



**Diabetes Care Link  
Physician Assessment  
Policies and Procedures  
Manual for Data Aggregator  
Submissions**

Bridges to Excellence  
13 Sugar Street  
Newtown, CT 06470

[Hbteinformation@bridgestoexcellence.org](mailto:Hbteinformation@bridgestoexcellence.org)  
[H Hhttp://www.bridgestoexcellence.orgH](http://www.bridgestoexcellence.org)

Rev: 8/26/08

## Table of Contents

<b>INTRODUCTION</b> .....	2
<b>Overview</b> .....	3
<b>Physician Benefits of Recognition</b> .....	4
<b>Background on the Measurement Criteria</b> .....	4
<b>Recognition Program Structure</b> .....	5
<b>What Recognition Requires</b> .....	5
<b>POLICIES AND PROCEDURES</b> .....	11
<b>Eligibility for Physician Participation</b> .....	11
<b>Applying for Recognition</b> .....	12
<b>Evaluation Process</b> .....	14
<b>Reporting Results</b> .....	18
<b>Duration of Recognition</b> .....	19
<b>Terms of Recognition</b> .....	20
<b>REQUIREMENTS FOR DIABETES CARE LINK RECOGNITION PROGRAM</b> .....	22
<b>Diabetes Care Link Measurement Set</b> .....	22
1. Hemoglobin A1c Control (HbA1c) : .....	22
2. Hemoglobin A1c Superior Control (HbA1c):.....	25
3. Blood Pressure Control:.....	28
4. Blood Pressure Superior Control: .....	31
5. Lipid Control:.....	34
6. Lipid Superior Control:.....	37
7. Ophthalmologic Examination: .....	40
8. Nephropathy Assessment:.....	44
9. Podiatry Examination: .....	49
10. Smoking Status and Cessation Advice and Treatment: .....	52
<b>Patient Eligibility Criteria</b> .....	55
<b>Minimum Patient Requirements</b> .....	58
<b>Retrospective Sampling Methodology</b> .....	59
<b>Appendix A: Audit Methodology</b> .....	60
<b>Level 1 Audit – Data Aggregator Data Extraction</b> .....	60
<b>Level 2 Audit – Data Validation</b> .....	60
<b>Level 3 Audit – Physician Chart</b> .....	65
<b>Appendix B: Sample Results Report</b> .....	67

## **INTRODUCTION**

Bridges to Excellence (BTE) is excited to offer this opportunity for physicians to pilot its automated performance assessment system. The BTE performance assessment organization (PAO) system allows for rapid and independent medical record-based physician performance evaluations by connecting local and national medical record data sources to a network of performance assessment organizations. BTE's goals are to: reduce the reporting burden for physicians; leverage existing reporting/data aggregation initiatives; reduce data collection and reporting costs; facilitate the connection between quality improvement and incentives; and speed up cycle times between reporting, improvement and reporting. Physicians who meet BTE performance thresholds may be eligible for BTE rewards through participating health plans, employers and coalitions.

This Policies and Procedures Manual provides information on the BTE Diabetes Care Link Physician Assessment process as well as instructions for data aggregators on how to submit physician data to a PAO through electronic data submissions in order to qualify these physicians for BTE recognition and rewards in the Diabetes Care Link Program. All data must be submitted electronically to a PAO through the methods described here, whether the data is manually entered through chart reviews or submitted through an electronic system, such as an electronic health record, patient registry or decision support tool. Paper submissions will not be accepted.

Measurement results will be determined by collecting denominator (population) and numerator (measurement results) information, for the most recent date of care within the last 12 months in order to calculate a result for each physician or physician group applicant.

BTE is partnering with two PAOs to implement its automated performance assessment system: Masspro and Minnesota Community Measurement (MNCM).

