HEDIS®

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

2023 PROVIDER GUIDE

An Independent Licensee of the Blue Cross and Blue Shield Association

HEDIS®/ STAR PROVIDER GUIDE – HEDIS MY 23 (Measurement Year 2023)

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 Ext. 4098, or email QualityManagement@fhcp.com.

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

Sincerely,
FHCP Quality Management

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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 during the C&M Phase)* ***Newly prescribed**- no ADHD Rx for 120 days prior*	**ADHD Medications:** **CNS Stimulants:** • Dextroamphetamine • Dexmethylphenidate • Lisdexamfetamine • Methylphenidate • Methamphetamine **Alpha-2 receptor agonists**: • Clonidine • Guanfacine **Miscellaneous ADHD Medication:** • Atomoxetine **Telephone/Telehealth Visits:** • CPT Codes 98966-68, 99441-99443 *Acceptable for both phases of the measure* **Online Assessments/E-visit/Virtual Check-in:** • CPT Codes 98969–98972, 99421–99423, 99444, 99457, 99458 *Can be used for 1 of the 2 C&M Phase visits* Exclusions: • Hospice • Narcolepsy • Had an acute inpatient encounter for mental, behavioral, or neurodevelopmental disorder: ✓ 30 days after first prescription (Initiation Phase) ✓ 300 days after first prescription (C&M phase)	• May use an e-visit or virtual check-in for one of the visits after the first 30 days. • 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.

Measure	Comments	More Tips
AHU **Acute Hospital Utilization** For age 18 and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year. Members in hospice are excluded.	Risk Adjustment Determination: • For each nonoutlier member in the eligible population, use the steps in the *Risk Adjustment Comorbidity Category Determination* section in the *Guidelines for Risk Adjusted Utilization Measures* to identify risk adjustment categories based on presence of comorbidities. Risk Adjustment Weighting & Calculation of Expected Events: • Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. • Weights from each model are combined to predict how many discharges each member might have during the measurement year, given age, gender and presence or absence of a comorbid condition. • Weights are specific to product line.	For observation and inpatient discharges, exclude any with the following on the discharge claim: • A principal diagnosis of mental health or chemical dependency • A principal diagnosis of live-born infant, or a maternity related principal diagnosis or stay • A planned hospital stay for a principal diagnosis of maintenance chemotherapy • A principal diagnosis of rehabilitation • An organ transplant • A potentially planned procedure without a principal acute diagnosis • Patient death

Measure	Comments	More Tips
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** / **Depression Severity** / **Proposed Treatment** 0-4 / None-minimal / None 5-9 / Mild / Watchful waiting; repeat PHQ-9 at follow-up 10-14 / Moderate / Treatment plan, considering counseling, follow-up and/or pharmacotherapy 15-19 / Moderately Severe / Pharmacotherapy and/or psychotherapy 20-27 / Severe / Immediate initiation of pharmacotherapy and, if severe impairment or poor response, psychotherapy and/or collaborative management Determine if patient has other depressive disorder that is not Major Depression: • 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 needed. • Contact Case Management/Coordination of Care when barriers to medication compliance are identified: unable to afford medication or follow-up appointment co-pay, lack of transportation, needs education, community resource and/or home care. • 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)**

Measure	Comments	More Tips
AMR **Asthma Medication Ratio** Ages 5 to 64 with persistent asthma, should have a ratio of controller medications to total asthma medications (controllers and relievers) **of 0.50 or greater during the measurement year.** The measure is intended to ensure members take an asthma controller consistently. The goal for our members is to take a controller daily, thus reducing the need for reliever medications. 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:** • **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 the following are documented at a visit: • 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 during the measurement year.	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. The numerator (compliance) is based on psychosocial care from 90 days prior to the first prescription for an antipsychotic during January 1 through December 1, through 30 days after (a 121-day period).	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-E ☆ **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 (denominator). 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 CPT Codes:** 77061-77063, 77065-77067. **Bilateral Mastectomy ICD10PCS Code (exclusion):** 0HT0ZZ **History of Bilateral Mastectomy ICD10CM Code (exclusion):** Z90.13

