SAN FRANCISCO HEALTH PLAN
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2014 HEDIS Criteria

Comprehensive Diabetes Care

Q: Which members are included in the sample? How is someone considered compliant?

A: Members 18-75 years of age with diabetes (type 1 & 2) are included in the sample. Each member in the sample is reviewed for compliance for each of the following criteria:

- Hemoglobin A1c testing with result in measurement year
- Hemoglobin A1c poor control (> 9.0%)
- Hemoglobin A1c good control (< 8.0%)
- Retinal eye exam in measurement year (or normal result in prior year)
- Medical attention for nephropathy in measurement year (either microalbumin test or ACEI/ARB use)
- Blood pressure control (last reading <140/90 mm Hg)

Q: What documentation is needed in the medical record?

A: The following documentation is needed in the medical record:

- (HbA1c) – Must include a note indicating the date on which the HbA1c test was performed and the result
- (Urine Microalbumin) – Must include a note indicating the date and result for a urine microalbumin test, OR documentation of macroalbuminuria (2+ or more protein) OR active use of ACEI/ARB
- (BP) – Documentation of the most recent blood pressure reading
- (Retinal Eye Exam) – Must show NORMAL results for retinal exam from prior year or ANY result from measurement year. Must include any one of the following:
    - Note or letter summarizing the date and results of the retinal exam. Visualization of the retina is required; dilation is not.
    - Dated retinal chart or photograph or fluorescein angiography report
    - Note or letter by healthcare provider (PCP, eye professional) that a retinal exam was performed, with the results, and the date of exam, is sufficient. For example: 'retinal exam normal 3/1/14' is adequate while 'negative retinal exam 2014' is not.
    - Documentation of certain therapeutic retinal surgical procedures done by eye specialist
- Exclusions: progress notes documenting that patient is not diabetic, or has a diagnosis of polycystic ovary disease, gestational diabetes and steroid-induced diabetes without notes indicating current diabetes

Q: How to determine if a member's BP is adequately controlled?

A: Identify the lowest systolic and lowest diastolic blood pressure from the most recent BP notation in the medical record. BP should be < 140/90 mm Hg.

Q: How to improve score for this HEDIS measure?

A: Some ideas for improving HEDIS scores for this measure are:

- IN-REACH Panel Management: train medical assistants or other support staff to prep the chart in advance of the visit, identifying overdue tests or eye exams. Identify patients with overdue tests when they come in for non-diabetes visits or urgent care.
- STANDING ORDERS: train support staff to order tests or eye exams whenever they are due. (Standing orders for medical assistants are allowed by the State for diagnostics, as long as there is no triage or treatment component.)
- OUT-REACH Panel Management: calls or letters to patients who are overdue for exams.
- REGISTRY USE: track patients with diabetes and generate reports on standardized measures.
- SFHP ASSISTANCE: SFHP can provide robo calls or personalized outreach letters.
- Ensure proper documentation in medical record, e.g. documentation of where an eye exam was performed.
- Documentation in the medical record of polycystic ovary disease, gestational diabetes and steroid-induced diabetes – will assist in excluding member from the HEDIS sample.
- Use of correct diagnosis and procedure codes.

*Note: **HEDIS 2014 Criteria** derived from the NCQA HEDIS 2014 Technical Specifications, Volume 2*
Adapted with permission from LA Care's HEDIS 2014 Guidelines https://www.lacare.org/providers/resources/hedis

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Q: What codes are used?

A: Codes used for this measure are:

Comprehensive Diabetes Care

Hemoglobin A1c	
CPT Procedure Code	83036, 83037, 3044F-3046F
LOINC	4548-4, 4549-2, 17856-6
Eye Exams	
CPT Procedure Code	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, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, 3072F, 2022F, 2024F, 2026F
HCPCS	S0620, S0621, S0625, S3000
ICD-9 Procedure Code	14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16
Nephropathy Screening Test	
CPT Procedure Code	82042-82044, 84156, 3060F, 3061F
LOINC	11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1, 9318-7
Urine Macroalbumin Test	
CPT Procedure Code	81000-81003, 81005
LOINC	50561-0, 5804-0, 57735-3, 53525-2, 20454-5
Evidence of Treatment for Nephropathy	
CPT Procedure Code	36145, 36147, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512, 3062F
HCPCS	G0257, G0392, G0393, S9339, S2065
ICD-9 Diagnosis Code	250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1
ICD-9 Procedure Code	38.95, 39.27, 39.42, 39.43, 39.53, 39.93- 39.95, 54.98, 55.4-55.6
UBREV	367, 800-804, 809, 820-829, 830-835, 839-845, 849-855, 859, 880-882, 889
UBTOB	720-725, 727, 728, 072A, 072B, 072C, 072D, 072E, 072F, 072G, 072H, 072I, 072J, 072K, 072M, 072O, 072X, 072Y, 072Z

Codes to identify exclusions:
ICD-9 CM Diagnosis: 249, 251.8, 256.4, 962.0, 648.8

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