**Masspro** is one of the leading performance improvement organizations in the United States, dedicated to advancing healthcare quality. Founded by the Massachusetts Medical Society, which publishes the New England Journal of Medicine, Masspro transforms healthcare through developing and disseminating innovative solutions across all sectors of the healthcare delivery system. For over 20 years, Masspro has been an independent, objective voice for improving patient care in Massachusetts, and continues to serve as a facilitator, leader, and key participant in performance improvement, quality measurement and utilization review.

**MN Community Measurement (MNCM)** was formed in 2002 by several local health plans as a collaborative to collect performance data. By aggregating health plan claims data and collecting clinical information from physician offices, MNCM publicly reports physicians' performance results in Minnesota. MNCM's goals include improving care and supporting the quality initiatives of providers, reducing reporting-related expenses for medical groups, health plans, and regulators through more efficient and effective regulation, and communicating findings in a fair, usable and reliable way to medical groups, regulators, purchasers and consumers.

## **Overview**

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

The Diabetes Care Link Program (DCL) is a BTE Physician Recognition Program intended to identify physicians who provide high-value diabetes care. The program is designed with an understanding that patients may seek the care of various types of practitioners—primary care (PCPs) and endocrinologists (Endos)—for treatment and management of their diabetes. Accordingly, the measures reflect that physicians should do the following.

- Provide high-quality care from the outset of patient contact
- Understand and consider previous treatment history to help avoid inappropriate treatment

The program comprises a set of measures and standards, based on available clinical evidence, that promote a model of care that includes the following criteria.

- Comprehensive patient assessment and reassessment
- Patient education
- Shared decision making

BTE's DCL requirements assess process measures and outcomes representing standards of care for patients with diabetes. BTE believes that the DCL program has the potential to significantly improve the quality of care experienced by many patients with diabetes and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn DCL recognition, physicians and physician practices voluntarily submit medical record data documenting their delivery of care to patients with diabetes. BTE has partnered with two objective third party independent Performance Assessment Organizations (PAOs) to evaluate physician data based on standard measures to publicly recognize those that meet the BTE DCL performance thresholds. Those physicians not meeting the BTE DCL performance thresholds remain anonymous to BTE and its health plan licensees. BTE has three performance thresholds.

## **Physician Benefits of Recognition**

- Physicians can demonstrate to the public and to their professional peers that they meet the standards of care assessed by the program by issuing a press release, as well as having their recognition achievements posted on BTE’s consumer portal, HealthGrades ([www.healthgrades.com](http://www.healthgrades.com)), and communicated to both health plans and employers.
- Physicians may use the BTE Recognition to demonstrate that they meet the standards of care assessed by the program when contracting with health organizations and purchasers of health services.
- Physicians can identify areas of their practice that vary from the performance criteria and take steps to improve quality of care.
- Where applicable, physicians can establish eligibility for pay-for-performance bonuses or differential reimbursement from payers and health plans.
- Physicians who achieve Level II or higher DCL recognition by submitting data through a CCHIT-certified<sup>1</sup> electronic health record will receive a waiver for the BTE Level II Physician Office Link (POL) criteria required for designation as a BTE Medical Home.

## **Background on the Measurement Criteria**

Eligible physicians and physician groups voluntarily apply for BTE Recognition by submitting information on how they treat and manage their patients with regard to the following.

### ***Clinical measures<sup>2</sup>***

1. Blood Pressure (BP) control
2. LDL control
3. HbA1c control
4. Documentation of Ophthalmologic exam
5. Documentation of Smoking status and cessation advice and treatment
6. Documentation of Nephropathy assessment
7. Documentation of Podiatry exam

Physicians who demonstrate high-quality performance based on these standards are awarded BTE DCL Recognition.

---

<sup>1</sup> The Certification Commission for Healthcare Information Technology or CCHIT is a recognized certification body for electronic health records and their networks, and an independent, voluntary, private-sector initiative, whose mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. A list of CCHIT-certified products can be found at <http://cchit.org/>.

<sup>2</sup> *Clinical measures* evaluate performance based on care provided to a sample of individual patients and documented in the medical records of those patients. Clinical measures are scored based on a specified percentage of the sample meeting the requirement (numerator) for the measure (pass/fail).

