**Comprehensive Diabetes Care (CDC)**

**Q: Which members are included in the sample?**

**A:** Members 18-75 years of age with diabetes (Type I & 2) who had *each* of the following:

- Hemoglobin A1c (HbA1c) testing in 2015
- HbA1c Control (< 8.0%)
- HbA1c Poor Control (> 9.0%)
- Retinal eye exam in 2014 or 2015
- Medical attention for nephropathy in 2015
- Blood pressure (BP) control (<140/90 mmHg) in 2015

**Q: What codes are used?**

**A:** Please reference attached sample codes; reference Value Set Directory for additional codes

**Q: What documentation is needed in the medical record?**

**A:**

- **Hemoglobin A1c (HbA1c) Testing and Control in 2015**
  - Date of the most recent HbA1c test and the result

- **Retinal Eye Exam**
  - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015.
  - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in 2014.
  - A note or letter from an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was performed 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.

- **Medical attention for nephropathy in 2015**
  - Urine microalbumin test with the date performed, and result/finding
  - Evidence of nephropathy (e.g., renal transplant, ESRD, visit to nephrologist)
  - Any urine protein testing or monitoring in 2015 (positive or negative result).
  - Evidence of ACE inhibitor/ARB therapy.

- **Blood pressure (BP) control (<140/90 mmHg)**
  - The most recent BP reading during an outpatient visit or a nonacute inpatient encounter in 2015 (use the lowest systolic and lowest diastolic BP on the same date of service).
## Comprehensive Diabetes Care (CDC)

### Q: What type of document is acceptable?

**A:**
- ✔ Progress notes
- ✔ Health Maintenance Log
- ✔ Lab reports
- ✔ Eye exam report from eye care professional (optometrist or ophthalmologist)
- ✔ Nephrology consult report
- ✔ Medication list
- ✔ Blood Pressure Log from the medical record

### Q: How to improve score for this HEDIS measure?

**A:**
- ✔ Use of complete and accurate Value Set Codes.
- ✔ Timely submission of claims and encounter data
- ✔ Review diabetes services needed at each office visit
- ✔ HbA1c control – schedule regular follow-up with patients to monitor changes and adjust therapies as needed.
- ✔ BP control – measure and document BP at each office visit and if elevated (>140/90), measure BP again at end of the visit.
- ✔ Ensure proper documentation in medical record. For example:
  - Coding is for *diabetic* retinal eye exam vs. general retinal eye exam
  - Date, time, and result of each BP taken
  - Gestational diabetes and steroid-induced diabetes – *documentation will assist in excluding members from the HEDIS sample*
**Comprehensive Diabetes Care (CDC)**

**SAMPLE CODES**

<table>
<thead>
<tr>
<th>ICD-10 codes</th>
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<th>CPT codes</th>
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<th>HCPCS ophthalmic examination codes and diabetic indicator</th>
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<th>Exclusion ICD-10 codes</th>
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