HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE®

Fair, Evidence-based Solutions. Real and Lasting Change.

Clinician Guide:
Bridges to Excellence
Diabetes Care Recognition Program

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Introduction

The Health Care Incentives Improvement Institute (HCI3) is excited to offer the opportunity for clinicians to participate in the Bridges to Excellence (BTE) recognition program and its automated EMR/Registry performance assessment system. The BTE EMR/Registry performance assessment system allows for rapid and independent medical record-based clinician performance evaluations by connecting local and national medical record data sources to a network of performance assessment organizations. HCI3's goals are to: reduce the reporting burden for clinicians; leverage existing reporting/data aggregation initiatives; reduce data collection and reporting costs; facilitate the connection between quality improvement and incentives; and speed up cycle times between reporting, improvement and reporting. Clinicians who meet BTE performance thresholds may be eligible for BTE incentives through participating health plans, employers and coalitions.

HCI3 has partnered with CECity as the Performance Assessment Organization (PAO) for all Bridges to Excellence (BTE) Recognition Programs submitted electronically or direct data submission through CECity's cloud-based MedConcert® platform. Clinicians will be provided with real-time performance assessments, feedback reports, and access to dynamically linked improvement tools and resources to help them close performance gaps.

About CECity
Pittsburgh, PA-based CECity is the health care industry's leading platform-as-a-service provider of cloud-based applications and distribution networks for performance improvement, quality reporting, and lifelong learning. Health care professionals and healthcare organizations, including QIOs, health plans, hospitals, chain pharmacies, professional medical certifying and licensing boards, publishers, professional societies, and academic medical centers, count on CECity to power their solutions for continuous performance improvement, performance assessment, clinical registries, professional development, patient safety, medication adherence, care coordination, population health informatics, and quality reporting.

About MedConcert®
MedConcert, healthcare's first social cloud platform for continuous performance improvement and lifelong learning, provides one convenient, integrated solution to help all stakeholders answer the question, "How Do We Improve?" Through MedConcert, providers, practices, and healthcare organizations engage in building secure social networks to share best practices and connect in meaningful ways to address a variety of critical needs driven by healthcare reform. Through the MedConcert App Store, individuals and health systems access a wide variety of applications for pay for performance, performance dashboards, population health management, clinical integration, performance improvement, professional certification, patient surveys, care coordination, patient registries, enterprise-wide benchmarking, and much more.

Overview

The Health Care Incentive Improvement Institute (HCI3) is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

The Diabetes Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value diabetes care to adult patients. The program is designed with an understanding that adult patients may seek the care of various types of practitioners—primary care (PCPs), endocrinologists (Endos) and others—for treatment and management of their diabetes. Accordingly, the measures reflect that clinicians should do the following.

- Deliver high-quality care from the outset of patient contact
- Understand and consider previous treatment history to help avoid inappropriate treatment

The program comprises a set of measures, based on available clinical evidence, that promote a model of care that includes the following criteria.

- Comprehensive patient assessment and reassessment
- Patient education
- Shared decision making

HCI3's Diabetes Care requirements assess clinical measures representing standards of care for patients with diabetes. HCI3 believes that the BTE Diabetes Care Recognition program has the potential to significantly improve the quality of care experienced by patients with diabetes and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn Diabetes Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with diabetes. HCI3 has partnered with an objective third-party independent Performance Assessment Organization (PAO) to evaluate clinician data based on standard measures to publicly recognize those that meet the BTE Diabetes Care performance thresholds. Those clinicians not meeting the BTE Diabetes Care performance thresholds remain anonymous to BTE and its health plan licensees. HCI3's Diabetes Care Recognition Program has three performance thresholds

Clinician Benefits of Recognition

- Clinicians can demonstrate to the public and to their professional peers that they meet the standards of care assessed by the program by issuing a press release, as well as having their recognition achievements posted on HCI3's web site www.hci3.org, and communicated to both health plans and employers.
- Clinicians may use the BTE Recognition to demonstrate that they meet the standards of care assessed by the program when contracting with health organizations and purchasers of health services.
- Clinicians can identify areas of their practice that vary from the performance criteria and take steps to improve quality of care.
- Where applicable, clinicians can establish eligibility for pay-for-performance bonuses or differential reimbursement or other incentives from payers and health plans.
- Clinicians who achieve Diabetes Care Recognition by submitting data through a CCHIT-certified[1] electronic health record or through an electronic health record certified to meet the federally-defined Meaningful Use criteria will also receive BTE Level II Physician Office Link (POL) recognition.

Background on the Measurement Criteria

Eligible clinicians and medical practices voluntarily apply for BTE Recognition by submitting information on how they treat and manage their patients with regard to the following.

Clinical measures[2]
1. Blood Pressure (BP) control
2. LDL control
3. HbA1c control
4. Documentation of Ophthalmologic exam
5. Documentation of Tobacco status and cessation advice and treatment
6. Documentation of Nephropathy assessment
7. Documentation of Podiatry exam
8. Documented Body Mass Index

[1] The Certification Commission for Healthcare Information Technology or CCHIT is a recognized certification body for electronic health records and their networks, and an independent, voluntary, private-sector initiative, whose mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. A list of CCHIT-certified products can be found at http://cchit.org/.

[2] *Clinical measures* evaluate performance based on care provided to a sample of individual patients and documented in the medical records of those patients. Clinical measures are scored based on a specified percentage of the sample meeting the requirement (numerator) for the measure (pass/fail).

Clinicians who demonstrate high-quality performance based on these measures are awarded BTE Diabetes Care Recognition.

Recognition Program Structure

Given the evidence in the literature advocating the creation of clinician quality programs that promote continuous quality improvement amongst its participants, the BTE Diabetes Care Recognition Program is designed to include 3 levels or tiers of recognition. Assessment for recognition in all 3 tiers is based upon data submitted on the same diabetes measures (listed above).

Level I: Focuses on a clinician-centric[3] view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of "minimum" performance requirements for all intermediate outcome control measures, both poor and superior (i.e., BP control, LDL control and HbA1c control). Thresholds have been set to focus on above average performance.

