluded. Also excluded are those or with frailty and advanced illness together. Multiple diagnoses apply and must be on a visit claim. For a frailty diagnosis, please be sure to document ICD 10 codes in a claim to include: pressure ulcers, sarcopenia, falls, muscle wasting or weakness, bed confinement, reduced mobility, or dependence on wheelchair or supplemental oxygen (not a complete list). **Mammogram Codes:** **CPT Codes:** 77061-77063, 77065-77067.

Measure	Comments	More Tips
BPD **Blood Pressure Control for Patients With Diabetes** Ages 18-75 with diabetes (types 1 and 2) should have adequately controlled BP (<140/90 mm Hg) during the measurement year. ***This metric was previously within the now retired Comprehensive Diabetes Care measure (CDC).***	Uses the most recent BP reading during the year. Exclude BPs in INP setting or ED visit. If a member demonstrates a high blood pressure, **a second blood pressure should always be taken at the same visit and documented in the chart.** Please remember that BP must be **BELOW 140/90** to be considered compliant. Control within the year of **139/89 or below** should be **documented in the EHR if attained**.	If you believe member is in the BPD measure population inappropriately, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these claims can be corrected if the member does not have diabetes. Members in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
CBP **Controlling High Blood Pressure** Ages 18 to 85 with a diagnosis of hypertension (HTN) should have adequately controlled blood pressure (BP) during the measurement year. **Control** is based upon: • Ages 18 to 85 have BP controlled at **LESS THAN 140/90.** **Compliance is 139/89 or below.** Blood pressure should be routinely assessed as part of a physical exam at each outpatient visit. If BP is elevated, **retake BP** and document in the chart. Treat as necessary. Chart all measurements, and efforts to obtain BP control. Control within the measurement year of **139/89 or below** should be **documented in the EHR** if attained.	**The measure uses**: • The most recently documented BP at an outpatient visit, Telephone or Telehealth visit, nonacute inpatient encounter, or remote monitoring event. • The BP reading to be used for the measure must occur on or after the second diagnosis of HTN. • BP readings taken or reported by the member are now acceptable, **as long as result is documented by the provider in the note.** This includes Telephone and Telehealth visits. Please monitor whether a member reported result is 139/89 or below. If not, have member retake, or bring member in for a visit to try to obtain a controlled BP. Document in chart. **The measure does not use**: • BP readings from an acute inpatient stay or ED visit. • BP readings taken same day as a diagnostic test or therapeutic procedure requiring a change of diet or medication on or one day before (other than fasting blood tests), such as colonoscopy, dialysis, infusions, chemotherapy, or a nebulizer treatment with albuterol.	Please remember that BP must be **BELOW 140/90** to be considered compliant. Schedule a follow-up visit if a controlled BP of 139/89 or below was not obtained (can be a nurse visit). **Essential (primary) Hypertension ICD 10 Code**: I10 **Diastolic 80-89 Code CPT-CAT-II Code (compliant):** 3079F **Diastolic Less Than 80 CPT-CAT-II Code (compliant):** 3078F **Systolic Less than 140 CPT-CAT-II Code (compliant):** 3074F (less than 130 mm Hg) 3075F (130-139 mm Hg) Members in hospice are excluded.

Measure	Comments	More Tips
CCS **Cervical Cancer Screening** Ages 21 to 64 should be screened for cervical cancer using ***any one*** of the following: • Age 21–64 have cervical cytology (Pap smear) performed every 3 years. • Age 30–64 years of age have cervical high-risk human papillomavirus (hrHPV) testing performed every 5 years. • Age 30–64 years of age have cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed every 5 years.	Exclusion: Member does not need this screening if they had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix. Documenting a hysterectomy alone does not exclude member; **the removal of cervix must also be documented.** Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.	**Cervical Cytology Lab Test CPT codes**: 88141-88143, 88147-88148, 88150, 88152-88154, 88164-88167, 88174-88175 **High Risk Human Papillomavirus (hrHPV) Lab Test CPT codes**: 87624-87625 **Absence of Cervix Diagnosis**: Q51.5, Z90.710, Z90.712 Documentation in the medical record must include **both** of the following: • A note indicating the date the procedure was performed. • The result or finding. Members in hospice are excluded.
CHL **Chlamydia Screening In Women** Sexually active females ages 16 to 24 should be screened for chlamydia at least once a year.	Chlamydia screening can be a urine test.	**Chlamydia Test CPT Codes**: 87110, 87270, 87320, 87490-87492, 87810

Measure	Comments	More Tips
CIS – Combo 10 **Childhood Immunization Status** By their 2nd birthday, children should receive all of the following: • Four: Diphtheria, tetanus, and acellular pertussis (DTaP) • Three: Polio (IPV) • One: Measles, mumps, and rubella (MMR) • Three: Haemophilus influenza type B (HiB) • Three: Hepatitis B (HepB) • One: Chicken pox (VZV) • Four: Pneumococcal conjugate (PCV) • One: Hepatitis A (HepA) • Two or Three: Rotavirus (RV) • Two: Influenza (flu) (6 months or older) Immunizations must be completed **before** member turns age 2. Please educate office staff to schedule appointments **PRIOR** to 2nd birthday. For **MMR**, **VZV** and **HepA**, vaccinations must be on or between 1st and 2nd birthday. If prior to 1st birthday, will not count for the measure.	For DTaP, count any of the following: • Evidence of the antigen or combination vaccine. • Anaphylaxis due to the vaccine. • Encephalitis due to the vaccine. For hepatitis B, count any of the following: • Evidence of the antigen or combination vaccine. • Documented history of the illness. • A seropositive test result. • Anaphylaxis due to the vaccine. For MMR, VZV and hepatitis A, count any of the following: • Evidence of the antigen or combination vaccine. • Documented history of the illness. • A seropositive test result. For HiB and rotavirus, count *either*: • Evidence of the antigen or combination vaccine. • Anaphylaxis due to the vaccine. For IPV, pneumococcal conjugate and influenza, count only: • Evidence of the antigen or combination vaccine. For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens.	**DTaP Procedure Codes:** 90697, 90698, 90700, 90723 **HepA Procedure Code:** 90633 **HepB Procedure Codes:** 90697**,** 90723, 90740, 90744, 90747, 90748 **HiB Procedure Codes:** 90644, 90647, 90648, 90697, 90698, 90748 **Influenza Procedure Codes:** 90655, 90657, 90661, 90673, 90685, 90686, 90687, 90688, 90689 **Influenza Virus LAIV Procedure Codes:** 90660, 90672 **IPV (Inactivated Polio Vaccine) Procedure Codes:** 90697**,** 90698, 90713, 90723 **MMR Procedure Codes:** 90707, 90710 **Pneumococcal Conjugate (PCV) Procedure Code:** 90670 **Rotavirus 2 dose Procedure Code:** 90681 **Rotavirus 3 dose Procedure Code:** 90680 **Varicella Zoster (VZV) Procedure Codes:** 90710, 90716 Document in medical record if member has evidence of the disease for which immunization is intended, or contraindication due to anaphylactic reaction, immunodeficiency, lymphoreticular cancer, multiple myeloma, or leukemia.