Measure	Comments	More Tips
BPD **Blood Pressure Control for Patients With Diabetes** Ages 18-75 with diabetes (Types 1 & 2) should have adequately controlled BP (**less than** 140/90 mm Hg) during the measurement year. Control within the year of **139/89 or below** should be **documented in the EHR if attained**.	Uses the most recent BP reading during the year. Exclude BPs in inpatient 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.	If you believe member does not have diabetes, please notify Quality Management. Hospital claims with a diabetes diagnosis are occasionally received (if glucose is elevated), and these can be corrected if not diabetic. Members in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).
CBP ★ **Controlling High Blood Pressure** Ages 18 to 85 with a diagnosis of hypertension (HTN) should have controlled 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 visit. If BP is elevated, **retake BP** and document in the chart. Treat as necessary. Chart all measurements, and efforts to obtain control. Control within the year of **139/89 or below** should be documented in the EHR if attained.	**The measure uses**: • The most recently documented BP on or after the second diagnosis of HTN. • BP readings taken or reported by the member using a digital device are now acceptable, **as long as result is documented by the provider in the note.** This includes Telephone and Telehealth visits. **Staff PCPs, please always add BP under Vital Signs** as well as in note**.** If member reported result is not 139/89 or below, have member retake, or bring member in to try to obtain a controlled BP, and document. **The measure does not use**: • BP from an acute inpatient stay or ED visit. • BP taken day of test/therapeutic procedure requiring change of diet or medication on or day before, such as colonoscopy, dialysis, infusions, chemotherapy, or albuterol nebulizer treatment. Fasting blood tests are acceptable.	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, and those with ESRD, Dialysis, Kidney Transplant, or Pregnancy are excluded. Also excluded are those age 66-80 with both frailty and advanced illness. Please document any exclusion.

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.	Documentation in the medical record must include **both** of the following: • A note indicating the **date** the procedure was performed. • The **result** or **finding**. Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test. 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.**	**Cervical Cytology Lab Test CPT codes**: 88141- 88143, 88147-88148, 88150, 88152-88153, 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 Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. 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.	Sexual activity identified by 2 methods: • Claim/encounter data: members who had a claim or encounter indicating sexual activity during the measurement year. • Pharmacy data: members who were dispensed contraceptives during the measurement year.	**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 MMR, VZV, hepatitis A, and hepatitis B, count any of the following: • Evidence of the antigen or combination vaccine. • Documented history of the illness. • Anaphylaxis due to the vaccine. For IPV, pneumococcal conjugate, influenza, HiB and rotavirus, count *either*: • Evidence of the antigen or combination vaccine. • Anaphylaxis due to the vaccine. For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens. For history of illness or anaphylaxis, provide a note with date, which must have occurred by the 2nd birthday.	**DTaP CPT Codes:** 90697, 90698, 90700, 90723 **HepA CPT Code:** 90633 **HepB CPT Codes:** 90697, 90723, 90740, 90744, 90747, 90748 **HiB CPT Codes:** 90644, 90647, 90648, 90697, 90698, 90748 **Influenza CPT Codes:** 90655, 90657, 90661, 90673, 90674, 90685-90689, 90756 **Influenza Virus LAIV CPT Codes:** 90660, 90672 **IPV (Inactivated Polio Vaccine) CPT Codes:** 90697, 90698, 90713, 90723 **MMR CPT Codes:** 90707, 90710 **Pneumococcal Conjugate (PCV) CPT Code:** 90670 **Rotavirus 2 dose CPT Code:** 90681 **Rotavirus 3 dose CPT Code:** 90680 **Varicella Zoster (VZV) CPT Codes:** 90710, 90716 Document in medical record by a note indicating name of the specific antigen and date of immunization, or a certificate of immunization prepared by an authorized provider or agency with dates and types of immunizations.