Level II: Focuses on a combination of clinician and patient-centric[4] measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of "minimum" performance requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Level III: Focuses on patient-centric view of measurement, looking at the defect rate of care delivery across superior control measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

What Recognition Requires

[3] Clinician centric refers to performance assessment involving evaluation of clinician performance based upon discrete measures (i.e. BP <130/80), which is applied across the eligible patient panel. The results provide a picture of a clinician's performance on a given measure across his or her eligible patient panel. Since the process leads to clinician-focused results it is said to be "clinician-centric."

[4] Patient centric refers to performance assessment involving evaluation of clinician performance based upon composite measures, created by combining 2 or more separate discrete measures into a single measure (i.e. combining BP <130/80 and LDL <100mg/dl into 1 single measure), which is applied on a per patient basis. The results provide a picture of an individual patient's performance on a set of measures which make–up the composite measure. Since the process leads to patient-focused results it is said to be "patient-centric."

To seek BTE Diabetes Care Recognition, clinician applicants must submit medical record data that demonstrates they meet BTE's Diabetes Care performance requirements. Each measure has an assigned maximum available point value; the total of all the measures is the same across all levels of recognition. A clinician achieves points for a measure based on the percentage of his or her patient sample that meets or exceeds the set thresholds for that measure.

Performance Assessment Organization (PAO) award recognition to clinicians who achieve at least:

Level I: 60% of the total possible points
Level II: 60% of the total possible points
Level III: 60% of the total possible points

Minimum Requirements

To be eligible for recognition, clinicians must attain at least 60 percent of the total possible points. In the case of clinical measures, this means a minimum of 25 patients for the denominator of each measure for individual clinician applicants, and a minimum of 10 patients for the denominator of each measure for each individual clinician in a practice level applicant, with a minimum practice average of 25 patients per clinician.

To achieve points for the discrete intermediate outcomes control measures (e.g. HbA1c, BP, LDL), applicants must meet certain minimum criteria. Applicants who fail to meet the minimum criteria on a measure will receive 0 points for that measure. Applicants must qualify for each level of recognition before they can be assessed for a subsequent level (e.g., must pass Level I to be assessed for Level II).

Tables 1, 2 and 3 show the program measures and the associated point values for scoring clinicians' performance.

Table 1: Diabetes Care Level I Measures, Performance Criteria and Scoring

Level I focuses on a clinician-centric view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of minimum requirements for intermediate outcome control measures (i.e., BP control, LDL control and HbA1c control). Thresholds have been set to focus on above average performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Poor Control Measures[5]			
HbA1c Control	> 9.0	≤ 27.5% of pts in sample	15
Blood Pressure Control	≥ 140/90	≤ 40% of pts in sample	15
LDL Control	≥ 130 mg/dl	≤ 40% of pts in sample	10
Superior Control Measures			
HbA1c Superior Control 1	< 7.0	≥ 40 % of pts in sample	5
HbA1c Superior Control 2	< 8.0	≥ 40 % of pts in sample	5
Blood Pressure Superior Control	< 130/80	≥ 30% of pts in sample	10
LDL Superior Control	< 100 mg/dl	≥ 35% of pts in sample	10
Process Measures			
Ophthalmologic Exam	N/A	N/A	10
Nephropathy Exam	N/A	N/A	5
Podiatry Exam	N/A	N/A	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Body Mass Index	N/A	N/A	0
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

[5] Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by (1 – the percentage of patients meeting the threshold) x the maximum points for that measure.

Table 2: Diabetes Care Level II Measures, Performance Criteria and Scoring

Level II focuses on a combination of clinician and patient-centric measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of "minimum" requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Poor Control Composite Measure			
HbA1c Control	> 9.0	N/A	40
Blood Pressure Control	≥ 140/90		
LDL Control	≥ 130 mg/dl		
Superior Control Measures			
HbA1c Superior Control 1	< 7.0	≥ 40 % of pts in sample	5
HbA1c Superior Control 2	< 8.0	≥ 40 % of pts in sample	5
Blood Pressure Superior Control	< 130/80	≥ 30% of pts in sample	10
LDL Superior Control	< 100 mg/dl	≥ 35% of pts in sample	10
Process Measures			
Ophthalmologic Exam	N/A	N/A	10
Nephropathy Exam	N/A	N/A	5
Podiatry Exam	N/A	N/A	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Body Mass Index	N/A	N/A	0
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

Table 3: Diabetes Care Level III Measures, Performance Criteria and Scoring

Level III focuses on patient-centric view of measurement, looking at the defect rate of care delivery across poor control and superior control measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Poor Control Composite Measure			
HbA1c Control	> 9.0	N/A	40
Blood Pressure Control	≥ 140/90		
LDL Control	≥ 130 mg/dl		
Superior Control Measures			
HbA1c Superior Control 1	< 7.0	≥ 40 % of pts in sample	5
Superior Control Composite Measure			
HbA1c Superior Control 2	< 8.0	N/A	25
Blood Pressure Superior Control	< 130/80		
LDL Superior Control	< 100 mg/dl		
Process Measures			
Ophthalmologic Exam	N/A	N/A	10
Nephropathy Exam	N/A	N/A	5
Podiatry Exam	N/A	N/A	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Body Mass Index	N/A	N/A	0
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

Eligibility for Clinician Participation

Clinicians may apply for BTE Diabetes Care Recognition as individuals or part of a medical practice. To be eligible, applicants must meet the following criteria.

- Applicants must be licensed as a medical doctor (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.).
- Applicants must provide continuing care for patients with diabetes and be able to meet the minimum patient sample sizes.
- Applicants must complete all application materials and agree to the terms of the program by executing a data use agreement and authorization with a data aggregator partner.
- Applicants must submit the required data documenting their delivery of care for all eligible patients in their full patient panel.
- Applicants must use PAO-supplied or approved methods for submitting data electronically.

Individual clinician applicant

An individual clinician applicant represents one licensed clinician practicing in any setting who provides continuing care for patients with diabetes[6].

Medical practice applicant

A medical practice applicant represents any practice with three or more licensed clinicians who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location or street address. For purposes of this assessment process practices of two clinicians or less must apply as individual applicants.

[6] **Eligible Diabetic patients** are 18-75 years of age, with a documented diagnosis of diabetes (as defined by criteria labeled "Patient Eligibility Criteria") for at least 12 months AND have been under the care of the applicant clinician or practice for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. Steroid-Induced diabetes and gestational diabetes are excluded.