Measure	Comments	More Tips
COL ★ **Colorectal Cancer Screening** Ages 50 to 75 should have appropriate screening for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT) during the measurement year. • Flexible sigmoidoscopy within the last 5 years. • Colonoscopy within the last 10 years. • CT colonography within the last 5 years. • FIT-DNA (*Cologuard*) during the last 3 years.	Documentation in the medical record must include a note indicating the date of the colorectal cancer screening within the time frame. Members who have had colorectal cancer or a total colectomy are excluded from this measure. • Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history, through December 31st of the measurement year.	Do not count digital rectal exams (DRE). Do not count FOBT tests performed in an office setting or performed on a sample collected via DRE. Members in hospice are excluded. Also excluded are those or with frailty and advanced illness together. Multiple diagnoses apply and must be on a visit claim. For a frailty diagnosis, please be sure to document ICD 10 codes in a claim to include: pressure ulcers, sarcopenia, falls, muscle wasting or weakness, bed confinement, reduced mobility, or dependence on wheelchair or supplemental oxygen (not a complete list).
COU **Risk of Continued Opioid Use** Members 18 and older who have a new episode of opioid use that puts them at risk for continued opioid use are tracked. Two rates are reported: 1. The percentage of members with at least 15 days of prescription opioids in a 30-day period. 2. The percentage of members with at least 31 days of prescription opioids in a 62-day period. A ***lower*** rate indicates better performance.	The measure counts the earliest prescription dispensing date for an opioid medication from November 1st of the prior year, and ending on October 31st of the current year. The following opioid medications are excluded: • Injectables • Opioid-containing cough and cold products • Single-agent and combination buprenorphine products used in medication-assisted treatment of opioid use disorder. • Ionsys® (fentanyl transdermal patch). • Methadone for the treatment of opioid use disorder.	Members in hospice are excluded. Also excluded are those with at least one of the following from 1 year prior to the earliest dispensing event for an opioid medication, through 61 days after: • Cancer • Sickle cell disease Please see Appendix 5, Opioid Medications.

Measure	Comments	More Tips
CWP **Appropriate Testing for Pharyngitis** Ages **3 and older** diagnosed with pharyngitis and dispensed an antibiotic, should also receive a **Group A streptococcus (strep) test** for the episode. **Note**: This measure now includes **both children and adults.**	A higher rate is better performance (i.e., appropriate strep test when an antibiotic is given for pharyngitis). **Group A Strep Tests:** **CPT Codes**: 87070, 87071, 87081, 87430, 87650, 87651, 87652, 87880 For a diagnosis of pharyngitis (see Column 3), **please be sure the Group A strep test CPT code is on the claim for the same visit.**	**Pharyngitis ICD-10 Codes – Perform Strep Test**: • **J02.0** Streptococcal pharyngitis • **J02.8** Acute pharyngitis due to other specified organisms • **J02.9** Acute pharyngitis, unspecified • **J03.00** Acute streptococcal tonsillitis, unspec. • **J03.01** Acute recurrent streptococcal tonsillitis • **J03.80** Acute tonsillitis due to other specified organisms • **J03.81** Acute recurrent tonsillitis due to other specified organisms • **J03.90** Acute tonsillitis, unspecified • **J03.91** Acute recurrent tonsillitis, unspecified
DAE **Use of High-Risk Medications in Older Adults** The percentage of Medicare members 67 years of age and older who had at least two dispensing events for the same high-risk medication during the measurement year. Three rates are reported: 1. Percentage who had at least two dispensing events for high-risk medications to avoid from the same drug class. 2. Percentage who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses. 3. Total rate (the sum of the two numerators divided by the denominator, deduplicating for members in both numerators).	Caution should be used in dispensing high-risk medications to the elderly. A ***lower*** rate represents better performance. The measure reflects potentially inappropriate medication use in older adults, both for: • Medications where ***any*** use is inappropriate (Rate 1); and • Medications where use ***under all but specific indications*** is potentially inappropriate (Rate 2). Members in hospice are excluded from this measure.	Please see **Appendix 6 for High-Risk Medications** for Rate 1, and for Rate 2. Rate 1: **High Risk Medications to Avoid**: • High-Risk Medications • High-Risk Medications With Days' Supply Criteria • High-Risk Medications With Average Daily Dose Criteria Rate 2: **High-Risk Medications to Avoid Except for Appropriate Diagnosis**: • High-Risk Medications Based on Prescription & Diagnosis Data

Measure	Comments	More Tips
DDE **Potentially Harmful Drug–Disease Interactions in Older Adults** The percentage of Medicare members age 65 and older with evidence of an underlying disease, condition or health concern: • who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Counts members with at least one disease, condition, or procedure within the last 2 years. The start date is the earliest diagnosis, procedure, or prescription between January 1 of the prior year, to December 1 of the current year.	Avoid the following conditions and drugs (three rates reported separately, and as total rate): • **A history of falls (accidental fall or hip fracture)** and a prescription for antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs). • **Dementia** and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents. • **Chronic Kidney Disease** and a prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs. Total rate is the sum of the three numerators divided by the sum of the three denominators.	A ***lower*** rate of these prescriptions for these conditions represents better performance. Always evaluate if the member has one of these conditions before dispensing these medications. Members in hospice are excluded from the measure. For falls, exclude members with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, or seizure disorder up to 2 years prior. For dementia, exclude members with a diagnosis of psychosis, schizophrenia, schizoaffective disorder, or bipolar disorder up to 2 years prior.
EDU **Emergency Department Utilization** For members 18 and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year. ***Lower*** rates signify better performance.	Assesses ED utilization by health plan members. Health plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. • The observed and expected rates are used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less emergency department visits than expected, while accounting for incremental improvements across all plans over time. • The observed-to-expected ratio is multiplied by the emergency department visit rate across all health plans to produce a risk-standardized rate which allows for national comparison.	ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed **to preventable or treatable conditions**. A high rate of ED utilization may indicate care management needing improvement, inadequate access to care, or poor patient choices, resulting in ED visits that could be prevented. Plans should try to ensure that members receive appropriate, coordinated primary care as well as education to address preventable ED visits.

