OPTUM™

Diabetes measures toolbook

Understanding diabetes measures and the requirements of Healthcare Effectiveness Data and Information Set (HEDIS®)

Medicare Advantage

About HEDIS requirements for comprehensive diabetes care

The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) includes standard measures that are used to evaluate a health plan's performance. Through data collection and reporting, health plans also use HEDIS measures as an opportunity to identify areas for improvement in care. The Centers for Medicare & Medicaid Services (CMS) also requires HEDIS data reporting to help monitor the quality of Medicare Advantage plans and to provide information to help members compare those plans based on CMS' Star Ratings. This tool, which details HEDIS requirements for comprehensive diabetes care, a component of CMS' Star Ratings, is focused on the impact of that HEDIS measure for Medicare Advantage patients.

CMS Star Rating Weight

1

Comprehensive diabetes care (CDC): Diabetic eye exam

Description: Measures the percentage of plan members with diabetes who had a retinal or dilated eye exam by an eye care professional during measurement year.

Age: Members age 18–75 with diabetes (type 1 or type 2).

Requirements for compliance

A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year *or* a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

At a minimum, documentation in the medical record must include one of the following:

1. A note or letter prepared by an ophthalmologist, optometrist, primary care physician or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional and includes:
    - Date procedure was performed and
    - Results of exam
2. A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, you can submit results that were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
3. Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (that is, documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional, optometrist or ophthalmologist).

Description	CPT	CPT II	HCPCS
Eye exam	67028, 67030, 67031, 67036, 67039-67043,67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000

- To show evidence that a diabetic retinal eye exam was performed, an eye exam from a licensed eye care professional (optometrist or ophthalmologist) *must be* included in the medical record.
- Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.
- If not specified, verify that the eye exam performed was "retinal" or "dilated".
- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

CMS Star Rating Weight

1

Comprehensive diabetes care (CDC): Kidney disease monitoring

Description: Measures the percentage of plan members with diabetes who had a nephropathy test during the measurement year or evidence of nephropathy during the year.

Age: Members age 18 - 75 with diabetes (type 1 or type 2).

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

Nephropathy screening test

- Medical record indicating the date the urine microalbumin was performed
- Result or finding

Any of the following meet criteria for urine microalbumin test: 24 hour urine for microalbumin, timed urine for microalbumin, spot urine for microalbumin, urine for microalbumin/creatinine ratio, 24-hour urine for total protein and/or random urine for protein/creatinine ratio.

Evidence of nephropathy: Documentation of any of the following will meet the criteria for evidence of nephropathy

1. Documentation of a visit to a nephrologist.
2. Documentation of a renal transplant.
3. Documentation of medical attention for any of the following (no restriction on provider type): diabetic nephropathy, end stage renal disease, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), dialysis, hemodialysis and/or peritoneal dialysis.
4. A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
    - 24-hour urine for albumin or protein, timed urine for albumin or protein, spot urine for albumin or protein, urine for albumin/creatinine ratio, 24-hour urine for total protein, random urine for protein/creatinine ratio.
5. Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

- Ensure that the lab report with microalbumin results is included in the medical record.
- A screening or monitoring test meets criteria, whether result is positive or negative.
- If the patient was referred to a nephrologist for care, include a copy of the progress notes from those visit(s) in the medical record.