BTE Diabetes Care Recognition Clinical Measures

Clinical Measures

Clinical measures are standard measures with a numerator and denominator that reflect performance across a sample of eligible patients based on medical record documentation.

The following items are listed for each clinical measure.

Description: A statement of what is being measured specifically.

Data source: A list of the data sources accepted for the clinical measure.

Explanation: Additional information about the clinical measure.

Numerator: A description of the applicant's eligible patients (denominator) who meet the measure threshold or standard.

Frequency: Time frames associated with the numerator requirements.

Scoring: Performance level (percentage of patients meeting or complying with the measure) translated to points total for the clinical measure.

Information on the Domain Denominator is consistent across all of the clinical measures and is listed under "Patient Eligibility Criteria".

Diabetes Care Recognition Program Measurement Set

Hemoglobin A1c Control (HbA1c):

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c level in poor control (greater than 9.0%).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data for HbA1c test information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend a treatment goal of 7% or lower for HbA1c for adult patients with a diagnosis of diabetes. A HbA1c level greater than 9% is considered poor control and calls for treatment to improve glycemic control. This is a poor control measure. A lower rate indicates better performance (i.e., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent hemoglobin A1c (HbA1c) level > 9.0%. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent HbA1c test is > 9.0, is missing, or if the test was not done during the reporting period (i.e. last 12 months from the last day of the reporting period [3]). The patient is NOT numerator compliant if the laboratory result of the most recent HbA1c test during the reporting period is ≤ 9.0.

Medical Record Collection: The patient is numerator compliant if the result of the most recent HbA1c test is > 9.0, is missing, or if the test was not done during the reporting period. The patient is NOT numerator compliant if the result of the most recent HbA1c test during the reporting period is ≤ 9.0.

[3] The last day of the reporting period is anchored to the last day of the current quarter.

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

The following is not acceptable documentation of HbA1c results:

1. Fructosamine
2. HgB
3. Hemoglobin
4. Hb and Hg (without reference to either "glycated," "glycosylated," and "A1" or "A1c").
5. Patient self-reporting

Frequency: Most recent test result over the last 12 months from the last day of the reporting period.

Scoring: If [numerator/denominator] ≤ minimum criteria, then Earned Points = [1 – (numerator/denominator)] x maximum available points for the measure

If [numerator/denominator] > minimum criteria, then Earned Points = 0

Hemoglobin A1c Superior Control 1 (HbA1c):

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c level in superior control (less than 7.0%).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data for HbA1c test information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend a treatment goal of 7% or lower for HbA1c for adult patients with a diagnosis of diabetes. This is a superior control measure. A higher rate indicates better performance (i.e., high rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent hemoglobin A1c (HbA1c) level < 7.0%. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent HbA1c test during the reporting period is < 7.0. The patient is NOT numerator compliant if the laboratory result of the most recent HbA1c test is ≥ 7.0, is missing, or if the test was not done during the reporting period.

Medical Record Collection: The patient is numerator compliant if the result of the most recent HbA1c test during the reporting period is < 7.0. The patient is NOT numerator compliant if the result of the most recent HbA1c test is ≥ 7.0, is missing, or if the test was not done during the reporting period.

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

The following is not acceptable documentation of HbA1c results:

1. Fructosamine
2. HgB
3. Hemoglobin
4. Hb and Hg (without reference to either "glycated," "glycosylated," and "A1" or "A1c")
5. Patient self-reporting

Frequency: Most recent test result over the last 12 months from the last day of the reporting period.

Scoring: If [numerator/denominator] ≥ minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

Hemoglobin A1c Superior Control 2 (HbA1c):

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c in superior control (less than 8.0%).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data for HbA1c test information for the numerator.

Explanation: Based on results of the ACCORD study, it has been noted that the American Diabetes Association (ADA) guidelines recommendation of a treatment goal of 7% or lower for HbA1c for adult patients with a diagnosis of diabetes may not be appropriate for all populations. As such the NCQA Committee for Physician Performance Measurement has chosen to introduce a treatment goal of 8% or lower for HbA1c. This is a superior control measure. A higher rate indicates better performance (i.e., high rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent hemoglobin A1c (HbA1c) level < 8.0%. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent HbA1c test during the reporting period is < 8.0. The patient is NOT numerator compliant if the laboratory result of the most recent HbA1c test is ≥ 8.0, is missing, or if the test was not done during the reporting period.

Medical Record Collection: The patient is numerator compliant if the result of the most recent HbA1c test during the reporting period is < 8.0. The patient is NOT numerator compliant if the result of the most recent HbA1c test is ≥ 8.0, is missing, or if the test was not done during the reporting period.

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

The following is not acceptable documentation of HbA1c results:

1. Fructosamine
2. HgB
3. Hemoglobin
4. Hb and Hg (without reference to either "glycated," "glycosylated," and "A1" or "A1c")
5. Patient self-reporting

Frequency: Most recent test result over the last 12 months from the last day of the reporting period.

Scoring: If [numerator/denominator] ≥ minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

Blood Pressure Control:

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent blood pressure in poor control (greater than or equal to 140/90 mmHg).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data for blood pressure information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend treatment for adult patients with diabetes who have blood pressure ≥ 140/90 mmHg. This is a poor control measure. A lower rate indicates better performance (i.e., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent systolic blood pressure measurement of ≥ 140 mmHg OR diastolic blood pressure of ≥ 90 mmHg. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes. The steps below should be followed to determine the representative blood pressure reading.

1. *Identify the most recent visit to the doctor's office or clinic in which a BP reading was noted.* BP reading is acceptable if the representative BP was obtained during a visit to the clinician's office or non-emergency outpatient facility, such as clinic or urgent care center.

2. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record*. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is numerator compliant if the most recent systolic blood pressure measurement is ≥ 140 mmHg or missing, OR the most recent diastolic blood pressure measurement is ≥ 90 mmHg or missing, OR if the BP reading was not done during the reporting period. The patient is NOT numerator compliant if the most recent systolic blood pressure measurement during the reporting period is < 140 mmHg AND the most recent diastolic blood pressure measurement during the reporting period is < 90 mmHg.

The following are not acceptable forms of documentation of blood pressure:

1. Use of terms "VS within normal limits," "VS WNL," or "Vital signs normal"
2. BP measurements obtained on the same day as a diagnostic or surgical procedure or at an emergency room visit
3. Patient self-reporting

Frequency: Most recent reading over the last 12 months from last day of the reporting period.