Measure	Comments	More Tips
EED ☆ **Eye Exam for Patients With Diabetes** Age 18-75 with diabetes (types 1 and 2) should have a retinal eye exam, to include **one** of the following: 1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. 2. A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. **3.** Bilateral eye enucleation any time during the member's history through December 31 of the measurement year. ***This metric was previously within the now retired Comprehensive Diabetes Care measure (CDC).***	Documentation in the medical record must include **one** of the following: 1. A note by an ophthalmologist, optometrist, PCP or other health care professional indicating all of the following: ✓ An ophthalmoscopic exam was completed by an eye care professional; and ✓ the date when the procedure was performed; and ✓ the results. **OR** 2. A chart or photograph indicating the date when the fundus photography was performed and was reviewed by an optometrist or ophthalmologist.	If you believe member is in the EED measure population inappropriately, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these claims can be corrected if the member does not have diabetes. Members in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
FMC **Follow-Up After ED Visit for People With Multiple High-Risk Chronic Conditions** The percentage of ED visits for members 18 and older with multiple high-risk chronic conditions, who had a follow-up service within 7 days of the ED visit. Exclude ED visits that result in an inpatient stay, and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission.	For this measure, ED visits requiring a follow-up service within 7 days apply to members who had two or more different chronic conditions **prior** to the ED visit, within the past 2 years. The following are eligible chronic conditions: • COPD and Asthma. • Alzheimer's Disease and related disorders. • Chronic Kidney Disease. • Depression. • Heart Failure. • Acute Myocardial Infarction. • Atrial Fibrillation. • Stroke and Transient Ischemic Attack.	May count follow-up visits that occur on the date of the ED visit. Follow-up outpatient visits can include Behavioral Health, Telehealth, Telephone, or Case Management visits. Members in hospice are excluded.
FRM ★ **Fall Risk Management** For Medicare members: Two components of this measure assess different facets of fall risk management (see Column 2).	1. **Discussing Fall Risk:** The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner. 2. **Managing Fall Risk:** The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.	This measure is collected using survey methodology, in the Medicare Health Outcomes Survey (HOS).

Measure	Comments	More Tips
FUA **Follow-Up After Emergency Department Visit for Substance Use** The percentage of emergency department (ED) visits for age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. **Two rates for follow-up are reported:** 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.	• The follow-up visit can be with any practitioner, with any diagnosis of SUD, substance use, or drug overdose. • A pharmacotherapy dispensing event or medication treatment event also counts. • May include visits and pharmacotherapy events that occur on the date of the ED visit.	If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. Exclude ED visits that result in an inpatient stay, and exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. A Telehealth or Telephone visit can count for the measure.
FUH **Follow-Up After Hospitalization for Mental Illness** Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, should have a follow-up visit with a **mental health provider.** This measure counts an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim.	Two rates for follow-up are reported: 1. The member received follow-up with a mental health provider within 7 days after discharge. 2. The member received follow-up with a mental health provider within 30 days after discharge. Discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period are excluded regardless of principal diagnosis for the readmission (as may prevent an outpatient follow-up visit from taking place).	A follow-up visit with a mental health provider does not include visits that occur on the date of discharge. In addition to outpatient visits, Telehealth and Telephone visits with a mental health provider also count. This measure is based on discharges, not members. If more than 1 discharge, count all discharges between January 1 and December 1.

Measure	Comments	More Tips
FUI **Follow-Up After High-Intensity Care for Substance Use Disorder** Age 13 and older with an acute inpatient hospitalization, residential treatment or detoxification visit for a diagnosis of substance use disorder • should have a follow-up visit or service for substance use disorder.	**Two rates for follow-up are reported:** 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. Follow-up visit may be with any practitioner, but must have a **principal** diagnosis of **substance use disorder** on the claim for the visit to count.	The denominator for this measure is based on episodes, not on members. If members have more than episode, include all that fall on or between January 1 and December 1 of the measurement year.

Measure	Comments	More Tips
FUM **Follow-Up After ED Visit for Mental Illness** Age 6 years and older who had an ED visit with a principal diagnosis of mental illness or intentional self-harm, should have a follow-up visit for mental illness. **Two rates for follow-up are reported:** 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.	• Can be a follow-up visit with **any** practitioner, with a **principal diagnosis** of a mental health disorder, or with a **principal diagnosis** of intentional self-harm **and any diagnosis** of a mental health disorder. • May include visits that occur on the date of the ED visit. • May include Telehealth and Telephone visits.	If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. Exclude ED visits that result in an inpatient stay, and exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members in hospice are excluded.
FVA **Flu Vaccinations for Adults Ages 18-64** Members age 18-64 should receive an annual flu vaccination.	Please educate your patients on the importance of an annual flu shot.	This measure is collected using survey methodology, in the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
FVO ☆ **Flu Vaccinations for Adults Ages 65 and Older** Members age 65 and older should receive an annual flu vaccination.	Please educate your patients on the importance of an annual flu shot.	This measure is collected using survey methodology, in the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Measure	Comments	More Tips
HBD ☆ **Hemoglobin A1c Control for Patients With Diabetes** Members age 18-75 with diabetes (types 1 and 2) are rated for the following during the measurement year: 1. HbA1c control (<8.0%) **2.** HbA1c poor control (>9.0%) ***This metric was previously within the now retired Comprehensive Diabetes Care measure (CDC).*** The measure counts the most recent HbA1c test for the year by lab data or medical record review. Documentation in the medical record must include a note indicating the **date** when the HbA1c test was performed and the **result**.	1. **HbA1c control (<8.0%):** • The most recent HbA1c level during the year is <8.0%. • If no HbA1c was completed during the year, the member is noncompliant. Therefore, please ensure that your members with diabetes have an HbA1c performed during the year or they will be considered noncompliant even if their A1c has been controlled in the past. 2. **HbA1c poor control (>9.0%):** • The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing. **Note:** A ***lower*** rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).	Please document in chart and/or notify Quality Management if an A1c test occurred outside of FHCP, and where so the record may be obtained. If you believe member is in the HBD measure population inappropriately, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these claims can be corrected if the member does not have diabetes. Members in hospice are excluded.

Measure	Comments	More Tips
HDO **Use of Opioids at High Dosage** The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year. A ***lower*** rate indicates better performance. Eligible population: Members 18 and older who had two or more opioid dispensing events on different dates of service during the year, AND who had ≥15 total days covered by opioids. The tracked rate is the number of these members in the eligible population whose average MME was ≥90 during the treatment period. **See Appendix 3:** Opioid Medications / MME Conversion Factor	**MME**: Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic. **Opioid Dosage Unit**: For each dispensing event, use the following calculation to determine the Opioid Dosage Unit: • # of Opioid Dosage Units per day = (opioid quantity dispensed) / (opioid days supply) **MME Daily Dose:** For each dispensing event, use the following calculation to determine MME Daily Dose: Convert each medication into the MME using the appropriate MME conversion factor and strength associated with the opioid product of the dispensing event. **MME Daily Dose** = (# of opioid dosage units per day) X (strength (e.g., mg, mcg)) X (MME conversion factor). *Example 1*: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day. *Example 2*: 25 mcg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day.	*Cont'd from previous column* **Total Daily MME**: The total sum of the MME Daily Doses for all opioid dispensing events on one day. **Average MME**: The average MME for all opioids dispensed during the treatment period. • This measure does not include the following opioid medications: – Injectables. – Opioid cough and cold products. – Ionsys® (fentanyl transdermal patch). ▪ This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). – Methadone for the treatment of opioid use disorder. Excluded from the measure: hospice, cancer, or sickle cell disease during current year.