Measure	Comments	More Tips
COL ★ **Colorectal Cancer Screening** Ages 45 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. • Stool DNA (sDNA) with FIT test (*Cologuard*) during the last 3 years.	Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed 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. Members in hospice are excluded. Also excluded are ED visits with a principal diagnosis of mental health or chemical dependency, psychiatry, or electroconvulsive therapy.	Assesses ED utilization by health plan members. 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 ED visits than expected, while accounting for incremental improvements across all plans over time. • The observed-to-expected ratio is multiplied by the ED 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/medication 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.	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 **optometrist or ophthalmologist**, the **date** of the procedure, and the **results**. **OR** (2) A chart or photograph indicating the date the fundus photography was performed and **one** of the following: • Evidence that an optometrist or ophthalmologist reviewed the **results**. • Evidence that **results** were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.	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).
FMC **Follow-Up After ED Visit for People With Multiple High-Risk Chronic Conditions** Counts ED visits for age 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.	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.

Measure	Comments	More Tips
FUA **Follow-Up After Emergency Department Visit for Substance Use** The percentage of 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.	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 withdrawal management visits for a diagnosis of substance use disorder (SUD): • 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.	The population (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. 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.
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.

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%) 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 less than 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 greater than 9.0% or is missing. **Note:** A ***lower*** rate indicates better performance for the greater than 9.0% 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 percentage 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 to determine MME Daily Dose: Convert each medication into the MME using the appropriate MME conversion factor and strength for 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
HFS **Hospitalization Following Discharge From a Skilled Nursing Facility (SNF)** For age 65 and older: • The percentage of SNF discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.	The measure counts a SNF discharge between January 1 and November 1 of the measurement year. The population (denominator) is based on discharges, not on members.	A hospital stay is considered planned if it meets the following criteria: • Pregnancy • A principal diagnosis of a condition originating in the perinatal period • A principal diagnosis of maintenance chemotherapy • An organ transplant • A potentially planned procedure without a principal acute diagnosis
HPC **Hospitalization for Potentially Preventable Complications** For age 67 and older: • The rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed-to-expected discharges for ACSC by chronic and acute conditions. Members in hospice are excluded.	**Ambulatory care sensitive condition**: An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are: **Chronic ACSC:** • Diabetes short-term complications • Diabetes long-term complications • Uncontrolled diabetes • Lower-extremity amputation among patients with diabetes • COPD. • Asthma • Hypertension • Heart failure **Acute ACSC:** • Bacterial pneumonia • Urinary tract infection • Cellulitis • Pressure ulcer	Assesses hospital inpatient admissions and observation stays due to complications of ACSC. Health plans report observed ACSC hospitalization rates and expected ACSC hospitalization rates that take the member's health history into account. Rates are used to calculate a calibrated observed-to-expected ratio of hospitalizations for potentially preventable complications of ACSC that assesses whether plans had more, the same or less hospitalizations than expected, while accounting for incremental improvements across all plans over time. ACSCs can be acute or chronic. Hospitalizations for complications of ACSC can be prevented with appropriate access to ambulatory care services, timely delivery of care and high-quality care coordination. Reducing the rate of hospitalization for older adults will improve patient health, reduce costs and improve quality of life.