Scoring: If [numerator/denominator] ≤ minimum criteria, then Earned Points = [1 – (numerator/denominator)] x maximum available points for the measure

If [numerator/denominator] > minimum criteria, then Earned Points = 0

Blood Pressure Superior Control:

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent blood pressure in superior control (less than 130/80 mmHg).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data for blood pressure information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend blood pressure of <130/80 mmHg as a treatment goal for adults with diabetes. This is a superior control measure. A higher rate indicates better performance (i.e., high rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent systolic blood pressure measurement of < 130 mmHg AND diastolic blood pressure of < 80 mmHg . See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes. The steps below should be followed to determine the representative blood pressure reading.

1. *Identify the most recent visit to the doctor's office or clinic in which a BP reading was noted.* BP reading is acceptable if the representative BP was obtained during a visit to the clinician's office or non-emergency outpatient facility, such as clinic or urgent care center.

2. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record*. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is numerator compliant if the most recent systolic blood pressure measurement during the reporting period is < 130 mmHg AND the most recent diastolic blood pressure measurement during the reporting period is < 80 mmHg. The patient is NOT numerator compliant if the most recent systolic blood pressure measurement is ≥ 130 mmHg or missing, OR the most recent diastolic blood pressure measurement is ≥ 80 mmHg or missing, OR if the BP reading was not done during the reporting period.

The following are not acceptable forms of documentation of blood pressure:

1. Use of terms "VS within normal limits," "VS WNL," or "Vital signs normal"
2. BP measurements obtained on the same day as a diagnostic or surgical procedure or at an emergency room visit
3. Patient self-reporting

Frequency: Most recent reading over the last 12 months from the last day of the reporting period.

Scoring: If [numerator/denominator] ≥ minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

Lipid Control:

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent LDL-C level in poor control (greater than or equal to 130 mg/dl).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend treatment for patients with diabetes with an LDL-C level of ≥ 130 mg/dl. This is a poor control measure. A lower rate indicates better performance (i.e., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent LDL-C level ≥ 130 mg/dl. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent LDL-C test is ≥ 130 mg/dl, is missing, or if the test was not done during the reporting period. The patient is NOT numerator compliant if the laboratory result of the most recent LDL-C test during the reporting period is < 130 mg/dl.

Medical Record Collection: The patient is numerator compliant if the result of the most recent LDL-C test is ≥ 130 mg/dl, is missing, or if the test was not done during the reporting period. The patient is NOT numerator compliant if the result of the most recent LDL-C test during the reporting period is < 130 mg/dl.

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤ 400 mg/dl:

LDL-C = (total cholesterol) – (HDL) – (Triglycerides/5)

If the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, LDL-C levels should be entered as a value of 500 and the date of the test documented.

The following is not acceptable documentation of LDL-C test results:

1. LDL-to-HDL ratio
2. Patient self-reporting

Frequency: Most recent test result over the last 12 months from last day of the reporting period.

Scoring: If [numerator/denominator] ≤ minimum criteria, then Earned Points = [1 – (numerator/denominator)] x maximum available points for the measure

If [numerator/denominator] > minimum criteria, then Earned Points = 0

Lipid Superior Control:

Description: Percentage of patients aged 18 through 75 years with diabetes who had most recent LDL-C level in superior control (less than 100 mg/dl).

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend an LDL-C treatment goal of < 100 mg/dl for patients with diabetes. This is a superior control measure. A higher rate indicates better performance (i.e., high rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and most recent LDL-C level < 100 mg/dl. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent LDL-C test during the reporting period is < 100 mg/dl. The patient is NOT numerator compliant if the laboratory result of the most recent LDL-C test is ≥ 100 mg/dl, is missing, or if the test was not done during the reporting period.

Medical Record Collection: The patient is numerator compliant if the result of the most recent LDL-C test during the reporting period is < 100 mg/dl. The patient is NOT numerator compliant if the results of the most recent LDL-C test is ≥ 100 mg/dl, is missing, or if the test was not done during the reporting period.

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤ 400 mg/dl:

LDL-C = (total cholesterol) – (HDL) – (Triglycerides/5)

If the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, LDL-C levels should be entered as a value of 500 and the date of the test documented.

The following is not acceptable documentation of LDL-C test results:

1. LDL-to-HDL ratio
2. Patient self-reporting

Frequency: Most recent test result over the last 12 months from last day of the reporting period.

Scoring: If [numerator/denominator] ≥ minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

Ophthalmologic Examination:

Description: Percentage of patients aged 18 through 75 years with diabetes who had an eye screening exam for diabetic retinal disease.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter or medical record data for eye screening exam information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend that patients with diabetes have an annual dilated retinal examination to screen for diabetic retinal disease. It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and documentation of having received an eye screening exam for diabetic retinal disease. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

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Electronic Collection: The patient is numerator compliant if he or she has an eye screening exam for diabetic retinal disease as identified by claims data. This includes those patients with diabetes who had one of the following:

1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) over the last 12 months from the last day of the reporting period.

2. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) with a documented negative retinal exam result (no evidence of retinopathy) over the last 24 months from the last day of the reporting period.

3. Documentation of blindness, both eyes:
   ICD-9 codes: 369.20, 369.00, 369.07, 369.08, 369.3, 369.4;
   ICD-10 codes: H54.2, H54.0, H54.10, H54.3, H54.8

The following codes may be used to identify that a retinal or dilated eye exam has taken place. Note: evidence of a negative retinal exam result must be provided through medical record collection (see below):

CPT I Codes: 67028, 67038-67040, 67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260; 99203-99205, 99213-99215, 99242-99245;

HCPCS Codes: S0620, S0621, S0652, S3000;

ICD-9-CM Codes: 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0.
ICD-10-PCS Codes: Z01.00, Z01.01

Medical Record Collection: The patient is numerator compliant if he or she has an eye screening exam for diabetic retinal disease OR has documentation of blindness, both eyes. This includes those patients with diabetes who had one of the following:

1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) over the last 12 months from the last day of the reporting period.

2. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) with a documented negative retinal exam result (no evidence of retinopathy) over the last 24 months from the last day of the reporting period.

