Proposed Changes to Existing Measure for HEDIS® 2015: Comprehensive Diabetes Care (CDC)

NCQA seeks comments on proposed modifications to the Comprehensive Diabetes Care measure. We propose to retire the LDL-C Screening, LDL-C Control (<100 mg/dL) and BP Control (<140/80 mm Hg) indicators. The Comprehensive Diabetes Care measure would continue to assess the percentage of members 18–75 years of age with diabetes who received recommended care with the following indicators:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

In November 2013, the American College of Cardiology/American Heart Association (ACC/AHA) Task Force on Practice Guidelines released updated guidance for the treatment of blood cholesterol. The new recommendations remove treatment targets for LDL-C for the primary or secondary prevention of atherosclerotic cardiovascular disease (ASCVD) and recommend high- or moderate-intensity statin therapy based on patient risk factors.

The stated rationale for removing LDL-C treatment targets is that no studies have focused on treatment or titration to a specific LDL-C goal in adults with clinical ASCVD. The majority of randomized controlled studies confirming the efficacy of cholesterol reduction in improving clinical outcomes in patients with clinical ASCVD used a single fixed-dose statin therapy to lower LDL-C levels.

In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for the treatment of hypertension. The new guidelines recommend that all diabetic patients 18 years of age and older be treated to a blood pressure (BP) goal of <140/90 mm Hg. Additional BP goals were not recommended for patients with diabetes.

Retiring the LDL-C Screening, LDL-C Control (<100 mg/dL), and BP Control (<140/80 mm Hg) indicators aligns with the latest ACC/AHA and JNC 8 recommendations.

Supporting documents for the proposed measure include the draft measure specification and recent performance data.

NCQA acknowledges the contributions of the Cardiovascular Measurement Advisory Panel.

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Comprehensive Diabetes Care (CDC)

**SUMMARY OF CHANGES TO HEDIS® 2015**

- Removed the LDL-C screening indicator and specifications.
- Removed the LDL-C control (<100 mg/dL) indicator and specifications.
- Removed the BP control (<140/80 mm Hg) indicator and specifications.

**Description**

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- LDL-C screening.
- LDL-C control (<100 mg/dL).
- Medical attention for nephropathy.
- BP control (<140/80 mm Hg).
- BP control (<140/90 mm Hg).
- Eye exam (retinal) performed.

*Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.

**Eligible Population**

**Product lines**

Commercial, Medicaid, Medicare (report each product line separately).

**Ages**

18–75 years as of December 31 of the measurement year.

**Continuous enrollment**

The measurement year.

**Allowable gap**

No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

**Anchor date**

December 31 of the measurement year.

**Benefit**

Medical.

**Event/diagnosis**

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

*Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):*
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).
- At least one ED visit (ED Value Set) with a diagnosis of diabetes (Diabetes Value Set).

**Pharmacy data.** Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).

### Table CDC-A: Prescriptions to Identify Members with Diabetes

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-glucosidase inhibitors</td>
<td>• Acarbose • Miglitol</td>
</tr>
<tr>
<td>Amylin analogs</td>
<td>• Pramlintide</td>
</tr>
<tr>
<td>Antidiabetic combinations</td>
<td>• Glimepiride-pioglitazone • Metformin-metformin • Metformin-saxagliptin • Metformin-sitagliptin • Saxagliptin • Sitagliptin-simvastatin</td>
</tr>
<tr>
<td>Insulin</td>
<td>• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin inhalation • Insulin isophane beef-pork • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human</td>
</tr>
<tr>
<td>Meglitinides</td>
<td>• Nateglinide • Repaglinide</td>
</tr>
<tr>
<td>Miscellaneous antidiabetic agents</td>
<td>• Exenatide • Metformin-repaglinide • Sitagliptin</td>
</tr>
<tr>
<td>Sodium glucose cotransporter 2 (SGLT2) inhibitor</td>
<td>• Canagliflozin</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>• Acetohexamide • Glimepiride • Glyburide • Tolazamide • Tolbutamide</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>• Pioglitazone • Rosiglitazone</td>
</tr>
</tbody>
</table>

**Note:** Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2014.

### Administrative Specification

**Denominator**

The eligible population.

**Required exclusions for HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.**

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
**Selected Population Indicator**

- **CABG.** Members discharged alive for CABG (CABG Value Set) during the measurement year or the year prior to the measurement year. Use both facility and professional claims to identify CABG and include inpatient claims only.