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.** SUD episodes include diagnoses from one of the following Value Sets: (1) Alcohol Abuse and Dependence, (2) Opioid Abuse and Dependence, or (3) Other Drug Abuse and Dependence. When a new SUD diagnosis is detected, please immediately schedule the follow up visits to cover the required time frames.	Intake period: November 15 of prior year– November 14 of current year (new SUD episodes). 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)	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 CPT Codes**: 90619, 90733, 90734 **Tdap CPT Code**: 90715 **HPV CPT Codes**: 90649, 90650, 90651
KED **Kidney Health Evaluation for Patients With Diabetes** Members age 18-75 with diabetes (Types 1 and 2) should receive a **yearly kidney health evaluation** to include **both** of the following: 1. Estimated glomerular filtration rate (eGFR), **and** 2. Urine albumin-creatinine ratio (uACR). The above may be on the same dates of service.	Members must receive **BOTH** an eGFR and a uACR during the year on the same or different dates of service: 1. At least one eGFR: • **eGFR Lab Test CPT Codes**: 80047, 80048, 80050, 80053, 80069, 82565 2. At least one uACR identified by either of the following: • Both a quantitative urine albumin test (**CPT Code 82043**) and a urine creatinine test (**CPT Code 82570**) with service dates four days or less apart. • A uACR lab test (no CPT Code listed).	If you believe member is in the KED 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 with ESRD, Dialysis, or in hospice are excluded. Also exclude age 66 and older with both frailty and advanced illness (must be documented).

Measure	Comments	More Tips
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 (denominator).	**Exclusions** – Imaging acceptable within 28 days of a primary uncomplicated 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). See **Appendix 7** for Uncomplicated Low Back Pain codes for which imaging within 28 days should be avoided.

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. **Reminder**: If your care of the fracture is not an initial visit but rather a subsequent visit, please use a "D" code (subsequent) rather than an "A" code (initial) with the fracture diagnosis.	***Either*** a BMD test or the drug therapy within 6 months after the fracture meets the criteria. Drug therapy may be indicated (rather than another BMD test) if a previous test already shows osteoporosis. Members with either of the following are also considered compliant: (1) BMD test within the 24 months prior to the fracture; ***or*** (2) Osteoporosis drug therapy within the 12 months prior to the fracture. Members in hospice are excluded, as are age 67-80 with both frailty and advanced illness (must be documented), or on dementia medication.	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 a BMD test, from an EHR Task). **BMD Test CPT Codes**: 76977, 77078, 77080, 77081, 77085, 77086
OSW **Osteoporosis Screening in Older Women** The percentage of women 65–75 years of age who received osteoporosis screening.	One or more osteoporosis screening tests should occur during the year for women ages 65 to 75.	Members in hospice are excluded, as are age 67-80 with both frailty and advanced illness (must be documented), or on dementia medication. **Osteoporosis Screening Tests CPT Codes**: 76977, 77078, 77080, 77081, 77085

Measure	Comments	More Tips
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 discharges 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.
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

Measure	Comments	More Tips
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.
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. The measure uses deliveries of live births on or between October 8 of the year prior and October 7 of the current measurement year.	**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, Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 **Postpartum Bundled Services:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 Members in hospice are excluded.

Measure	Comments	More Tips
PRS-E **Prenatal Immunization Status** The percentage of deliveries in the measurement year in which members had received the following: • Influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations. Clinical recommendation statement: Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines.	ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap. The following are considered compliant in the measure (Numerators): **Numerator 1—Immunization Status: Influenza** • Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, ***or*** • Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date.	**Numerator 2—Immunization Status: Tdap** • Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), ***or*** • Deliveries where members had any of the following: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date. **Numerator 3—Immunization Status: Combination** • Deliveries that met criteria for both numerator 1 and numerator 2. Exclude deliveries that occurred at less than 37 weeks gestation, or members were in hospice.
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.