Description	CPT	CPT II	ICD-10-CM
Nephropathy treatment		3066F, 4010F	**E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0,** I12.9, **I13.0**, I13.10, **I13.11**, **I13.2**, I15.0, I15.1, N00.0, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N01.0, N01.1, N01.2, N01.3, N01.4, N01.5, N01.6, N01.7, N01.8, N01.9, N02.0, N02.1, N02.2, N02.3, N02.4, N02.5, N02.6, N02.7, N02.8, N02.9, N03.0, N03.1, N03.2, N03.3, N03.4, N03.5, N03.6, N03.7, N03.8, N03.9, N04.0, N04.1, N04.2, N04.3, N04.4, N04.5, N04.6, N04.7, N04.8, N04.9, N05.0, N05.1, N05.2, N05.3, N05.4, N05.5, N05.6, N05.7, N05.8, N05.9, N06.0, N06.1, N06.2, N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N07.0, N07.1, N07.2, N07.3, N07.4, N07.5, N07.6, N07.7, N07.8, N07.9, N08, N14.0, N14.1, N14.2, N14.3, N14.4, **N17.0**, **N17.1**, **N17.2**, **N17.8**, **N17.9**, N18.1, N18.2, N18.3, **N18.4**, **N18.5**, **N18.6**, N18.9, N19, N25.0, **N25.1**, **N25.81**, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0, Q60.1, Q60.2, Q60.3, Q60.4, Q60.5, Q60.6, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q61.9, R80.0, R80.1, R80.2, R80.3, R80.8, R80.9
Urine protein test	81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, 84156	3060F, 3061F, 3062F	

CMS Star Rating Weight

3

Comprehensive diabetes care (CDC): Blood sugar controlled

Description: Measures the percentage of plan members who had an HbA1c test during the year and demonstrate good control.

Age: Members age 18 - 75 with diabetes (type 1 or type 2).

Requirements for compliance

Hemoglobin A1c screening test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

HbA1c Control is based the last test value of the year.

What to report for compliance

This screening is typically closed by claims but can also be closed from medical record documentation.

What you need to include in medical record documentation

- HbA1c test performed during the measurement year
- Date the HbA1c test was performed
- Result

HEDIS specifies that HbA1c control for this population <8%. The member is compliant if the result for the most recent HbA1c level during the measurement year is <8.0%. The Five-Star Quality Rating defines poor control for this measure as >9.0%. *Missing test result (HbA1c value) is considered not compliant for HbA1c control for HEDIS and Five-Star Quality Ratings.*

Description	CPT	CPT II
HbA1c test	83036, 83037	
HbA1c level less than 7.0%		3044F
HbA1c level 7.0- 9.0%		3045F
HbA1c level greater than 9.0%		3046F

- Always document the most recent HbA1c test results in the progress note.
- NCQA only recognizes the last HbA1c result of the measurement year.
- Only the HbA1c test will close this measure.
- Ensure that the name of the test performed specifically includes "A1c" and that this label translates from lab results to the electronic medical record and/or to printed medical record.
- If using a CPT-II code to report the result, a copy of the lab results *must be* included in the medical record.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2016: "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required."

Thus the bolding of ICD-10-CM codes represents only those fully reportable codes, not categories or subcategories, that map to the 2014 CMS-HCC risk adjustment model for Payment Year 2016.

For additional information as well as publications and products available for HEDIS®, please visit the National Committee for Quality Assurance (NCQA) website at ncqa.org

For additional information about the Medicare Advantage Five-Star Quality Rating System, please refer to: http://go.cms.gov/partcanddstarratings

Blood pressure control for diabetics

Description: Measures the percentage of members with diabetes during the measurement year who had blood pressure control (<140/90 mm Hg).

Age: Members age 18–75 with diabetes (type 1 or type 2).

What to report for compliance

The member is numerator compliant if the blood pressure (BP) is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there are no BP readings during the measurement year or if the reading is incomplete (for example, the systolic or diastolic level is missing). If there are multiple BP readings on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Requirements for compliance

The most recent BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Description	CPT II
Systolic	3074F <130, 3075F <140, 3077F ≥140
Diastolic	3078F <80, 3079F <90, 3080F ≥90

- Do not include BP readings taken in these circumstances:
  - An acute inpatient stay or an ED visit.
  - An outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed.
  - On the same day as a major diagnostic or surgical procedure.
  - Reported by or taken by the member.
- The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date.

How can we help you?

Our goal is to help healthcare professionals facilitate and support accurate, complete and specific documentation and coding with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with the Centers for Medicare & Medicaid Services (CMS) risk adjustment requirements

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