## **Recognition Program Structure**

Given the evidence in the literature advocating the creation of physician quality reward programs that promote continuous quality improvement amongst its participants, the BTE Diabetes Care Link program is designed to include 3 levels or tiers of recognition. Assessment for recognition in all 3 tiers is based upon data submitted on the same diabetes measures and standards (listed above).

- Level I:* Focuses on a physician-centric<sup>3</sup> view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of “must pass” elements for intermediate outcome control measures (i.e., BP control, LDL control and HbA1c control). Thresholds have been set to focus on above average performance.
- Level II:* Focuses on a combination of physician and patient-centric<sup>4</sup> measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of “must pass” elements for all intermediate outcome control measures, both poor and superior. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.
- Level III:* Focuses on patient-centric view of measurement, looking at the defect rate of care delivery across superior control measures on a per patient basis. Physicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

## **What Recognition Requires**

To seek BTE DCL Recognition, physician applicants must submit medical record data that demonstrates they meet BTE’s DCL performance criteria. Each measure or standard has an assigned point value; the total of all the measures and standards is the same across all levels of recognition (100 points). A physician achieves points for a measure if his or her performance

---

<sup>3</sup> Physician centric refers to performance assessment involving evaluation of physician performance based upon discrete measures (i.e. BP <130/80), which is applied across the eligible patient panel. The results provide a picture of a physician’s performance on a given measures across his or her eligible patient panel. Since the process leads to physician-focused results it is said to be “physician-centric.”

<sup>4</sup> Patient centric refers to performance assessment involving evaluation of physician performance based upon composite measures, created by combining 2 or more separate discrete measures into a single measure (i.e. combining BP <130/80 and LDL <100mg/dl into 1 single measure), which is applied on a per patient basis. The results provide a picture of an individual patient’s performance on a set of measures which make-up the composite measure. Since the process leads to patient-focused results it is said to be “patient-centric.”

meets or exceeds the set thresholds for the measure. A physician earns points for a standard by demonstrating how structure or process meets the standards.

Performance Assessment Organizations (PAOs) award recognition to physicians who achieve at least:

- Level I:* 75 of the 100 possible points
- Level II:* 75 of the 100 possible points
- Level III:* 75 of the 100 possible points

### **Must-Pass Requirements**

To be eligible for recognition, physicians must submit data sufficient to score at least 75 out of a total of 100 points. In the case of clinical measures, this means a minimum of 25 patients for the denominator of each measure for individual physician applicants, and a minimum of 10 patients for the denominator of each measure for each individual physician in a physician group applicant, with a minimum group average of 25 patients per physician.

To achieve recognition in the different tiers, applicants **must pass** certain requirements. Applicants must qualify for each level of recognition before they can be assessed for a subsequent level (e.g., must pass Level I to be assessed for Level II).

#### **LEVEL I:**

1. HbA1c Control
2. Blood Pressure Control
3. LDL Control

#### **LEVEL II:**

1. HbA1c Control
2. HbA1c Superior Control
3. Blood Pressure Control
4. Blood Pressure Superior Control
5. LDL Control
6. LDL Superior Control
7. Poor control composite measure

#### **LEVEL III:**

1. HbA1c Control
2. HbA1c Superior Control
3. Blood Pressure Control

4. Blood Pressure Superior Control
5. LDL Control
6. LDL Superior Control
7. Poor control composite measure
8. Superior control composite measure

Tables 1, 2 and 3 show the program standards and the associated point values for scoring physicians' performance.

**Table 1: DCL Level I Measures, Performance Criteria and Scoring**

Level I focuses on a physician-centric view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of “must pass” elements for intermediate outcome control measures (i.e., BP control, LDL control and HbA1c control). Thresholds have been set to focus on above average performance.