Measure	Comments	More Tips
IET **Initiation and Engagement of Substance Use Disorder Treatment** Age 13 and older who have a new substance use disorder (SUD) episode during the intake period with a diagnosis of SUD, should have treatment initiation and engagement. Two rates for follow-up are reported: • **Initiation of SUD Treatment**. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, Telehealth visit or medication treatment within 14 days. • **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. When a new SUD diagnosis is detected please immediately schedule **3 follow up visits**: • 1 Initiation visit in 7 days and 2 Engagement visits within 24 days. This will allow time to reschedule missed visits within the 14-day / 34-day compliance windows. Members in hospice are excluded.	Intake period: November 15 of prior year– November 14 of current year (new SUD episodes). • For visits that result in an inpatient stay or medical management withdrawal event (i.e. inpatient detoxification), the inpatient discharge is the SUD episode. • For an outpatient, intensive outpatient, partial hospitalization, observation, Telehealth, detoxification (not inpatient), or ED visit, the SUD episode is date of service. • For direct transfers, the SUD episode is the discharge date from the last admission. Educate patients on the effects of alcohol or other drug abuse and discuss treatment options. Refer to Behavioral Health as indicated. When SUD is no longer active, please remove or replace with an appropriate "in remission" diagnosis. **Alcohol Use Disorder Treatment Medications:** • Aldehyde dehydrogenase inhibitor: disulfiram (oral) • Antagonist: naltrexone (oral/injectable) • Other: acamprosate (oral; delayed-release tablet) **Opioid Use Disorder Treatment Medications:** • Antagonist: naltrexone (oral) • Antagonist: naltrexone (injectable) • Partial agonist: buprenorphine (sublingual tablet, injection, or implant) • Partial agonist: buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	Consider using the AUDIT-C to screen patients for symptoms of substance use disorders upon intake, annually, and as indicated: AUDIT-C-Plus-2-Screening-Questionnaire.pdf (nationalcouncildocs.net) AUDIT-C-Plus-2-Screening-Results.pdf (nationalcouncildocs.net) If a drug is **prescribed, monitored**, **and used as directed** do not use a diagnosis placing patient in this measure. Examples: • F10.10 Alcohol Abuse • F11.20 Opiate dependence • F13.20 Benzodiazepine dependence • F15.20 Caffeine dependence (maps to stimulant abuse) • F12.90 Marijuana user Patients described as using a substance associated with words like "use" "abuse" or "dependence" are going to be assigned an "F" code in EHR thus placing them in this measure. **Please do not use an "F" code to denote the use of a substance but not necessarily a diagnosable disorder**; for instance, someone who has been on medically supervised opioid therapy for chronic pain. **Instead, please consider "Z" codes when appropriate** (indicates use of a substance but not necessarily a disorder), and thus patient will not be in the measure: Examples – **please consider using**: • Z72.89 Alcohol Use • Z71.41 Alcohol abuse counseling/surveillance of alcoholic • Z79.891 Long term (current) use of opiate analgesic • Z79.899 Long term (current) use of benzodiazepine • Z78.9 Caffeine use • Z79.899 Medical marijuana use

Measure	Comments	More Tips
IMA **Immunizations for Adolescents** By age 13, member should have had: • One dose of meningococcal vaccine • One tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and • Completed the human papillomavirus (HPV) vaccine series. The measure calculates a rate for each vaccine and two combination rates.	Please educate staff to schedule **PRIOR** to 13th birthday. Must be **completed by the 13th birthday.** Document and submit timely with correct code. Offer HPV Vaccine to members age 9 to age 13. • Two doses should be completed prior to age 13.	**Meningococcal Procedure Code**: 90619, 90733, 90734 **Tdap Procedure Code**: 90715 **HPV Procedure Codes**: 90649, 90650, 90651
LBP **Use of Imaging Studies for Low Back Pain** Ages 18--75 with a primary diagnosis of uncomplicated low back pain should **not** have an imaging study (plain x-ray, MRI, or CT scan) **within 28 days of the diagnosis**. There are exclusions where imaging *may* be clinically appropriate within the first 28 days. Exclusion diagnoses (such as a fracture) must be submitted in a **claim** to count. Members in hospice, those with both frailty and advanced illness (must be documented), and those on dementia medication are excluded from the measure population.	**Exclusions** – Imaging acceptable within 28 days of a primary low back pain diagnosis if member had one of the following (please use a code on claim): **Cancer, HIV, major organ transplant, osteoporosis therapy, lumbar surgery, or spondylopathy** any time during the member's history through 28 days after the low back pain diagnosis. **Recent trauma (fractures, fragility fractures, dislocations, lacerations, internal injuries, etc.).** Trauma any time during the 3 months prior to the low back pain diagnosis through 28 days after. **Intravenous drug abuse, neurologic impairment, or spinal infection** any time during the 12 months prior to the low back pain diagnosis through 28 days after. **Prolonged use of corticosteroids.** 90 consecutive days of corticosteroids any time during the 12 months prior to the low back pain diagnosis.	**Alternate codes:** Please consider if any of these apply in the primary position rather than one of the uncomplicated low back pain diagnoses, and then imaging within 28 days would be acceptable (**not a complete list**): • Discitis, unspecified, lumbar region (M46.46) • Discitis, unspecified, lumbosacral region (M46.47) • Muscle spasm of back (M62.830) • Contusion of lower back (S30.0XXA) • Unspecified superficial injury of lower back (S30.91XA) A higher score/rating for this measure indicates appropriate treatment of low back pain (imaging studies did **NOT** occur within the 28 days).

Measure	Comments	More Tips
OMW ☆ **Osteoporosis Management in Women Who Had a Fracture** Ages 67 to 85 who suffered a fracture (other than finger, toe, face, or skull), should have ***either one*** of the following **within the 6 months after the fracture**: • A bone mineral density (BMD) test, also known as a DEXA scan, ***OR*** • Fill a prescription for a drug to treat osteoporosis.	***Either*** a BMD test or the drug therapy within 6 months after the fracture meets the criteria. Drug therapy would be indicated (rather than another BMD test) if a previous test already shows osteoporosis. Members with either of the following are also considered compliant: • BMD test within the 24 months prior to the fracture; ***or*** • Osteoporosis drug therapy within the 12 months prior to the fracture.	Osteoporosis drug therapies: • **Bisphosphonates**: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid. • **Other agents**: abaloparatide, denosumab, raloxifene, romosozumab, teriparatide. **Reminder to Staff PCPs**: Please put in the BMD test order after a fracture, and notify the patient how to call and schedule an appointment. (For example, FHCP Radiology in Daytona Beach does not call patients to schedule, from an EHR Task). Members in hospice are excluded, as are age 67-80 with both frailty and advanced illness (must be documented), or on dementia medication.
PCE **Pharmacotherapy Management of COPD Exacerbation** Age 40 and older with an acute inpatient (INP) discharge or emergency department (ED) visit for a COPD exacerbation should fill a prescription for **both**: • Systemic corticosteroid within 14 days of discharge **and** • Bronchodilator within 30 days of discharge.	In addition to filling these medications timely after discharge from INP or ED, the member's medications will also count if: • Member has previously filled prescriptions for both medications, with enough days' supply to cover date of admission for inpatient stay, or to cover ED date of service. The eligible population is based on INP and ED visits, so the member may appear more than once in the measure for the year.	**PCPs**: At the 7-day follow-up visit after an INP or ED hospital encounter for a COPD exacerbation, please ask the member when they last filled these medications. If not yet filled, please consider prescribing both a systemic corticosteroid and a bronchodilator (if there are no contraindications), and encourage patient to fill immediately. For example, the patient may tell the hospitalist they have a nebulizer at home; however, prescriptions for a bronchodilator have not been filled recently.