Measure	Comments	More Tips
RDM **Race / Ethnicity Diversity of Membership** An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity. Report the number of members for whom data have been collected from each data source for race and ethnicity.	Reporting categories for race: • White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Some Other Race • Two or More Races • Asked but No Answer • Unknown Reporting categories for ethnicity: • Hispanic or Latino • Not Hispanic or Latino • Asked but No Answer • Unknown	Data sources include data collected directly from members (direct data), or data generated indirectly. Direct data includes sources such as, surveys, health risk assessments, disease management registries, and CMS/state databases. Indirect data includes imputation methods such as surname analysis or geo-coding.
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 during the measurement year. • **Statin Adherence 80%:** Remained on a **high or moderate intensity** statin for at least 80% of the treatment period. Treatment period is the earliest prescription date for a high or moderate intensity statin, through the last day of the year.	Noncompliant with statin members can be **excluded** if they have a side effect of: • Myalgia, myositis, myopathy, or rhabdomyolysis. **IMPORTANT**: **Physicians**: If your patient cannot tolerate a statin due to one of the above, please document the diagnosis on a visit claim during the **current year**. This includes if patient had side effects from a statin in the past. **Please re-document the side effect diagnosis each year in a visit claim if patient is not on a statin.**	Other exclusions in addition to myalgia 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 the above in a visit claim during the current year if not on a statin. ASCVD includes members with MI, CABG, PCI, other revascularization, or a diagnosis of ischemic vascular disease (IVD) 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 of **any intensity** during the measurement year. • **Statin Adherence 80%:** Remained on a statin of **any intensity** for at least 80% of the treatment period. Treatment period is the earliest prescription date for a statin of any intensity, through the last day of the year.	Noncompliant with statin members can also be **excluded** if they have a side effect of: • Myalgia, myositis, myopathy, or rhabdomyolysis. **IMPORTANT**: **Physicians**: If your patient cannot tolerate a statin due to one of the above, please document the diagnosis on a visit claim during the **current year**. This includes if patient had side effects from a statin in the past. **Please re-document the side effect diagnosis each year in a visit claim if patient is not on a statin.**	ASCVD includes: MI inpatient, CABG, PCI, other revascularization, or ischemic vascular disease (IVD) during the year or year prior (excludes member with diabetes from SPD). Other exclusions in addition to myalgia 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 if not on a statin. **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 percentage 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 **CPT Codes**: 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 • 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
Fentanyl buccal or sublingual tablet,	Fentanyl 100 mcg Medications List Fentanyl 200 mcg Medications List	100 mcg 200 mcg	0.13

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
transmucosal lozenge (mcg)[2]	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	
	Hydrocodone 50 mg Medications List	50 mg	
	Hydrocodone 60 mg Medications List	60 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	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	
	Meperidine 150 mg Medications List	150 mg	
Meperidine	Meperidine Promethazine 50 mg Medications List	50 mg	0.1

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Methadone[6]	Methadone 1 MGPML Medications List	1 mg	3
	Methadone 2 MGPML Medications List	2 mg	
	Methadone 5 mg Medications List	5 mg	
	Methadone 10 mg Medications List	10 mg	
	Methadone 10 MGPML Medications List	10 mg	
	Methadone 40 mg Medications List	40 mg	
Morphine	Morphine 2 MGPML Medications List	2 mg	1
	Morphine 4 MGPML Medications List	4 mg	
	Morphine 5 mg Medications List	5 mg	
	Morphine 10 mg Medications List	10 mg	
	Morphine 15 mg Medications List	15 mg	
	Morphine 20 MGPML Medications List	20 mg	
	Morphine 20 mg Medications List	20 mg	
	Morphine 30 mg Medications List	30 mg	
	Morphine 40 mg Medications List	40 mg	
	Morphine 45 mg Medications List	45 mg	
	Morphine 50 mg Medications List	50 mg	
	Morphine 60 mg Medications List	60 mg	
	Morphine 75 mg Medications List	75 mg	
	Morphine 80 mg Medications List	80 mg	
	Morphine 90 mg Medications List	90 mg	
	Morphine 100 mg Medications List	100 mg	
	Morphine 120 mg Medications List	120 mg	
	Morphine 200 mg Medications List	200 mg	
Morphine	Morphine Naltrexone 20 mg Medications List	20 mg	1
	Morphine Naltrexone 30 mg Medications List	30 mg	
	Morphine Naltrexone 50 mg Medications List	50 mg	
	Morphine Naltrexone 60 mg Medications List	60 mg	
	Morphine Naltrexone 80 mg Medications List	80 mg	
	Morphine Naltrexone 100 mg Medications List	100 mg	
Opium	Belladonna Opium 30 mg Medications List	30 mg	1
	Belladonna Opium 60 mg Medications List	60 mg	
Oxycodone	Oxycodone 1 MGPML Medications List	1 mg	1.5
	Oxycodone 5 mg Medications List	5 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	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	4.84 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
	Tapentadol 75 mg Medications List	75 mg	
	Tapentadol 100 mg Medications List	100 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Tapentadol 150 mg Medications List Tapentadol 200 mg Medications List Tapentadol 250 mg Medications List	150 mg 200 mg 250 mg	
Tramadol	Tramadol 5 MGPML Medications List Tramadol 50 mg Medications List Tramadol 100 mg Medications List Tramadol 150 mg Medications List Tramadol 200 mg Medications List Tramadol 300 mg Medications List	5 mg 50 mg 100 mg 150 mg 200 mg 300 mg	0.1
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 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
• Opium	Belladonna Opium Medications List Opium Medications List