Clinical Measures	Threshold	Criteria	Points	Required
<i>Poor control measures</i>				
HbA1c Control	> 9.0	≤20% of pts in sample	15	YES
Blood Pressure Control	≥ 140/90	≤ 35% of pts in sample	15	YES
LDL Control	≥ 130 mg/dl	≤ 37% of pts in sample	10	YES
<i>Superior control measures</i>				
HbA1c Superior Control	< 7.0	≥ 40 % of pts in sample	10	NO
Blood Pressure Superior Control	< 130/80	≥ 35% of pts in sample	10	NO
LDL Superior Control	< 100 mg/dl	≥ 36% of pts in sample	10	NO
<i>Process measures</i>				
Ophthalmologic Exam	N/A	≥ 50% of pts in sample	10	NO
Nephropathy Exam	N/A	≥ 70% of pts in sample	5	NO
Podiatry Exam	N/A	≥ 70% of pts in sample	5	NO
Smoking Status and Cessation Advice and Treatment	N/A	≥ 80% of pts in sample	10	NO
<b>Total Points</b>			<b>100</b>	
<b>Points Needed to Achieve Recognition</b>			<b>75</b>	

**Table 2: DCL Level II Measures, Performance Criteria and Scoring**

Level II focuses on a combination of physician and patient-centric measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of “must pass” elements for all intermediate outcome control measures, both poor and superior. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Clinical Measures	Threshold	Criteria	Points	Required
<i>Poor control measures</i>				
HbA1c Control	> 9.0	≤20% of pts in sample	0	YES
Blood Pressure Control	≥ 140/90	≤ 35% of pts in sample	0	YES
LDL Control	≥ 130 mg/dl	≤ 37% of pts in sample	0	YES
<i>Poor control composite measure</i>				
HbA1c Control	> 9.0	≤20% of pts in sample meet threshold for any 1 of the 3 poor control measures	40	YES
Blood Pressure Control	≥ 140/90			
LDL Control	≥ 130 mg/dl			
<i>Superior control measures</i>				
HbA1c Superior Control	< 7.0	≥ 40 % of pts in sample	10	YES
Blood Pressure Superior Control	< 130/80	≥ 35% of pts in sample	10	YES
LDL Superior Control	< 100 mg/dl	≥ 36% of pts in sample	10	YES
<i>Process measures</i>				
Ophthalmologic Exam	N/A	≥ 50% of pts in sample	10	NO
Nephropathy Exam	N/A	≥ 70% of pts in sample	5	NO
Podiatry Exam	N/A	≥ 70% of pts in sample	5	NO
Smoking Status and Cessation Advice and Treatment	N/A	≥ 80% of pts in sample	10	NO
<b>Total Points</b>			<b>100</b>	
<b>Points Needed to Achieve Recognition</b>			<b>75</b>	

**Table 3: DCL Level III Measures, Performance Criteria and Scoring**

Level III focuses on patient-centric view of measurement, looking at the defect rate of care delivery across superior control measures on a per patient basis. Physicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

Clinical Measures	Threshold	Criteria	Points	Required
<i>Poor control measures</i>				
HbA1c Control	> 9.0	≤20% of pts in sample	0	YES
Blood Pressure Control	≥ 140/90	≤ 35% of pts in sample	0	YES
LDL Control	≥ 130 mg/dl	≤ 37% of pts in sample	0	YES
<i>Poor control composite measure</i>				
HbA1c Control	> 9.0	≤20% of pts in sample meet thresholds for any 1 of the 3 poor control measures	40	YES
Blood Pressure Control	≥ 140/90			
LDL Control	≥ 130 mg/dl			
<i>Superior control measures</i>				
HbA1c Superior Control	< 7.0	≥ 40 % of pts in sample	0	YES
Blood Pressure Superior Control	< 130/80	≥ 35% of pts in sample	0	YES
LDL Superior Control	< 100 mg/dl	≥ 36% of pts in sample	0	YES
<i>Superior control composite measure</i>				
HbA1c Superior Control	< 7.0	≥ 30% of pts in sample meet thresholds for all 3 superior control measures on a per patient basis	30	YES
Blood Pressure Superior Control	< 130/80			
LDL Superior Control	< 100 mg/dl			
<i>Process measures</i>				
Ophthalmologic Exam	N/A	≥ 50% of pts in sample	10	NO
Nephropathy Exam	N/A	≥ 70% of pts in sample	5	NO
Podiatry Exam	N/A	≥ 70% of pts in sample	5	NO
Smoking Status and Cessation Advice and Treatment	N/A	≥ 80% of pts in sample	10	NO
<b>Total Points</b>			<b>100</b>	
<b>Points Needed to Achieve Recognition</b>			<b>75</b>	

