Effectiveness of Care Measure

# Comprehensive Diabetes Care

Health Net®

*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:<br>• Hemoglobin A1c (HbA1c) testing and control<br>• Retinal eye exam<br>• Medical attention for nephropathy*<br>• Blood pressure (BP) control (< 140/90 mm Hg)<br>*Medical attention for nephropathy is only reported for the Medicare product line. |
| **Exclusions** | Patients are excluded if they:<br>• Received palliative care in the measurement year.<br>• Are in hospice care.<br>• Are Medicare patients ages 66 and older, enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.<br>• Are age 66 or older with frailty and advanced illness.<br>• 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.<br>• Phone visits, e-visits and virtual check-ins were added:<br>– To the advanced illness exclusion list.<br>– As appropriate settings for blood pressure readings.<br>• 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:<br>• HbA1c control < 8.0%<br>• HbA1c poor control > 9.0%[1]<br>[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, |

*(continued)*

**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.

## Medical attention for nephropathy

A nephropathy screening or monitoring test or evidence of nephropathy. This includes diabetics who had any of the following:

- A nephropathy screening or monitoring test.
- Evidence of treatment for nephropathy or angiotensin converting enzyme (ACE) or angiotensin receptor blocker (ARB) therapy.
- Evidence of stage 4 chronic kidney disease (CKD), end-stage renal disease (ESRD), kidney transplant, or nephrology visit.
- At least one ACE inhibitor or ARB dispensing event.

**Codes to identify urine protein tests, nephropathy treatment, CKD Stage 4, ESRD, dialysis, nephrectomy, and kidney transplant.**

| Description | Codes |
|---|---|
| Urine protein tests | **CPT:** 81000–81003, 81005, 82042–82044, 84156 |
| Positive microalbuminuria test result documented and reviewed | **CPT II:** 3060F |
| Negative microalbuminuria test result documented and reviewed | **CPT II:** 3061F |
| Positive macroalbuminuria test result documented and reviewed | **CPT II:** 3062F |

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**Medical attention for nephropathy *(continued)***

| Codes to identify urine protein tests, nephropathy treatment, CKD Stage 4, ESRD, dialysis, nephrectomy, and kidney transplant. (continued) | |
|---|---|
| **Description** | **Codes** |
| Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) | **CPT II:** 3066F |
| ACE or ARB therapy prescribed or currently being taken (CAD, CKD, HF) | **CPT II:** 4010F |
| CKD Stage 4 | **ICD-10:** N18.4 |
| ESRD | **ICD-10:** N18.5, N18,6, Z99.2 |
| Dialysis | **CPT:** 90935, 90937, 90945, 90947, 90997, 90999, 99512 **HCPCS codes:** G0257, S9339 |
| Nephrectomy | **CPT:** 50340, 50370 |
| Kidney Transplant | **CPT:** 50340, 50370 |

| ACE Inhibitor and ARB Medications | |
|---|---|
| **Description** | **Prescriptions** |
| 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 |
| Anti-hypertensive combinations | Amlodipine-benazepril, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-olmesartan, Amlodipine-perindopril, Amlodipine-telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Benazepril-hydrochlorothiazide, Candesartan-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-irbesartan, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-losartan, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-quinapril, Hydrochlorothiazide-telmisartan, Hydrochlorothiazide-valsartan, Nebivolol-valsartan, Sacubitril-valsartan, Trandolapril-verapamil |

## Medical attention for nephropathy *(continued)*

**Tips to improve HEDIS performance**

- Document date urine protein screening was completed with result, or
- Provide confirmatory documentation such as proteinuria (unspecific), albuminuria (specific), BUN/creatinine ratio (urine), or
- Documentation of a visit to a nephrologist, kidney transplant or nephrectomy, or
- Documentation of medical attention for diabetic nephropathy, ESRD, chronic renal failure (CRF), CKD, acute renal failure (ARF), renal insufficiency, renal dysfunction, dialysis, hemodialysis or peritoneal dialysis, or
- Clear evidence that patient received ACE/ARB therapy during the measurement year:
  - Documentation that a prescription for an ACE/ARB therapy was written, or
  - Documentation that a prescription for an ACE/ARB was filled, or
  - Documentation that patient took an ACE/ARB

## 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, |

## 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<br>**HCPCS**: G0402, G0438, G0439, G0463, T1015 |
| Phone Visits | **CPT:** 98966-98968, 99441–99443 |
| Online Assessments | **CPT:** 98969–98972, 99421-99423, 99444, 99458<br>**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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