- **PCI.** Members who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year.

- **IVD.** Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).

- **Thoracic aortic aneurysm.** Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).

- Any of the following, in any setting, any time during the member’s history through December 31 of the measurement year.
  - **Chronic heart failure (CHF).** A diagnosis of CHF (CHF Value Set).
  - **Prior MI.** A diagnosis of MI (MI Value Set).
  - **ESRD.** ESRD (ESRD Value Set; ESRD Obsolete Value Set).
  - **Chronic kidney disease (stage 4).** Stage 4 chronic kidney disease (CKD Stage 4 Value Set).
  - **Dementia.** A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set).
  - **Blindness.** A diagnosis of blindness (Blindness Value Set).
  - **Amputation (lower extremity).** Lower extremity amputation (Lower Extremity Amputation Value Set).

**Numerators**

- **HbA1c Testing**
  - An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

- **HbA1c Poor Control >9%**
  - Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.
<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Not compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant*</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

HbA1c Control <8%

Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant*</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>

*The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed.

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**HbA1c Control <7% for a Selected Population**

Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not performed during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>

**Note:** This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).

**Eye Exam**

An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

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

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

**LDL-C Screening**

An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The organization may use a calculated or direct LDL for LDL-C screening and control indicators.
**LDL-C Control <100 mg/dL**

Use codes in the LDL-C Tests Value Set to identify the most recent LDL-C test during the measurement year. The member is numerator compliant if the most recent LDL-C level is <100 mg/dL. If the result for the most recent LDL-C test during the measurement year is ≥100 mg/dL or is missing, or if an LDL-C test was not performed during the measurement year, the member is not numerator compliant.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and must use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C Level Less Than 100 Value Set</td>
<td>Compliant</td>
</tr>
<tr>
<td>LDL-C Level Greater Than/Equal To 100 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>

**Medical Attention for Nephropathy**

A nephropathy screening test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening test (Nephropathy Screening Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Value Set).
- Evidence of kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- A positive urine macroalbumin test (Positive Urine Macroalbumin Tests Value Set).
- A urine macroalbumin test (Urine Macroalbumin Tests Value Set) where laboratory data indicates a positive result (“trace” urine microalbumin test results are not considered numerator compliant).
- At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

**Note:** A process flow diagram is included at the end of this specification to help implement this specification.

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Table CDC-L: ACE Inhibitors/ARBs

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
</table>
| Angiotensin converting enzyme inhibitors | • Benazepril  
• Captopril  
• Enalapril  
• Fosinopril  
• Lisinopril  
• Moexipril  
• Perindopril  
• Quinapril  
• Ramipril  
• Trandolapril |
| Angiotensin II inhibitors | • Azilsartan  
• Candesartan  
• Eprosartan  
• Irbesartan  
• Losartan  
• Olmesartan  
• Telmisartan  
• Valsartan |
| Antihypertensive combinations | • Amlodipine-benazepril  
• Amlodipine-hydrochlorothiazide  
• Amlodipine-olmesartan  
• Amlodipine-valsartan  
• Aliskiren-valsartan  
• Amlodipine-hydrochlorothiazide-valsartan  
• Hydrochlorothiazide-lisinopril  
• Hydrochlorothiazide-losartan  
• Hydrochlorothiazide-moexipril  
• Hydrochlorothiazide-olmesartan  
• Hydrochlorothiazide-telmisartan  
• Hydrochlorothiazide-valsartan  
• Trandolapril-verapamil |

Note: NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2014.

**BP Control <140/80 mm Hg**

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

The member is numerator compliant if the BP is <140/80 mm Hg. The member is not compliant if the BP is ≥140/80 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Less Than 140 Value Set</td>
<td>Systolic compliant</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal To 140 Value Set</td>
<td>Systolic not compliant</td>
</tr>
<tr>
<td>Diastolic Less Than 80 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic 80-89 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal To 90 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
</tbody>
</table>

**BP Control <140/90 mm Hg**

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Visit Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

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

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Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Less Than 140 Value Set</td>
<td>Systolic compliant</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal To 140 Value Set</td>
<td>Systolic not compliant</td>
</tr>
<tr>
<td>Diastolic Less Than 80 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic 80–89 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal To 90 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
</tbody>
</table>

**Exclusions (optional)**

Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member’s history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes (Gestational or Steroid-Induced Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.