For a physician data submission sample and scoring report, see Appendix B.

## **POLICIES AND PROCEDURES**

### **Eligibility for Physician Participation**

Physicians may apply for BTE DCL Recognition as individuals or part of a physician group. To be eligible, applicants must meet the following criteria.

- Applicants must be licensed as a medical doctor (MD) or doctor of osteopathy (DO).
- Applicants must provide continuing care for people with diabetes and be able to meet the minimum patient sample sizes.
- Applicants must complete all application materials and agree to the terms of the program by executing a data use agreement and authorization with a data aggregator partner.
- Applicants must submit the required data documenting their delivery of care for all eligible patients in their full patient panel, when available, otherwise for a specified sample of eligible patients with diabetes.
- Applicants must use PAO-supplied or approved methods for submitting data electronically.

#### ***Individual physician applicant***

An individual physician applicant represents one licensed physician practicing in any setting who provides continuing care for patients with diabetes<sup>5</sup>.

#### ***Physician group applicant***

A physician group applicant represents any group with three or more licensed physicians who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location or street address. For purposes of this assessment process groups of two physicians or less must apply as individual applicants.

---

<sup>5</sup> **Eligible Diabetic patients** are 18-75 years of age, with a documented diagnosis of diabetes (as defined by criteria listed on p.55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the reporting period and one that predates the last day of the reporting period by at least 12 months. Steroid-Induced diabetes and gestational diabetes are excluded.

## **Applying for Recognition**

Physician applicants opt to voluntarily submit their data to a PAO for performance assessment through the Diabetes Care Link program. Participating physicians must execute a data use agreement with the data aggregator partner through which they plan to submit data for BTE’s automated performance assessment process. All data aggregator partners have data use agreements executed with their partnering PAO. All necessary steps will be taken by the data aggregator and PAO to protect the confidentiality of patient data, as required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist with physician compliance with HIPAA, the data aggregator partner provides a Business Associate addendum referenced in the data use agreement, which states that both the data aggregator and the physician applicant will comply with HIPAA requirements.

Physicians considering applying for recognition should:

1. Determine eligibility. See “Eligibility for Physician Participation” on page 11 for more information.
2. Familiarize themselves with the BTE DCL measures and specifications. See “What Recognition Requires” on page 5 and “Requirements for Diabetes Care Link Recognition Program” on page 22 for more information.
3. Determine whether to apply as an individual physician or physician group.

The following outlines the submission process for applicants with electronic data collection systems:

Physicians submitting through a data aggregator partner are required to submit medical record data for all eligible patients across their full patient population. Data aggregators will submit the most recent patient level data for each participating physician’s full panel of eligible patients on a quarterly calendar schedule. Physicians are required to continue submitting data for all eligible patients each quarter unless they cease using the data aggregator’s electronic system.

Physicians with paper chart-based practices that are new to a electronic data aggregator partner’s system, where the system is not yet fully integrated in the physicians’ office, have the option of applying for BTE DCL recognition in two steps.

Step 1: Physicians may choose to submit medical record data for a one-time retrospective sample of 25 patients. All required data elements for the 25 patients must be pulled from the patient charts and entered into the data aggregator’s electronic system for submission to the PAO. Physicians who meet the thresholds for the BTE criteria for this patient sample will be awarded a one-year preliminary BTE DCL recognition. The one-year preliminary BTE DCL recognition is available for DCL Levels I and II recognition.