Measure	Comments	More Tips
PCR **Plan All-Cause Readmissions** For ages 18 and older, the number of acute inpatient and observation stays during the year: • that were followed by an unplanned acute readmission for any diagnosis within 30 days, and the predicted probability of an acute readmission.	Discharge from the hospital is a critical transition point in a patient's care. Hospital readmission is associated with longer lengths of stay and higher mortality for patients. Hospital readmissions are commonly related to CHF, Acute MI, COPD, and pneumonia. Members in hospice are excluded.	Also exclude hospital stays from the measure for the following reasons: • Pregnancy • A principal diagnosis of a condition originating in the perinatal period • Member died during hospital stay • A principal diagnosis of maintenance chemotherapy • An organ transplant
PNU **Pneumococcal Vaccination Status for Older Adults** The percentage of Medicare members 65 years of age and older, who have ever received one or more pneumococcal vaccinations.	Please educate your older patients on the importance of a pneumococcal vaccination.	This measure is collected using survey methodology, in the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
POD **Pharmacotherapy for Opioid Use Disorder** Age 16 and older with a diagnosis of OUD (Opioid Use Disorder) should have OUD pharmacotherapy for 180 or more days. See Column 3 for OUD pharmacotherapy.	Identify members with any diagnosis of OUD during July 1 of the prior year to June 30 of the measurement year. The Treatment Period of 180 calendar days should not contain any gaps in treatment of 8 or more consecutive days. Exclude any Treatment Period Start Dates where the member had an acute or nonacute inpatient stay of 8 or more days during the Treatment Period.	• Antagonist: naltrexone (oral) • Antagonist: naltrexone (injectable) • Partial agonist: buprenorphine (sublingual tablet) • Partial agonist: buprenorphine (injection) • Partial agonist: buprenorphine (implant) • Partial agonist: buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film) Methadone (agonist) not included. Methadone for OUD from federally certified opioid treatment programs is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

Measure	Comments	More Tips
PPC **Prenatal & Postpartum Care** For members with live births: • Timeliness of Prenatal Care: Members should receive a prenatal care visit in the **first trimester**, on or before the enrollment start date or within 42 days of enrollment in the health care plan. • Postpartum Care: Members should have a postpartum visit **on or between 7 and 84 days after delivery.** Telephone visits may be used for both prenatal and postpartum care.	**Prenatal**: Please educate staff to schedule first appointment with the OB/GYN, other prenatal care practitioner, or PCP in the first trimester. • For visits to a PCP, a diagnosis of pregnancy must be present. **Postpartum:** • Should be visit to an OB/GYN or other prenatal care practitioner, or PCP. • Postpartum visit for a pelvic exam meets the requirement. • Do not include postpartum care provided in an acute inpatient setting. • Do not count visits that occur on the date of delivery.	**Prenatal Visit Codes:** 99201-99205, 99211-99215, 99241-99245, 99483. (Please also include a pregnancy related diagnosis code). **Stand Alone Prenatal Visit Codes:** 99500, 0500F, 0501F, 0502F **Prenatal Bundled Services Codes:** 59400, 59425, 59426, 59510, 59610, 59618 **Postpartum Visit Codes:** 57170, 58300, 59430, 99501, 0503F **Postpartum Bundled Services:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 Members in hospice are excluded.

Measure	Comments	More Tips
PSA **Non-Recommended PSA-Based Screening in Older Men** Ages **70 and older** should **not** be screened unnecessarily for prostate cancer, using prostate-specific antigen (PSA)-based screening. A ***lower*** rate indicates better performance. Members in hospice are excluded.	PSA-based screening for prostate cancer for men age 70 and older should not be used unless a clinically indicated diagnosis is present. The following are considered clinically appropriate indicators for PSA-based testing for age 70 and older: 1. Prostate cancer any time during the member's history. 2. Dysplasia of the prostate during the measurement year, or year prior.	Cont'd 3. A PSA test during the year prior to the measurement year, where lab data indicate an elevated result (>4.0 ng/mL). 4. An abnormal PSA test result or finding during the prior year. 5. Dispensed prescription for 5-alpha reductase inhibitor (finasteride or dutasteride) during the measurement year.
SAA **Adherence to Antipsychotic Medications for Individuals With Schizophrenia** Age 18 and older with schizophrenia or schizoaffective disorder: • should be dispensed and remain on an antipsychotic medication for at least 80% of their treatment period.	The treatment period is the earliest prescription dispensing date for any antipsychotic medication during the year, through the last day of the year.	Members in hospice are excluded. Also excluded are those with dementia, and age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
SPC ☆ **Statin Therapy for Patients with Cardiovascular Disease** Males ages 21 to 75, and females ages 40 to 75, who were identified **with clinical atherosclerotic cardiovascular disease** (ASCVD), should meet the following criteria: • **Received Statin Therapy:** Dispensed at least one **high or moderate intensity** statin medication during the measurement year. • **Statin Adherence 80%:** Remained on a **high or moderate intensity** statin medication for at least 80% of the treatment period.* *Treatment period is the earliest prescription dispensing date for any high or moderate intensity statin medication, through the last day of the year.	Members can be **excluded** from this measure population if the following is documented: • Myalgia, myositis, myopathy, or rhabdomyolysis during the current year. **IMPORTANT**: **Physicians**: If your patient cannot tolerate a statin due to one of these side effects, please put the corresponding diagnosis as listed above on a visit claim during the **current measurement year**. Diagnoses of myalgia, myositis, myopathy, or rhabdomyolysis **must be on a claim during the current year** for the member to be excluded. Includes patients who have ASCVD and suffered side effects when trying a statin in the past. **Please re-document the side effect diagnosis each year in a visit claim.**	Other exclusions for this measure include: • End Stage Renal Disease (ESRD), cirrhosis, pregnancy, in vitro fertilization, hospice, and age 66 and older with both advanced illness and frailty. Please document any of the above in a visit claim during the current year. ASCVD includes members with MI, CABG, PCI, other revascularization, or a diagnosis of ischemic vascular disease (IVD) with treatment during the year or year prior. **See Appendix 4** for Statin Medications.
SPD ☆ **Statin Therapy for Patients with Diabetes** Ages 40 to 75 with diabetes, but **without** clinical atherosclerotic cardiovascular disease (ASCVD), should meet the following criteria: • **Received Statin Therapy:** Dispensed at least one statin medication of **any intensity** during the measurement year. • **Statin Adherence 80%:** Remained on a statin medication of **any intensity** for at least 80% of the treatment period.	Members are not included in this measure if they have: • MI inpatient, CABG, PCI, other revascularization, or a diagnosis of ischemic vascular disease (IVD) with treatment during the year or year prior.	Other exclusions for this measure include: • End Stage Renal Disease (ESRD), cirrhosis, pregnancy, in vitro fertilization, hospice, and age 66 and older with both advanced illness and frailty. Please document any of the above in a visit claim during the current year. **See Appendix 4** for Statin Medications.