**Hybrid Specification**

**Denominator**

A systematic sample of 548 drawn from the eligible population for each product line. A sample size of 548 is based on the goal of achieving a sample of at least 411 for the HbA1c <7% denominator after required exclusions. The HbA1c Control <7% for a Selected Population indicator is not collected or reported for the Medicare product line. Organizations should use a sample size of 411 for the Medicare product line or if they do not report the HbA1c Control <7% for a Selected Population indicator.

Members who meet the required exclusion criteria for the HbA1c Control <7% for a Selected Population indicator should not be substituted with members from the oversample. These members will only be excluded when reporting the denominator for the HbA1c <7% for a Selected Population indicator. In other words, organizations should report the FSS for this indicator as 548 minus the required exclusions.

**Note:** The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.
The organization may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate for the lowest rate among all the reported CDC indicators. For indicators not reported in the prior year, the same audit result must apply to the current year (e.g., if the audit result for HbA1c Control <7% for a Selected Population was NR in the prior year, the organization must take an NR for the current year) and the lowest rate for all reported indicators should be used when reducing the sample size.

If the organization chooses to reduce the sample size and report the HbA1c Control <7% for a Selected Population indicator, the sample size for this indicator must still be the appropriate sample size as specified in Table 1: Sample Sizes When Data Are Available on the Product Line Being Measured (in the Guidelines for Calculations and Sampling) after the required exclusions are removed.

### Required exclusions for HbA1c Control <7% for a Selected Population

**Administrative**

Refer to Administrative Specification to identify required exclusions from administrative data.

**Medical record**

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- **CABG.** Dated documentation of CABG in the measurement year or the year before the measurement year.
- **PCI.** Dated documentation of PCI in the measurement year or the year before the measurement year.
- **IVD.** Documentation of an IVD diagnosis. Look as far back as possible in the member’s history through December 31 of the measurement year. Appropriate diagnoses include:
  - IVD.
  - Ischemic heart disease.
  - Angina.
  - Coronary atherosclerosis.
  - Coronary artery occlusion.
  - Cardiovascular disease.
  - Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
  - Atherosclerosis of renal artery.
  - Atherosclerosis of native arteries of the extremities.
  - Chronic total occlusion of artery of the extremities.
  - Arterial embolism and thrombosis.
  - Atheroembolism.
- **Thoracoabdominal or thoracic aortic aneurysm.** Documentation of thoracoabdominal aneurysm or thoracic aortic aneurysm. Look as far back as possible in the member’s history through December 31 of the measurement year.
- **CHF.** Documentation of CHF or cardiomyopathy diagnosis. Look as far back as possible in the member’s history through December 31 of the measurement year.
• **Prior MI.** Documentation of prior MI. Look as far back as possible in the member’s history through December 31 of the measurement year.

• **ESRD.** Documentation of stage 5 chronic kidney disease, ESRD or dialysis. Look as far back as possible in the member’s history through December 31 of the measurement year.

• **Chronic kidney disease (stage 4).** Documentation of stage 4 chronic kidney disease. Look as far back as possible in the member’s history through December 31 of the measurement year.

• **Dementia.** Documentation of dementia. Look as far back as possible in the member’s history through December 31 of the measurement year.

• **Blindness.** Documentation of blindness in one or both eyes. Look as far back as possible in the member’s history through December 31 of the measurement year.

• **Amputation (lower extremity).** Documentation of lower extremity amputation. Look as far back as possible in the member’s history through December 31 of the measurement year.

**Note:** For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but should exclude these members if they are discovered during medical record review.

### Numerators

#### HbA1c Testing

An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

#### Administrative

Refer to Administrative Specification to identify positive numerator hits from administrative data.

#### Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Organizations may count notation of the following in the medical record:

- A1c
- Hemoglobin A1c
- HgbA1c
- HbA1c
- Glycohemoglobin A1c

#### HbA1c Poor Control >9%

The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

**Note:** A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

#### Administrative

Refer to Administrative Specification to identify positive numerator hits from administrative data.

#### Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.
**HbA1c Control**

**<8%**

The most recent HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.

**Medical record**

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

**HbA1c Control**

**<7% for a Selected Population**

The most recent HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.

**Note:** This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions).

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.

**Medical record**

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥7.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

**Eye Exam**

An eye screening for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

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

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.

**Medical record**

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

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results.
- 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, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
• 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 (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional meets criteria).

**LDL-C Screening**

An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data or medical record review.

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.

**Medical record**

At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result or finding.