Step 2: Physicians who apply for this one-time retrospective assessment are then required to prospectively enter all eligible patients from their full patient panel into the data aggregator's electronic system. Physicians can opt to forego this one-time retrospective patient sample submission and wait for data to be entered into the system to apply through the prospective patient collection. For individual applicants, physician assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for 50 patients or one year, whichever occurs first. For group applicants, assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for 20 patients per individual physician and a group average of 50 patients per physician or one year, whichever occurs first. It is assumed that after one full year of usage of the data aggregator's electronic system that all eligible patients will be included.

Once a physician or physician group has opted to send their data to a PAO, the necessary data elements, including de-identified patient information for each DCL standard as well as physician identifiers, will be transmitted from the data aggregator partner to the pre-identified PAO. Clinical information and physician identifiers will be maintained in separate files to ensure that the identities of the physicians remain unknown during scoring. Clinical data should be linked to the treating physician through a unique coded physician identifier assigned by the data aggregator. For group applications, the clinical patient data should be linked to the individual physician group members so that the PAOs can verify that all members of the group meet the eligibility requirements. Clinical information must be transmitted at the individual patient level so that numerators and denominators presented in any summary data submission can be validated. Physician identifiers to be submitted include:

- Responsible provider identifier (unique coded physician identifier assigned by the data aggregator)
- Physician name (first, middle, last)
- Physician address
- Physician degree
- Physician specialty
- Physician gender
- Physician date of birth
- Medical license number
- DEA number
- Physician NPI or UPIN
- Whether data submission occurred through a CCHIT-certified system

It is the responsibility of the data aggregator to ensure that the responsible provider identifier assigned to each physician remains the same over time. This is necessary for the PAO to be able to track recognition status and apply changes to recognition level appropriately.

Physician groups may apply for recognition as a group or as individual physicians. However, individual physician identifiers must be provided for each physician included in a physician group recognition application. Two additional identifiers are also included for physicians applying for recognition as part of a group:

- Group identifier (unique coded group identifier assigned by the data aggregator)
- Group name

Relevant deidentified medical record data should be submitted from the data aggregator partner to the pre-identified PAO for each eligible patient in the physician applicant's patient panel, when available, otherwise for each patient in the physician patient sample (as indicated above). As part of their agreement with the selected data aggregator, physicians will be asked to sign an attestation verifying that all eligible patients are being entered into the data aggregator's electronic system as they are seen, and verify whether all eligible patients are included in the system at the time of submission. The physician identifier file contains an additional field for data aggregators to indicate whether data submitted represents all eligible patients treated by the physician (full patient panel). For instructions on completing medical record abstraction, see the "Required Standards for Diabetes Care Link Recognition" section in this document.

PAOs will provide data aggregators with standard file formats for both the clinical data and physician identifier data files.

## **Evaluation Process**

The PAO reviews and assesses the completeness of physician data submitted each quarter and notifies the data aggregator partner if additional information is required. The PAO runs and provides the data aggregator with a file load summary either accepting or rejecting the data aggregator file if invalid or incomplete information is submitted. The load summary will identify which records contain invalid or incomplete data. It is the data aggregator's responsibility to correct or remove the problematic data and resubmit the file(s) to the PAO. The PAO is not required to make any changes to the files submitted by the data aggregators. Completed applications are processed for compliance with performance criteria, and applicant-specific reports with results for all DCL measures are produced within 30 days.

All applicants must meet the DCL program eligibility requirements to be scored. For physician group applicants, all individual physicians included in the group application must meet the DCL program eligibility requirements to be scored. If a physician included in a group application does not meet the requirements, his or her designated patients' data should be excluded from the scoring. If the remaining members of the group still meet the eligibility requirements without the backed out physician and his or her patients, then the PAO can proceed to score the remaining members of the application as a group. Only physicians included in the scoring should be sent to BTE's Recognition Data Exchange (RDE) upon a Recognition determination. If the remaining members of the group do not meet the eligibility requirements without the backed out physician and his or her patients, then these physicians will be assessed as individual applicants, if they meet the individual applicant eligibility requirements. The PAO will inform the data aggregator in its results reports which applicants, if any, were not scored due to inability to meet the eligibility requirements.