Measure	Comments	More Tips
TRC **Transitions of Care** The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year (**see second column – four rates are reported**). The record where documentation is expected is with the member's Primary Care Physician (PCP). However, if a practitioner other than the PCP manages the member's ongoing care, the health plan may use the medical record kept by that practitioner.	1. **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). 2. **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). At a minimum, must include the practitioner responsible for the member's care during the inpatient stay, procedures or treatment provided, diagnoses at discharge, current medication list, test results, and instructions for patient care post-discharge. 3. **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits to the home, Telehealth, Telephone) provided within 30 days after discharge. May not occur on date of discharge. 4. **Medication Reconciliation Post-Discharge.** ☆ Documentation of medication reconciliation on the date of discharge through 30 days after discharge. Conducted by a prescribing practitioner, Clinical Pharmacist, Physician Assistant, or RN. Patient does not have to be present.	Applies to discharges for acute and non-acute inpatient stays. A Telephone visit may count for the measure. May not use documentation that the member or the member's family notified the PCP or ongoing care provider of the admission or discharge. There must be a time frame or date when the documentation was received. Members in hospice excluded.

Measure	Comments	More Tips
UOP **Use of Opioids From Multiple Providers** The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, **who received opioids from multiple providers.** Three rates are reported (see Column 2). A **lower** rate indicates better performance for all three rates. **Eligible population**: Members 18 & older who met both of the following criteria during the year: • At least two or more opioid dispensing events on different dates of service. • ≥15 total days covered by opioids.	1. **Rate 1: Multiple Prescribers**. The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. 2. **Rate 2: Multiple Pharmacies**. The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. 3. **Rate 3: Multiple Prescribers and Multiple Pharmacies**. The proportion of members receiving prescriptions for opioids from four or more different prescribers ***and*** four or more different pharmacies during the measurement year. **See Appendix 5** for Opioid Medications List.	Members in hospice are excluded. • The following opioid medications are excluded from this measure: – Injectables. – Opioid cough and cold products. – Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder (i.e., buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products). – Ionsys® (fentanyl transdermal patch). – Methadone for opioid use disorder.
URI **Appropriate Treatment for Upper Respiratory Infection** Age **3 months and older** with a diagnosis of upper respiratory infection (URI) should ***not*** be dispensed an antibiotic prescription. URIs should be treated symptomatically, and not with an antibiotic. **Note**: This measure now includes **both children and adults.**	**URI codes** (please do not give antibiotic): • **J00:** Acute nasopharyngitis (common cold) • **J06.0:** Acute laryngopharyngitis • **J06.9:** Acute upper respiratory infection, unspecified Antibiotics filled on or within 3 days of the visit with a diagnosis of URI, count in the measure as non-compliant. Outpatient, Telephone, Telehealth, and ED visits count in the measure (other than those ED visits resulting in an inpatient stay).	**Alternate Codes:** Acceptable with an antibiotic per the measure (**not a complete list**): **H66.90**: Otitis media, unspec. **J01.90:** Acute sinusitis, unspec. **J02.9:** Acute pharyngitis (**perform strep test**) **J03.90**: Acute tonsillitis (**perform strep test**) Also ok to give antibiotic with URI if these **co-morbid conditions** are coded at the visit or up to a year prior (not a complete list)**:** -Cancer -COPD -Cystic fibrosis -HIV -Pulmonary edema -Respiratory failure -TB

Measure	Comments	More Tips
WCC **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** Ages 3 to 17 should have an outpatient visit with a PCP or OB/GYN annually, with evidence of all of the following: • **BMI Percentile documentation*** • **Counseling for Nutrition** • **Counseling for Physical Activity** Service may be rendered at other than a well-child visit, but notation/services specific to an acute or chronic condition may **not** count toward Counseling for Nutrition or Physical Activity. • For example, noting a member with diarrhea is following the BRAT diet, or noting a member with chronic knee pain is able to run without limping, do not count. *Percentile ranking based on the CDC's BMI-for-age growth charts, indicating relative position of the patient's BMI number among others of the same gender and age.	**BMI Percentile:** Must include height, weight, and a distinct BMI percentile, from the same data source. BMI percentile can be a value (e.g., 85th percentile), or plotted on an age-growth chart. **Counseling for Nutrition:** Must include a note with date and at least one of the following: (1) Discussion of current nutrition behaviors (eating habits, dieting behaviors, etc.) (2) Checklist that nutrition was addressed (3) Counseling or referral for nutrition education (4) Received nutrition educational materials in a face-to-face visit (5) Anticipatory guidance for nutrition (6) Weight or obesity counseling Documentation related to a member's "appetite" does not meet criteria for Counseling for Nutrition. Referral to WIC may be used. Services rendered for obesity or eating disorders may be used for both Nutrition & Physical Activity. Services rendered during a Telephone or Telehealth visit meet criteria.	**Counseling for Physical Activity:** Must include a note with date, and at least one of the following: (1) Discussion of current physical activity behaviors (exercise routine, participation in sport, exam for sport participation etc.) (2) Checklist indicating physical activity was addressed (3) Counseling or referral for physical activity (4) Received physical activity education materials in face-to-face visit (5) Anticipatory guidance specific to child's physical activity (6) Weight or obesity counseling **BMI Percentile**: **ICD-10**: Z68.51-Z68.54 **Nutrition Counseling**: **ICD-10**: Z71.3 **Procedure Code**: 97802-97804 **Physical Activity Counseling**: **ICD-10**: Z02.5, Z71.82

APPENDIX 1:

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

APPENDIX 2:

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurisadone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine ~~• Quetiapine fumarate~~ • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine	• Thioridazine • Trifluoperazine	
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	• Prochlorperazine

APPENDIX 3:

Opioid Medications / MME Conversion Factor[1]

