Effectiveness of Care Measure

Comprehensive Diabetes Care

Use this tip sheet for key details of the Comprehensive Diabetes Care (CDC) measure, its codes and guidance for documentation.

Measure	The percentage of patients ages 18–75 with diabetes who had each of the following: • Hemoglobin A1c (HbA1c) testing and control • Retinal eye exam • Blood pressure (BP) control (< 140/90 mm Hg)
Exclusions	Patients are excluded if they: • Received palliative care in the measurement year. • Are in hospice care. • Are age 66 or older with frailty and advanced illness. • Do not have a diagnosis of diabetes during the measurement year or year prior and had a diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes (optional exclusion).
Telehealth services	• The restriction that only one of the two visits with a diabetes diagnosis be an outpatient telehealth, phone visit, e-visit or virtual check-in when identifying the event/diagnosis was removed. • Phone visits, e-visits and virtual check-ins were added: – To the advanced illness exclusion list. – As appropriate settings for blood pressure readings. • The requirements for remote monitoring was removed to allow blood pressures taken by any digital device.
Hemoglobin A1c (HbA1c) testing and control	An HbA1c test performed during the measurement year with value. Depending on the test value, patients will fall into different categories of controls: • HbA1c control < 8.0% • HbA1c poor control > 9.0%[1] [1]A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care). For CMS Star Ratings, Diabetes Care – Blood Sugar Control is calculated as subtraction of the HbA1c poor control (> 9.0%) rate from 100.

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PROVIDER COMMUNICATIONS

Hemoglobin A1c (HbA1c) testing and control *(continued)*

Codes to identify HbA1c test and level	
Description	**Codes**
HbA1c test	CPT: 83036, 83037
HbA1c test and level < 7.0%	CPT II: 3044F
HbA1c test and level ≥ 7.0% and < 8.0%	CPT II: 3051F
HbA1c test and level ≥ 8.0% and ≤ 9.0%	CPT II: 3052F
HbA1c test and level > 9.0%	CPT II: 3046F

Tips to improve HEDIS performance

- Evaluate and document HbA1c every three to six months. The last HbA1c result of the year counts toward the HEDIS score.
- Need date and most recent result during measurement year in chart – use reported value and not threshold for result. Documentation of "A1c," "HbA1c," "HgbA1c," "HB1c," "Hemoglobin A1c," "Glycohemoglobin A1c," "Glycohemoglobin," "Glycated hemoglobin," and "Glycosylated hemoglobin" count toward the A1c testing indicator.
- If result is missing or test was not done during measurement year then member will be counted as poorly controlled.
- Re-evaluate patient's care plan and repeat testing as needed.

Retinal eye exam

Eye screening or monitoring for diabetic retinal disease. This includes diabetics who had any 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.
- Bilateral eye enucleation anytime during patient's history through December 31 of the measurement year.

Codes to identify diabetic retinal screening, eye exam with evidence of retinopathy, eye exam without evidence of retinopathy, diabetic retinal screening negative in prior year, and eye enucleation.	
Description	**Codes**
Diabetic Retinal Screening	**CPT:** 67028, 67030, 67031, 67036, 67039, 67040–67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012,

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Retinal eye exam *(continued)*

Codes to identify diabetic retinal screening, eye exam with evidence of retinopathy, eye exam without evidence of retinopathy, diabetic retinal screening negative in prior year, and eye enucleation. *(continued)*

Description	Codes
Diabetic Retinal Screening (*continued*)	**CPT:** 92014, 92018, 92019, 92134, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213–99215, 99242–99245 **HCPCS:** S0620, S0621, S3000
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**	**CPT II:** 2022F
Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**	**CPT II:** 2024F
Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; **with evidence of retinopathy**	**CPT II:** 2026F
Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**	**CPT II:** 2023F
Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**	**CPT II:** 2025F
Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; **without evidence of retinopathy**	**CPT II:** 2033F
Diabetic retinal screening negative in prior year	**CPT II:** 3072F
Unilateral eye enucleation	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Unilateral eye enucleation left	**ICD-10:** 08T1XZZ
Unilateral eye enucleation right	**ICD-10:** 08T0XZZ
Bilateral modifier	50

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Retinal eye exam *(continued)*

Tips to improve HEDIS performance

- Document date of service eye exam was rendered by an eye care professional (specialty must be noted), and the results, or
- A chart or photograph indicating the date when fundus photography was performed with evidence that the 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 or read by a system that provides an artificial intelligence (AI) interpretation, or
- Evidence that member had bilateral eye enucleation or acquired absence of both eyes:
  - Unilateral eye enucleation with a bilateral modifier
  - Two unilateral eye enucleations with service dates 14 days or more apart
  - Left unilateral eye enucleation and right unilateral enucleation on the same or different dates of service, or
- Documentation of a negative retinal or dilated eye exam must clearly note in the medical record that the retinopathy was not present.
- Review eye exam report (from an eye care professional) and place it in patient's medical record.

Blood pressure control (< 140/90 mm Hg)

The most recent BP reading taken during outpatient visit, phone visit, e-visit or virtual check, non-acute inpatient encounter or remote monitoring event during the measurement year.

Codes to identify blood pressure

Description	CPT II Codes	Compliance
Systolic < 130 mm Hg	3074F	Systolic compliant
Systolic 130–139 mm Hg	3075F	Systolic compliant
Systolic ≥ 140 mm Hg	3077F	Systolic not compliant
Diastolic < 80 mm Hg	3078F	Diastolic compliant
Diastolic 80–89 mm Hg	3079F	Diastolic compliant
Diastolic ≥ To 90 mm Hg	3080F	Diastolic not compliant

Codes to identify outpatient visit, phone visit, online assessments (e-visit or virtual check-in), remote blood pressure monitoring and telehealth modifier/place of service (POS)

Description	Codes
Outpatient Visits	**CPT:** 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397,

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Blood pressure control (< 140/90 mm Hg)

Codes to identify outpatient visit, phone visit, online assessments (e-visit or virtual check-in), remote blood pressure monitoring and telehealth modifier/place of service (POS) *(continued)*	
Description	**Codes**
Outpatient Visits	**CPT:** 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS**: G0402, G0438, G0439, G0463, T1015
Phone Visits	**CPT:** 98966-98968, 99441–99443
Online Assessments	**CPT:** 98969–98972, 99421-99423, 99444, 99458 **HCPCS:** G2010, G2012, G2061, G2062, G2063
Remote Blood Pressure Monitoring	**CPT:** 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474
Telehealth Modifier	GT, 95
Telehealth POS	02

Tips to improve HEDIS performance

- Determine the representative BP
  - Identify the most recent BP reading noted during the measurement year on or after the second diagnosis of hypertension.
  - If multiple BP readings were recorded on 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.
- If no BP is recorded during the measurement year or if the reading is incomplete, assume that the patient is "not controlled."
- Bill BP CPT II codes on each office visit claim along with a hypertensive condition.
- Do not include BP readings:
  - Taken during an acute inpatient stay or an ED visit.
  - Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood test.
  - Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
- Remote measurements by any digital device are acceptable.
- Instruct staff to take a repeat reading if abnormal BP is obtained.
- Promote use of proper blood pressure monitoring technique by staff taking BP readings.

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