Documentation in the medical record of a retinal or dilated eye exam must include:

1. A note or letter from the eye care professional summarizing the date on which the procedure was performed and the results of a retinal eye evaluation

OR

2 A chart or photograph of retinal abnormalities

OR

3. A note, which may be prepared by a primary care clinician, indicating the date on which the procedure was performed, and that an ophthalmoscopic exam was completed by an eye care professional, with the results of the exam

The following is not acceptable documentation for a retinal or dilated eye exam:

1. Referral for an eye exam or referral with no documentation that an eye exam was completed
2. An eye exam that simply states the eyes were within normal limits (WNL)
3. A primary care clinician note that states only that the fundi were normal without specifically stating that the eyes were dilated
4. Visit to an eye care professional where it is clear that a dilated exam was not performed
5. Patient self-reporting

Frequency: If patient with positive diagnosis of retinopathy: most recent test result over the last 12 months from last day of the reporting period.

If patient with negative retinal exam (no evidence of retinopathy): most recent test result over the last 24 months from last day of the reporting period.

If patient with blindness, both eyes: patient's lifetime.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Nephropathy Assessment:

Description: Percentage of patients aged 18 through 75 years with diabetes who had evidence of nephropathy or a nephropathy screening.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter, pharmacy, laboratory or medical record data for nephropathy diagnosis, medical treatment or screening information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend routine urinalysis and microalbuminuria testing for adult patients with diabetes to detect nephropathy. It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and documentation of evidence of nephropathy or nephropathy screening. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if he or she has evidence of nephropathy or screening for nephropathy, as identified by claims or pharmacy data. This includes those patients with diabetes who had one of the following:

1. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.
2. Nephropathy screening during the reporting period.

Evidence of Nephropathy: The following codes may be used to identify nephropathy diagnosis or treatment:

CPT I Codes: 36145, 36800, 36810, 36815, 36818, 36819, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512;
ICD-9-CM Codes: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0;
V-Codes: V42.0, V45.1, V56, UB-92;
Revenue Codes: 0367, 080X, 082X-085X, 088X;
DRGs: 316, 317

ICD-10 Codes: N14.0 – N14.4, N15.0, N13.71, N07.0 – N07.9, E08.21, E09.21, E10.21, E11.21, E13.21, A36.84

Nephropathy Screening: The following codes may be used to identify nephropathy screening tests (microalbuminuria and/or macroalbuminuria test):

CPT I Codes:

Microalbuminuria Test: 82042, 82043, 82044, 83518, 84156, 84160*, 84166*, 84165*. Codes marked by an asterisk (*) must be accompanied by CPT I code 81050 indicating test was a urinalysis.

Macroalbuminuria Test: 81000-81003*, 81005*.

Codes marked by an asterisk (*) must be accompanied by CPT II code 3062F indicating a positive macroalbuminuria result.

Medical Record Collection: The patient is numerator compliant if he or she has evidence of nephropathy or screening for nephropathy. This includes those patients with diabetes who had one of the following:

1. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.
2. Evidence of drug therapy for nephropathy during the reporting period.
3. Nephropathy screening during the reporting period.

Evidence of Nephropathy: Documentation in the medical record must include diagnosis of or medical treatment for one of the following during the patient's lifetime:

- Diabetic nephropathy
- Diabetic kidney disease
- Diffuse diabetic or nodular glomerularsclerosis
- Kimmesstiel-Wilson lesion
- Papillary necrosis
- Arterionephrosclerosis
- End-stage renal disease (ESRD)
- Chronic renal failure (CRF)
- Chronic Renal insufficiency
- Chronic renal disorder
- Renal Dialysis
- Acute renal failure
- Proteinuria
- Azotemia
- Microalbuminuria

Nephropathy Drug Therapy: Documentation in the medical record must indicate the patient was dispensed or prescribed an Angiotensin-Converting Enzyme (ACE) Inhibitor or ACE Receptor Blocker (ARB) medication over the past 12 months, from the last day of the reporting period.

Nephropathy Screening: Documentation in the medical record must include the date on which the screening test was performed, and the test result, over the past 12 months, from the last day of the reporting period. Notation of the following may count for microalbuminuria screening test:

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for micro albumin
- Microalbumin/Creatine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Notation of the following may count for macroalbuminuria screening test:

- Positive result on urine dipstick

Note: A negative result on urine dipstick is insufficient for numerator compliance.

The following is not acceptable documentation for nephropathy assessment:

1. Patient self-reporting

Frequency: If patient with diagnosis of or medical treatment for nephropathy: during patient lifetime.

If patient with drug therapy treatment for nephropathy or nephropathy screening: most recent prescription or test result over the last 12 months from last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Podiatry Examination:

Description: Percentage of patients aged 18 through 75 years with diabetes who had a diabetic foot exam performed.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter and medical record data for foot exam information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend foot examination, with shoes and socks removed, for adult patients with diabetes to avoid lower extremity amputations, foot ulcers and other foot problems. It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and documentation of having received a diabetic foot exam (which includes visual inspection of skin integrity and documentation of sensitivity to light touch or vibration) or bilateral foot amputation. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if he or she has received a diabetic foot exam during the reporting period, as identified by claims data. The following codes may be used to identify a diabetic foot exam:

CPT II Codes: 2028F

Medical Record Collection: The patient is numerator compliant if he or she has received a diabetic foot exam OR bilateral foot amputation. This includes those patients with diabetes who had one of the following:

1. Foot exam including visual inspection and sensory exam with monofilament or tuning fork test during the reporting period
2. Documentation of a "diabetic foot exam" during the reporting period
3. Bilateral foot amputation in the patient's lifetime

4 Documentation in the medical record must include test result and exam date.

The following are not acceptable documentation for diabetic foot exam:

1. Documentation of general extremity exam without mention of the foot, such as extremities—no edema or Doppler
2. Range of motion or ROM exams
3. Patient self-reporting

Frequency: If patient with bilateral foot amputation: during patient lifetime.