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Benzhydrocodone	Acetaminophen Benzhydrocodone 4.08 mg Medications List Acetaminophen Benzhydrocodone 6.12 mg Medications List Acetaminophen Benzhydrocodone 8.16 mg Medications List	4.08 mg 6.12 mg 8.16 mg	1.2
Butorphanol	Butorphanol 10 MGPML Medications List	10 mg	7
Codeine	Codeine Sulfate 15 mg Medications List Codeine Sulfate 30 mg Medications List Codeine Sulfate 60 mg Medications List	15 mg 30 mg 60 mg	0.15
Codeine	Codeine Phosphate 15 mg Medications List Codeine Phosphate 2 MGPML Medications List	15 mg 2 mg	0.15
Codeine	Acetaminophen Codeine 2.4 MGPML Medications List Acetaminophen Codeine 15 mg Medications List Acetaminophen Codeine 30 mg Medications List Acetaminophen Codeine 60 mg Medications List	2.4 mg 15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Codeine	Aspirin Codeine 8 mg Medications List	8 mg	0.15
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Dihydrocodeine	Aspirin Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg)[2]	Fentanyl 100 mcg Medications List	100 mcg	0.13
	Fentanyl 200 mcg Medications List	200 mcg	
	Fentanyl 300 mcg Medications List	300 mcg	
	Fentanyl 400 mcg Medications List	400 mcg	
	Fentanyl 600 mcg Medications List	600 mcg	
	Fentanyl 800 mcg Medications List	800 mcg	
	Fentanyl 1200 mcg Medications List	1200 mcg	
	Fentanyl 1600 mcg Medications List	1600 mcg	
Fentanyl oral spray (mcg)[3]	Fentanyl 100 MCGPS Oral Medications List	100 mcg	0.18
	Fentanyl 200 MCGPS Oral Medications List	200 mcg	
	Fentanyl 400 MCGPS Oral Medications List	400 mcg	
	Fentanyl 600 MCGPS Oral Medications List	600 mcg	
	Fentanyl 800 MCGPS Oral Medications List	800 mcg	
Fentanyl nasal spray (mcg)[4]	Fentanyl 100 MCGPS Nasal Medications List	100 mcg	0.16
	Fentanyl 300 MCGPS Nasal Medications List	300 mcg	
	Fentanyl 400 MCGPS Nasal Medications List	400 mcg	
Fentanyl transdermal film/ patch (mcg/hr)[5]	Fentanyl 12 MCGPH Medications List	12 mcg	7.2
	Fentanyl 25 MCGPH Medications List	25 mcg	
	Fentanyl 37.5 MCGPH Medications List	37.5 mcg	
	Fentanyl 50 MCGPH Medications List	50 mcg	
	Fentanyl 62.5 MCGPH Medications List	62.5 mcg	
	Fentanyl 75 MCGPH Medications List	75 mcg	
	Fentanyl 87.5 MCGPH Medications List	87.5 mcg	
	Fentanyl 100 MCGPH Medications List	100 mcg	
Hydrocodone	Hydrocodone 10 mg Medications List	10 mg	1
	Hydrocodone 15 mg Medications List	15 mg	
	Hydrocodone 20 mg Medications List	20 mg	
	Hydrocodone 30 mg Medications List	30 mg	
	Hydrocodone 40 mg Medications List	40 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Hydrocodone 50 mg Medications List	50 mg	
	Hydrocodone 60 mg Medications List	60 mg	
	Hydrocodone 80 mg Medications List	80 mg	
	Hydrocodone 100 mg Medications List	100 mg	
	Hydrocodone 120 mg Medications List	120 mg	
Hydrocodone	Acetaminophen Hydrocodone .5 MGPML Medications List	.5 mg	1
	Acetaminophen Hydrocodone .67 MGPML Medications List	.67 mg	
	Acetaminophen Hydrocodone 2.5 mg Medications List	2.5 mg	
	Acetaminophen Hydrocodone 5 mg Medications List	5 mg	
	Acetaminophen Hydrocodone 7.5 mg Medications List	7.5 mg	
	Acetaminophen Hydrocodone 10 mg Medications List	10 mg	
Hydrocodone	Hydrocodone Ibuprofen 2.5 mg Medications List	2.5 mg	1
	Hydrocodone Ibuprofen 5 mg Medications List	5 mg	
	Hydrocodone Ibuprofen 7.5 mg Medications List	7.5 mg	
	Hydrocodone Ibuprofen 10 mg Medications List	10 mg	
Hydromorphone	Hydromorphone 1 MGPML Medications List	1 mg	4
	Hydromorphone 2 mg Medications List	2 mg	
	Hydromorphone 3 mg Medications List	3 mg	
	Hydromorphone 4 mg Medications List	4 mg	
	Hydromorphone 8 mg Medications List	8 mg	
	Hydromorphone 12 mg Medications List	12 mg	
	Hydromorphone 16 mg Medications List	16 mg	
	Hydromorphone 32 mg Medications List	32 mg	
Levorphanol	Levorphanol 2 mg Medications List	2 mg	11
	Levorphanol 3 mg Medications List	3 mg	
Meperidine	Meperidine 10 MGPML Medications List	10 mg	0.1
	Meperidine 50 mg Medications List	50 mg	
	Meperidine 75 mg Medications List	75 mg	
	Meperidine 100 mg Medications List	100 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Meperidine 150 mg Medications List	150 mg	
Meperidine	Meperidine Promethazine 50 mg Medications List	50 mg	0.1
Methadone[6]	Methadone 1 MGPML Medications List Methadone 2 MGPML Medications List Methadone 5 mg Medications List Methadone 10 mg Medications List Methadone 10 MGPML Medications List Methadone 40 mg Medications List	1 mg 2 mg 5 mg 10 mg 10 mg 40 mg	3
Morphine	Morphine 2 MGPML Medications List Morphine 4 MGPML Medications List Morphine 5 mg Medications List Morphine 10 mg Medications List Morphine 15 mg Medications List Morphine 20 MGPML Medications List Morphine 20 mg Medications List Morphine 30 mg Medications List Morphine 40 mg Medications List Morphine 45 mg Medications List Morphine 50 mg Medications List Morphine 60 mg Medications List Morphine 75 mg Medications List Morphine 80 mg Medications List Morphine 90 mg Medications List Morphine 100 mg Medications List Morphine 120 mg Medications List Morphine 200 mg Medications List	2 mg 4 mg 5 mg 10 mg 15 mg 20 mg 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Morphine	Morphine Naltrexone 20 mg Medications List Morphine Naltrexone 30 mg Medications List Morphine Naltrexone 50 mg Medications List Morphine Naltrexone 60 mg Medications List Morphine Naltrexone 80 mg Medications List Morphine Naltrexone 100 mg Medications List	20 mg 30 mg 50 mg 60 mg 80 mg 100 mg	1
Opium	Belladonna Opium 30 mg Medications List Belladonna Opium 60 mg Medications List	30 mg 60 mg	1