- The organization may use a calculated or direct LDL for LDL-C screening and control indicators.
- The most recent LDL-C level performed during the measurement year is <100 mg/dL, as documented through automated laboratory data or medical record review.

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.

**Medical record**

Documentation in the medical record must include, at a minimum, a note indicating the date when the LDL-C test was performed and the result. The member is numerator compliant if the most recent LDL-C level during the measurement year is <100 mg/dL. The member is not numerator compliant if the result for the most recent LDL-C test is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year.

- A documented range or threshold that indicates the most recent result is less than 100 mg/dL meets criteria.

- The organization may calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

\[
(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5)
\]

If lipoprotein (a) is measured, use the following calculation.

\[
(\text{LDL-C}) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5) - 0.3 [\text{lipoprotein (a)}]
\]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

- The Friedewald equation may not be used if a direct or calculated result is present in the medical record for the most recent LDL-C test.

**Medical Attention for Nephropathy**

A nephropathy screening test during the measurement year or evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

**Note:** A process flow diagram is included at the end of this specification to help implement this specification.

**Administrative**

Refer to Administrative Specification to identify positive numerator hits from administrative data.
**Medical record**  
*Nephropathy screening test.* At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a 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.
- Random urine for protein/creatinine ratio.

**Evidence of nephropathy.** Any of the following meet the criteria for evidence of nephropathy:

- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.
- A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date when the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test:
  - Positive urinalysis (random, spot or timed) for protein.
  - Positive urine (random, spot or timed) for protein.
  - Positive urine dipstick for protein.
  - Positive tablet reagent for urine protein.
  - Positive result for albuminuria.
  - Positive result for macroalbuminuria.
  - Positive result for proteinuria.
  - Positive result for gross proteinuria.

  **Note:** “Trace” urine macroalbumin test results are not considered numerator compliant.

- 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.

**BP Control**  
*<140/<80 mm Hg*  
The most recent BP level (taken during the measurement year) is <140/80 mm Hg, as documented through administrative data or medical record review.
BP Control

<140/90 mm Hg

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

Administrative

Refer to Administrative Specification to identify positive numerator hits from administrative data.

Medical record

The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member’s diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.

To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below.

Step 1

Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

Step 2

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP 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 when multiple readings are recorded for a single date.

The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, and who meet either of the following criteria:

- A diagnosis of polycystic ovaries, in any setting, any time during the member’s history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Note

- Organizations may select data collection method (Administrative vs. Hybrid) at the indicator level, but the method for screening and control rates must be consistent, as must the methodology for BP control indicators.
- 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.
• If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.

Monitoring for Diabetic Nephropathy

**STEP 1:**
Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy or dialysis?

- YES → **STOP!** Member is compliant
- NO → **STEP 2:**

**STEP 2:**
Review for a urinalysis test that indicates a protein test was run or a dipstick was performed for gross protein macro-albuminuria in the measurement year. Was the test **positive** for the measurement year?

- YES → **STOP!** Member is compliant
- NO → **STEP 3:**

**STEP 3:**
Review for a microalbumin lab test. Was the test done in the measurement year?

- YES → **STOP!** Member is compliant
- NO → **STEP 4:**

**STEP 4:**
Review for evidence of ACE inhibitor/ARB therapy. Is there evidence of therapy in the measurement year?

- YES → **STOP!** Member is compliant
- NO → **STOP!** Member is not compliant
## Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

### Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Administrative</th>
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<td>Each of the 740 rates</td>
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<tr>
<td>Data collection methodology (Administrative or Hybrid)</td>
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<td>Eligible population with required exclusions applied</td>
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<td>Number of numerator events by administrative data in eligible population</td>
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<td>(before optional exclusions)</td>
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<td>Oversampling rate</td>
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<td>Number of employee/dependent medical records excluded</td>
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<td>Number of HbA1c &lt;7 required medical records excluded</td>
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<td>Upper 95% confidence interval</td>
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*The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied. Additional exclusion criteria are required for this indicator which will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*
## Comprehensive Diabetes Care (CDC) Performance Data

### CDC—COMMERCIAL

#### LDL-C Control (<100 mg/dL)

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#### LDL-C Screening

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#### BP Control (<140/80 mm Hg)

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# BP Control (<140/90 mm Hg)

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# CDC—MEDICAID

## LDL-C Control (<100 mg/dL)

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## LDC-C Screening

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## BP Control (<140/80 mm Hg)

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### CDC—MEDICARE

#### LDL-C Control (<100 mg/dL)

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