If patient with diabetic foot exam: most recent test result over the last 12 months from last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Tobacco use and Cessation Advice and Treatment:

Description: Percentage of patients aged 18 through 75 years with diabetes who have documentation of tobacco use, and if a tobacco user, received cessation counseling or treatment.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data for documentation of tobacco use status, and if a user, pharmacy or medical record data for documentation of cessation counseling or treatment information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recommend that diabetics do not use tobacco products and that those who do received cessation counseling and treatment. It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and documentation of tobacco use status, and if tobacco user, date of cessation counseling or treatment. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if he or she has tobacco use status documented (see Medical Record Collection below) AND if a tobacco user has documented date of receipt of cessation counseling and/or treatment during the reporting period, as identified by claims data. The following codes may be used to identify smoking cessation counseling and/or treatment:

CPT I Codes: 99406, 99407;
CPT II Codes: 1000F, 1032F, 1033F, 1034F, 1035F, 1036F
HCPCS Codes: S9453.

Medical Record Collection: The patient is numerator compliant if he or she has tobacco status documented AND if tobacco user has documented date of receipt of cessation counseling and/or treatment during the reporting period. Acceptable forms of cessation counseling and treatment methods/resources include dated documentation of patient receiving/ participating in at least one of the following:

1. 1:1 teaching
2. Written or web-based risk-based educational materials
3. Group education class focused on tobacco cessation
4. Drug therapy

If the patient is a non-tobacco user, the patient is NOT numerator compliant if:

1. His or her tobacco use status documentation is missing

OR

2. His or her tobacco status was not asked

If the patient is a tobacco user, the patient is NOT numerator compliant if:

1. His or her status documentation is missing

OR

2. His or her tobacco user status was not asked

OR

3. His or her documentation on receiving cessation counseling and/or treatment is missing

OR

4. He or she has not received cessation counseling and/or treatment

OR

5. He or she has not received cessation counseling and/or treatment during the reporting period

OR

6. His or her documentation on receiving cessation counseling and/or treatment is not during the reporting period

Frequency: If not a tobacco user: most recent status.

If tobacco user: most recent status and counseling/treatment over the last 12 months from last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Body Mass Index:

Description: Percentage of patients' aged 18 through 75 years with diabetes for whom a documented body mass index (BMI) is calculated.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter and medical record data for BMI information for the numerator.

Explanation: American Diabetes Association (ADA) guidelines recognized that overweight and obesity are strongly linked to the development of type 2 diabetes and can complicate its management. Obesity is an independent risk factor for hypertension, dyslipidemia, and cardiovascular disease, which is the major cause of death in persons with diabetes. Individuals with a BMI of 25 kg per m^2 or greater and who have diabetes or are at risk of developing diabetes should be counseled to lose weight. It is anticipated that clinicians who provide services for the primary management of diabetes will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of diabetes and a documented BMI calculated. See "Patient Eligibility Criteria" for further information on codes to identify patients with diabetes.

Electronic Collection: The patient is numerator compliant if he or she has a calculation of their BMI documented during the reporting period, as identified by claims data. The following codes may be used to identify a documented BMI:

CPT II Code: 3008F
HCPCS Codes: G8417-G8420
ICD-9: V-Codes: V85.0 BMI less than 19, adult; V85.1 BMI between 19-24, adult; V85.2 BMI between 25-29, adult; V85.3 BMI between 30-39, adult; V85.4 BMI between 40 and over, adult.

ICD-10: Z68.1 BMI less than 19, adult; Z68.20 – Z68.24 BMI between 20-24, adult; Z68.25-Z68.29 BMI between 25-29, adult; Z68.30 – Z68.39 BMI between 30-39, adult; Z68.4 BMI between 40 and over, adult.

Medical Record Collection: The patient is numerator compliant if he or she has had their BMI calculated and documented. This includes those patients with diabetes who had one of the following:

1. Documentation of the result of a BMI calculation during the reporting period
2. Documentation in the medical record must include BMI result and exam date.

3. **Calculated BMI** – Requires that both the height and weight are actually measured by an eligible professional or by their staff.

The following are not acceptable documentation for documented BMI calculation:

1. Patient self-reporting

Frequency: Most recent test result over the last 12 months from last day of the reporting period.

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

1. If the patient has a terminal illness – life expectancy less than 6 months
2. If the patient is pregnant

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Patient Eligibility Criteria

An **eligible** diabetes patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.[4]

2. Has had a documented diagnosis of diabetes (as defined in Table 1 below) and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics (as defined in Table 2 below) for at least 12 months, from the last day of the reporting period.

3. Has been under the care of the applicant for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

There are three accepted data sources that can be used to identify patients with diabetes: claims/encounter data, medical record data and pharmacy data.

Claims/Encounter data: Patient is denominator compliant if he or she is aged 18-75 and has had at least two face-to-face encounters for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See Table 1 below for further information on codes to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list AND has been under the care of the applicant for at least 12 months. See Table 1 below for further information on diagnoses to identify patients with diabetes.

Pharmacy data: Patient is denominator compliant if he or she is aged 18-75 and was prescribed/dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemic/antihyperglycemic prescriptions. See Table 2 below for further information on eligible drugs to identify patients with diabetes.

Exclusions: Patients with a diagnosis of polycystic ovaries, gestational or steroid-induced diabetes who do not also have a primary or secondary diagnosis of diabetes during the reporting period are excluded from the denominator. Patients in hospice or palliative care are also excluded from the denominator. See Table 3 below for further information on codes to identify patients with exclusions.

[4] As of the last date of the reporting period. Patients known to be deceased should be excluded.

Table 1: Codes and Descriptions to Identify Patients with a Diagnosis of Diabetes

Diabetes Care Recognition Program Coding Conventions: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x," which represents a required digit: for example, ICD-9-CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.