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Oxycodone	Oxycodone 1 MGPML Medications List	1 mg	1.5
	Oxycodone 5 mg Medications List	5 mg	
	Oxycodone 7.5 mg Medications List	7.5 mg	
	Oxycodone 9 mg Medications List	9 mg	
	Oxycodone 10 mg Medications List	10 mg	
	Oxycodone 13.5 mg Medications List	13.5 mg	
	Oxycodone 15 mg Medications List	15 mg	
	Oxycodone 18 mg Medications List	18 mg	
	Oxycodone 20 mg Medications List	20 mg	
	Oxycodone 20 MGPML Medications List	20 mg	
	Oxycodone 27 mg Medications List	27 mg	
	Oxycodone 30 mg Medications List	30 mg	
	Oxycodone 36 mg Medications List	36 mg	
	Oxycodone 40 mg Medications List	40 mg	
	Oxycodone 60 mg Medications List	60 mg	
	Oxycodone 80 mg Medications List	80 mg	
Oxycodone	Acetaminophen Oxycodone 1 MGPML Medications List	1 mg	1.5
	Acetaminophen Oxycodone 2 MGPML Medications List	2 mg	
	Acetaminophen Oxycodone 2.5 mg Medications List	2.5 mg	
	Acetaminophen Oxycodone 5 mg Medications List	5 mg	
	Acetaminophen Oxycodone 7.5 mg Medications List	7.5 mg	
	Acetaminophen Oxycodone 10 mg Medications List	10 mg	
Oxycodone	Aspirin Oxycodone 4.8355 mg Medications List	4.8355 mg	1.5
Oxycodone	Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	Oxymorphone 5 mg Medications List	5 mg	3
	Oxymorphone 7.5 mg Medications List	7.5 mg	
	Oxymorphone 10 mg Medications List	10 mg	
	Oxymorphone 15 mg Medications List	15 mg	
	Oxymorphone 20 mg Medications List	20 mg	
	Oxymorphone 30 mg Medications List	30 mg	
	Oxymorphone 40 mg Medications List	40 mg	
Pentazocine	Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	Tapentadol 50 mg Medications List	50 mg	0.4

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Tapentadol 75 mg Medications List	75 mg	
	Tapentadol 100 mg Medications List	100 mg	
	Tapentadol 150 mg Medications List	150 mg	
	Tapentadol 200 mg Medications List	200 mg	
	Tapentadol 250 mg Medications List	250 mg	
Tramadol	Tramadol 5 MGPML Medications List	5 mg	0.1
	Tramadol 50 mg Medications List	50 mg	
	Tramadol 100 mg Medications List	100 mg	
	Tramadol 150 mg Medications List	150 mg	
	Tramadol 200 mg Medications List	200 mg	
	Tramadol 300 mg Medications List	300 mg	
Tramadol	Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

[1] National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version. Atlanta, GA: Centers for Disease Control and Prevention; 2017. Available at https://www.cdc.gov/drugoverdose/resources/data.html.

[2] MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

[3] MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

[4] MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

[5] MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

[6] Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

APPENDIX 4:

High, Moderate, & Low Intensity Statin Medications

High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1–4 mg
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg
Low-intensity statin therapy	Fluvastatin 20 mg
Low-intensity statin therapy	Lovastatin 10-20 mg
Low-intensity statin therapy	Pravastatin 10–20 mg
Low-intensity statin therapy	Simvastatin 5-10 mg

APPENDIX 5: Opioid Medications

Prescription	Medication Lists
• Benzhydrocodone	Acetaminophen Benzhydrocodone Medications List
• Buprenorphine (transdermal patch and buccal film)	Buprenorphine Medications List
• Butorphanol	Butorphanol Medications List
• Codeine	Acetaminophen Butalbital Caffeine Codeine Medications List Acetaminophen Codeine Medications List Aspirin Butalbital Caffeine Codeine Medications List Aspirin Carisoprodol Codeine Medications List Aspirin Codeine Medications List Codeine Phosphate Medications List Codeine Sulfate Medications List
• Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine Medications List Aspirin Caffeine Dihydrocodeine Medications List
• Fentanyl	Fentanyl Medications List
• Hydrocodone	Acetaminophen Hydrocodone Medications List Hydrocodone Medications List Hydrocodone Ibuprofen Medications List
• Hydromorphone	Hydromorphone Medications List
• Levorphanol	Levorphanol Medications List
• Meperidine	Meperidine Medications List Meperidine Promethazine Medications List
• Methadone	Methadone Medications List
• Morphine	Morphine Medications List Morphine Naltrexone Medications List

Prescription	Medication Lists
• Opium	Belladonna Opium Medications List Opium Medications List
• Oxycodone	Acetaminophen Oxycodone Medications List Aspirin Oxycodone Medications List Ibuprofen Oxycodone Medications List Oxycodone Medications List
• Oxymorphone	Oxymorphone Medications List
• Pentazocine	Naloxone Pentazocine Medications List
• Tapentadol	Tapentadol Medications List
• Tramadol	Acetaminophen Tramadol Medications List Tramadol Medications List

APPENDIX 6: Use of High-Risk Medications in Older Adults

Rate 1: High-Risk Medications

Drug Class	Prescription	Prescription cont'd
Anticholinergics, first-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine • Dexchlorpheniramine • Diphenhydramine (oral)	• Dimenhydrinate • Doxylamine • Hydroxyzine • Meclizine • Promethazine • Pyrilamine • Triprolidine
Anticholinergics, anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antispasmodics	• Atropine (exclude ophthalmic) • Belladonna alkaloids • Chlordiazepoxide-clidinium • Dicyclomine	• Hyoscyamine • Methscopolamine • Propantheline • Scopolamine
Antithrombotic	• Dipyridamole, oral, excluding extended release	
Cardiovascular, alpha agonists, central	• Guanfacine • Methyldopa	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, excluding extended release
Central nervous system, antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Imipramine	• Nortriptyline • Paroxetine • Protriptyline • Trimipramine

APPENDIX 6 CONT'D:

Rate 1: High Risk Medications cont'd

Drug Class	Prescription	Prescription cont'd
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergoloid mesylates	• Isoxsuprine
Central nervous system, other	• Meprobamate	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide • Glimepiride	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Nonbenzodiazepine hypnotics	• Eszopiclone • Zaleplon	• Zolpidem
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine

APPENDIX 6 CONT'D:

Rate 1: High-Risk Medications With Days' Supply Criteria

Description	Prescription	Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals • Nitrofurantoin macrocrystals- monohydrate	>90 days

Rate 1: High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

APPENDIX 6 CONT'D:

Rate 2: High-Risk Medications Based on Prescription and Diagnosis Data

Drug Class	Prescription	Prescription cont'd
Antipsychotics, first (conventional) and second (atypical) generation	• Aripiprazole • Aripiprazole lauroxil • Asenapine • Brexpiprazole • Cariprazine • Chlorpromazine • Clozapine • Fluphenazine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone	• Olanzapine • Paliperidone • Perphenazine • Pimavanserin • Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene • Trifluoperazine • Ziprasidone
Benzodiazepines, long, short and intermediate acting	• Alprazolam • Chlordiazepoxide • Clonazepam • Clorazepate • Diazepam • Estazolam • Flurazepam • Lorazepam	• Midazolam • Oxazepam • Quazepam • Temazepam • Triazolam