Physician assessment will be ongoing for continuous data submissions. Assessment will be conducted quarterly based on the most current medical record data submitted for each eligible patient (see measures specifications for further details). For patients with no new data submitted in the current quarter, data aggregators will look back up to a year for patient information to be included in the current data submission for performance assessment.

## **Audit**

The PAO is responsible for conducting three levels of audit pertaining to applicant submissions for BTE DCL recognition. The first level of audit is the data aggregator data extraction code review, the second level of audit is the data validation or load summary, and the third level of audit is the physician chart audit.

**Level 1 – Audit of data aggregator data extraction:** The PAO will conduct an audit of each data aggregator’s data extraction process prior to accepting applications. The PAO will review the code that the data aggregator is using to extract the physician data and verify that all eligible patients are accurately included in the denominator. Each data aggregator needs to pass the extraction audit before numerator data is abstracted for submission to the PAO. This level of review will also be conducted annually and upon any changes to the data aggregator data extraction code. Data aggregators are responsible for informing the PAO when any changes are made. See Appendix A for a list of requirements each data aggregator needs to supply to the PAO for the data extraction audit.

**Level 2 – Data validation:** As stated above, the PAO runs and provides the data aggregator with a file load summary for each file submission, ensuring that each data field contains a valid data value that meets the data field specifications and makes sense in relation to itself and related data fields. The load summary will identify which records contain incomplete or invalid data values. There is a zero tolerance policy for errors on required data fields and data values that do not meet data field specifications. It is the data aggregator’s responsibility to correct or remove the problematic data and resubmit the file to the PAO. Files will not be rejected for invalid data values in clinical measures fields, but will be counted as a numerator miss for scoring purposes (with the exception of the poor control measures for which it will be counted as a numerator hit). Invalid data values in clinical measures fields are however identified in the load summary to the data aggregator, which is responsible for reporting this information back to the applicant in order to improve data collection. See Appendix A for the list of data validation checks used by the PAO.

**Level 3 – Physician chart audit:** Additionally, BTE reserves the right to complete an audit of any individual or group application for Recognition. PAOs or specified local organization subcontractors conduct audits of at least 5 percent of applicants from each data aggregator partner each year. DCL audits may be completed by fax, mail, electronically or on site. Any data identified by the PAO as irregular will be subject to audit. The remainder of the 5 percent will be selected through a random sampling methodology.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited

organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission. Failure to pass an audit results in no further consideration for the DCL program for six months to two years (depending on the audit score) from the date of submission of the application. For further information on physician chart audit methodology and scoring, see Appendix A.

## Scoring

The PAO makes a decision on whether to award Recognition on the basis of the applicant's overall performance against the criteria. Decisions are based on a numeric score. The DCL program evaluates performance against each applicable element within a standard, and assigns a scoring level to the element of Met (element has been met = 100%) or Not Met (element has not been met = 0%). The PAO multiplies the scoring level for the element's points to determine the element score. There is no partial credit available.

*Example 1:* For Level I, for HbA1c Superior Control, there is a total of 10 points for HbA1c Control <7.0%. If 40 percent or more of the patient sample has this level of HbA1c control, then the physician has met the criteria for the element and receives 100 percent of the 10 points. If the applicant's performance on this measure is less than 40 percent of the patient sample with this level of HbA1c control, then the applicant receives 0 points.

*Example 2:* For Level II, for the poor control composite measure, there is a total of 40 points for HbA1c Control >9.0%, BP Control  $\geq$ 140/90, and LDL Control  $\geq$ 130. If 20 percent or less of the patient sample meets at least one of these thresholds, then the physician has met the criteria for the poor control composite measure and receives 100 percent of the 40 points. If the applicant's performance on this measure is greater than 20 percent of the patient sample, then the applicant receives 0 points.