Diagnosis Codes			
ICD-9/ICD-10 Code and Criteria	**Definition**	**Synonyms**	**Exclusions**
Diabetes Mellitus **ICD-9:** 250.00 - 250.03, 250.30 - 250.33, 250.40 - 250.43, or 648.0 - 648.04 **ICD-10:** E11.9, E10.9, E11.65, E1065, or O24.319, O24.32, O24.92, O24.911 – O24.913, O24.93	The need for diet management, insulin, or oral hypoglycemic agent, report of home urine or home blood glucose testing or the presence of an insulin pump anywhere in the medical record	Insulin-dependent diabetes mellitus (IDDM), non-insulin dependent diabetes (NIDDM), Type I, Type II, DM, AODM, sugar diabetes, maturity onset diabetes, diet controlled diabetes	Documentation of family history of diabetes without personal diagnosis, steroid-induced diabetes, gestational diabetes (ICD-9 code 648.8), R/O diabetes, diabetes insipidus, questionable or "?" diabetes mellitus, or hyperglycemia, glucose intolerance, borderline diabetes
Diabetic Polyneuropathy **ICD-9:** 357.2 **ICD-10:** E08.42, E09.42, E10.42, E11.42, E13.42	Any mention of a diagnosis of diabetic polyneuropathy in the medical record	Neuropathy or peripheral neuropathy, decreased or altered sensation, extremity numbness or tingling, paresthesia in the lower extremity, foot ulcers, distal symmetric polyneuropathy, loss of sensation (vibration/touch) in the feet, loss of ankle reflexes, Charcot's joints, malperforans ulcer, loss of light touch and pin prick, knife-like or burning pain of feet, sensory loss or pain in hands, or mononeuropathy	Rule out or R/O neuropathy, extremity weakness, or probable or "?" neuropathy
Diabetes with neurological manifestations **ICD-9:** 250.60 - 250.63 **ICD-10:** E11.40, E10.40, E11.65, E10.65			**Excludes**: endocrine and metabolic disturbances specific to the fetus and newborn (775.0-775.9)
Diabetes with			**Excludes**: endocrine and

Peripheral Circulatory Disorder **ICD-9:** 250.70 - 250.73 **ICD-10:** E11.51, E10.51, E11.65, E10.65			metabolic disturbances specific to the fetus and newborn (775.0-775.9)
Diabetes with other specified manifestations **ICD-9:** 250.80 – 250.83 **ICD-10:** E10.65, E10.69, E10.618, E10.620 – E10.622, E10.628, E10.630, E10.638, E10.649, E11.65, E11.69, E11.618, E11.620 – E11.622, E11.628, E11.630, E11.638, E11.649			**Excludes**: endocrine and metabolic disturbances specific to the fetus and newborn (775.0-775.9)
Diabetes with unspecified complications **ICD-9:** 250.90 – 250.93 **ICD-10:** E11.8, E10.8, E11.65, E10.65			**Excludes**: endocrine and metabolic disturbances specific to the fetus and newborn (775.0-775.9)

Diabetic Retinopathy **ICD-9:** 362.0 - 362.07, 250.50 - 250.53 **ICD-10:** E11.319, E11.359, E11.329, E11.339, E11.349, E11.311	Any mention of a diagnosis of diabetic retinopathy in the medical record	Diabetic eye changes: - Proliferative diabetic retinopathy - New vessels on the disc (NVD) - New vessels elsewhere in iris or retina - Preretinal or vitreous hemorrhage - Fibrosis rubeosis diabetic retinal changes - Macular lesion - Background retinopathy - preproliferative Retinopathy - Venous beading/looping - Large retinal blot hemorrhages - Multiple cotton wool spots - Multi-preintroretinal microvascular abnormalities - Diabetic macular edema - Nonproliferative diabetic retinopathy - Microaneurysms - Blot hemorrhage - Hard exudates - ½ soft exudates	Rule out or R/O diabetic retinopathy
Diabetic cataract **ICD-9:** 366.41 **ICD-10:** E08.36, E09.36, E10.36, E11.36, E13.36	Any mention of a diagnosis of diabetic cataract in the medical record	N/A	Patients with congenital cataract, senile cataract, traumatic cataract, cataract secondary to ocular disorders or after-cataract

Table 2: Descriptions to Identify Patients with Notation of Prescribed Insulin or Oral Hypoglycemics/Antihyperglycemics

Criteria	Definition	Synonyms	Exclusions
Insulin	Any mention of routine insulin use during the past 12 months in the medical record	Any insulin, including regular insulin, insulin pump, insulin pen, 70/30, CSII (continuous subcutaneous infusion of insulin) Humalog, Humulin, Lente, Lispro, MDI (multiple daily injections), Novolin, Novolin Penfill, NPH Novo Nordisk, Semilente, Ultralente, Velosulin	Insulin given only during hospitalization, or briefly to help a patient through an acute illness, such as with steroid treatment or active infection does not constitute documentation of insulin use for diabetes
Oral hypoglycemic / anti-hyperglycemic	Any mention of oral hypoglycemic or antihyper-glycemic use during the past 12 months in the medical record	Acarbose, Acetohexamide, Amaryl, Chlorpropamide, Diabeta, Diabinase, Dymelor, Glipizide, Glipizide XL, Glucamide, Glucophage, Glucotrol, Glucotrol XL, Glyburide, Glynase, Metformin, Micronase, Orinase, Orimide, Prandin (Repaglinide), Precose, Tolazamide, Tolamide, Tolbutamide, Tolinase, Troglitazone	N/A

Table 3: Codes to Identify Patients with Exclusions

Diagnosis Codes
Polycystic Ovaries **ICD-9**: 256.4 **ICD-10**: E28.2 **Gestational Diabetes** **ICD-9**: 648.8 **ICD-10**: O24.424 **Hospice and Palliative Care** **ICD-9**: V66.7 **ICD-10**: Z51.5 **CPT**: 99377, 99378

Applying for Recognition

Clinician applicants opt to voluntarily submit their data to a PAO for performance assessment through the Diabetes Care Recognition program. Participating clinicians must execute a data use agreement with the data aggregator partner through which they plan to submit data for HCI3's automated performance assessment process. All data aggregator partners have data use agreements executed with their partnering PAO. All necessary steps will be taken by the data aggregator and PAO to protect the confidentiality of patient data, as required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist with clinician compliance with HIPAA, the data aggregator partner provides a Business Associate addendum referenced in the data use agreement, which states that both the data aggregator and the clinician applicant will comply with HIPAA requirements.

Clinicians considering applying for recognition should:

1. Determine eligibility. See "Eligibility for Clinician Participation" for more information.

2. Familiarize themselves with the BTE Diabetes Care measures and specifications. See "What Recognition Requires".

3. Determine whether to apply as an individual clinician or medical practice.

Clinicians submitting through a data aggregator partner are required to submit medical record data for all eligible patients across their full patient population on a quarterly calendar schedule. Clinicians are required to continue submitting data for all eligible patients each quarter unless they cease using the data aggregator's electronic system.