Prescription	Medication Lists
• 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

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

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

Description	Prescription	Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • 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

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

APPENDIX 7

Uncomplicated Low Back Pain – LBP Trigger Codes – Do Not Use these Diagnosis Codes Along With Imaging Within 28 Days

Code	Definition
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.2X6	Spinal instabilities, lumbar region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.16	Radiculopathy, lumbar region

M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
M99.83	Other biomechanical lesions of lumbar region
M99.84	Other biomechanical lesions of sacral region
S33.100A	Subluxation of unspecified lumbar vertebra, initial encounter
S33.100D	Subluxation of unspecified lumbar vertebra, subsequent encounter
S33.100S	Subluxation of unspecified lumbar vertebra, sequela
S33.110A	Subluxation of L1/L2 lumbar vertebra, initial encounter
S33.110D	Subluxation of L1/L2 lumbar vertebra, subsequent encounter
S33.110S	Subluxation of L1/L2 lumbar vertebra, sequela
S33.120A	Subluxation of L2/L3 lumbar vertebra, initial encounter
S33.120D	Subluxation of L2/L3 lumbar vertebra, subsequent encounter
S33.120S	Subluxation of L2/L3 lumbar vertebra, sequela

S33.130A	Subluxation of L3/L4 lumbar vertebra, initial encounter
S33.130D	Subluxation of L3/L4 lumbar vertebra, subsequent encounter
S33.130S	Subluxation of L3/L4 lumbar vertebra, sequela
S33.140A	Subluxation of L4/L5 lumbar vertebra, initial encounter
S33.140D	Subluxation of L4/L5 lumbar vertebra, subsequent encounter
S33.140S	Subluxation of L4/L5 lumbar vertebra, sequela
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.9XXA	Sprain of unspecified parts of lumbar spine and pelvis, initial encounter
S39.002A	Unspecified injury of muscle, fascia and tendon of lower back, initial encounter
S39.002D	Unspecified injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.002S	Unspecified injury of muscle, fascia and tendon of lower back, sequela
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
S39.012S	Strain of muscle, fascia and tendon of lower back, sequela
S39.092A	Other injury of muscle, fascia and tendon of lower back, initial encounter
S39.092D	Other injury of muscle, fascia and tendon of lower back, subsequent encounter
S39.092S	Other injury of muscle, fascia and tendon of lower back, sequela
S39.82XA	Other specified injuries of lower back, initial encounter
S39.82XD	Other specified injuries of lower back, subsequent encounter
S39.82XS	Other specified injuries of lower back, sequela
S39.92XA	Unspecified injury of lower back, initial encounter
S39.92XD	Unspecified injury of lower back, subsequent encounter
S39.92XS	Unspecified injury of lower back, sequela