Clinicians that are new to an electronic data aggregator partner's system, where the system is not yet fully integrated in the clinicians' office and patient records have not been backloaded, are required to prospectively enter all eligible patients from their full patient panel into the data aggregator's electronic system. For individual applicants, clinician assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for the minimum requirement of 25 eligible patients. For practice level applicants, assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for 10 patients per individual clinician and a practice average of 25 patients per clinician. It is assumed that after one full year of usage of the data aggregator's electronic system that all eligible patients will be included.

Completed applications are processed for compliance with performance requirements, and applicant-specific reports with results for all Diabetes Care measures are produced within 30 days. The begin recognition date is calculated based on the date that the applicant's data is scored. BTE issues an official certificate to each recognized clinician or medical practice.

Additionally, BTE reserves the right to complete an audit of any individual or practice application for Recognition. PAO or specified local organization subcontractors conduct audits of at least 5 percent of the recognized clinicians from each data aggregator partner each year. Audits may be completed by fax, mail, electronically or on site, as determined by the PAO. The remainder of the five percent will be identified by a single methodology that randomizes the medical groups who submit to the data aggregator and then sequentially selecting medical groups. The number of medical groups selected is dependent on the total number of recognized clinicians in each medical group, enough groups will be selected to account for 5% of total recognized clinicians submitted by the data aggregator.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission. Upon passing an audit, the applicant's recognition dates are assigned retroactively to the date the applicant's data was scored. Failure to pass an audit or failure to respond to an audit request and complete the audit within 30 days results in no further consideration for the program for six months to two years (depending on the audit score) from the date of submission of the application.

Duration of Recognition

The Chronic Care Recognition Programs have duration of two years from the date on which the recognition was awarded; regardless of the pathway the clinician achieved the recognition – electronic data submission, direct data manual submission or NCQA. Patient Centered Medical Home Recognitions achieved through the NCQA have a three-year duration.

For continuously assessed applicants who maintain their current level of recognition, new begin and end recognition dates will be assigned at the time of the most recent assessment. Recognition determinations are made on the basis of a specific patient population. Recognition status remains in effect for the duration of recognition as long as the clinician maintains his or her current practice and patient base. ***Clinicians are responsible for informing the data aggregator within 30 days who will inform the PAO if they move or change practices.***

Changes in Recognition Levels

Continuous data submission applicants are eligible for changes in recognition level. Clinicians who achieve at least Level I Diabetes Care Recognition will maintain their Diabetes Care Recognition for the duration of recognition outlined above. However, during this time it is possible for the recognition status to move between program levels (I, II and III) based on changes in clinical data from quarter to quarter. Changes to program level and recognition dates occur according to the following rules:

- Clinicians who achieve a higher level of recognition for two consecutive assessment periods will have their recognition level changed effective the date of the most recent assessment.
- Clinicians recognized at Level II or III can drop in levels of recognition based on lower scoring results for two consecutive assessment periods.
- Each time a clinician's recognition status changes levels in either direction a new begin recognition date is assigned for the date of the most recent assessment and a new end recognition date is calculated.
- Clinicians who drop below Level I for two consecutive quarterly assessments will be assigned or maintain Level I Diabetes Care Recognition status and maintain their current begin and end recognition dates.

Example 1: Clinician A assessment history

Assessment period	*Assessment date*	*Assessed (Scored) Level*[7]	*Recognition Level*[8]	*Recognition Dates*
10/1/07-9/30/08	10/22/08	Level III	Level III	10/22/08-10/22/2011
1/1/08-12/31/09	1/21/09	Level III	Level III	1/21/09-1/21/2012
4/1/08-3/31/09	4/18/09	Level III	Level III	4/18/09-4/18/2012
7/1/08-6/30/09	7/25/09	Level II	Level III	4/18/09-4/18/2012
10/1/08-9/30/09	10/16/09	Level II	Level II	10/16/09-10/16/2012

Example 2: Clinician B assessment history

Assessment period	Assessment date	Assessed (Scored) Level	Recognition Level	Recognition Dates
10/1/08-9/30/09	10/22/09	Not Pass	N/A	N/A
1/1/09-12/31/10	1/21/10	Level II	N/A	N/A
4/1/09-3/31/10	4/18/10	Level II	Level II	4/18/2010-4/18/2012
7/1/09-6/30/10	7/25/10	Not Pass	Level II	4/18/2010-4/18/2012

[7] A clinician's Assessed Level is the BTE level at which the clinician's data is scored for the current measurement period.

[8] A clinician's Recognition Level is the BTE level at which the clinician is currently recognized and the level that is distributed to HCI3's health plan licensees and the BTE consumer portal at HealthGrades. A clinician's Recognition Level may or may not be the same as a clinician's Assessed Level.

10/1/09-9/30/10	10/16/10	Not Pass	Level I	4/18/2010-4/18/2012

Reporting Results to BTE and Its Partners

As part of HCI3's mission to identify and promote quality, the PAO report results to the following:

- To the data aggregator partner through which the recognition application was submitted. The data aggregator is required to share results reports with the clinician applicant to facilitate quality improvement.
- To BTE: Only Recognized statuses are reported to BTE for display on HCI3's web site: www.hci3.org and transmission to BTE-licensed health plans for associated rewards payments. Once the final decision is made, the PAO will reveal the identity, program name and program level of the recognized clinicians only. No clinical data is shared with BTE at any point in the process.

Terms of Recognition

When communicating with patients, third-party payers, managed care organizations (MCOs) and others, clinicians or practices who receive BTE Diabetes Care Recognition may represent themselves as BTE-recognized and meeting NQF/AQA quality measure requirements; however, clinicians or practices may not characterize themselves as "NQF/AQA-Approved" or "NQF/AQA-Endorsed." The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

Revoking Recognition

PAO may revoke a Recognition decision if any of the following occurs:

- The clinician or practice submits false data or does not collect data according to the procedures outlined in this manual, as determined by discussion with the clinician or practice or audit of application data and materials.
- The clinician or practice misrepresents the credentials of any of its clinicians.
- The clinician or practice misrepresents its Recognition status.
- The clinician or any of the practice's clinicians experience a suspension or revocation of medical licensure.
- The clinician or practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the clinician or practice's operations.
- BTE identifies a significant threat to patient safety or care.

Data Use Terms

Data use terms are outlined in the data use agreement that the applicant signs with the selected data aggregator partner.