*Example 3:* For Level III, for the superior control composite measure, there is a total of 30 points for HbA1c Control <7.0%, BP Control <130/80, and LDL Control <100. If 30 percent or more of the patient sample meets all three of these thresholds, then the physician has met the criteria for the superior control composite measure and receives 100 percent of the 30 points. If the applicant's performance on this measure is less than 30 percent of the patient sample, then the applicant receives 0 points.

Continuous performance will be assessed quarterly. Upon first assessment, physicians may be recognized at Level I or Level II. Level III recognition requires physicians to meet the necessary scoring requirements for 2 consecutive assessment periods (e.g. back-to-back calendar quarters). Physicians who meet Level III requirements after the first assessment period will be assigned Level II recognition for that quarter and informed that they have met Level III and will be awarded Level III recognition after achieving the Level III requirements the following quarter.

**Final Status Determinations**

The PAO completes, reviews and makes DCL Recognition status determinations. Applicants may, however, appeal a determination of Not Recognized, as described below under Reconsiderations.

The scoring threshold is shown in the table below. For DCL, there are two statuses for each level: Recognized and Not Recognized.

DCL Recognition	Points
Recognized	75-100
Not Recognized	0-74

“Recognized” indicates the applicant meets or exceeds the criteria acceptable for the standards and that DCL Recognition at that level has been achieved. DCL recognitions achieved on or before December 31, 2009 will be effective for three years. Beginning January 1, 2010, the DCL recognition term will be shortened to two years.

“Not Recognized” indicates that the applicant does not meet the criteria acceptable for the standards. PAOs do not release the identities of physicians or groups who do not achieve Level I DCL Recognition. Applicants who do not achieve Level I Recognition but continue to submit data on a quarterly basis will be reassessed six months after the date of data submission of their original application. The PAO will track this status and automatically trigger reassessment after two quarters.

**Reconsideration**

An applicant may request Reconsideration of a Recognition status decision of Not Recognized for any level. The Data Aggregator must receive a request for Reconsideration within 30 days after an applicant is notified of their recognition status. The request must list the standards or other information for which reconsideration is being requested. The physician or group may not submit additional documentation at this time, but may state how it believes the PAO misinterpreted the original documentation.

The first level of appeals is conducted at the data aggregator level. The data aggregator partner through which the recognition application was submitted will review the applicant’s data included in the request to ensure that the data submitted to the PAO was extracted in accordance with the BTE DCL measures and specifications. If no issues are found, the data aggregator will then verify the data with the PAO, and the PAO will review the scoring of the applicant’s data. In the case of a deadlock, the appeal will be referred to BTE’s Medical Director and Programs Manager for reconsideration. If necessary, final determination will be made by the physician members of the BTE Board.

The reconsideration decision is final and is provided in writing to the physician or physician group requesting Reconsideration.

## **Reporting Results**

As part of BTE's mission to identify and promote quality, PAOs report results to the following:

- To the data aggregator partner through which the recognition application was submitted. The data aggregator is required to share results reports with the physician applicant to facilitate quality improvement. See Appendix B for a sample results report.
- To BTE: Only Recognized statuses are reported to BTE for display on BTE's consumer portal for recognition information hosted by HealthGrades and transmission to BTE-licensed health plans for associated rewards payments. Once the final decision is made, the PAO will reveal the identity, program name and program level of the recognized physicians only. No clinical data is shared with BTE at any point in the process.

PAOs are responsible for monitoring and reporting to BTE through the BTE Recognition Data Exchange (RDE) which DCL Recognized physicians submitted data for assessment through a CCHIT-certified data aggregator product. These physicians will automatically receive a waiver for the Level II Physician Office Link (POL) requirement for the BTE Medical Home designation.

### **Certificates**

BTE issues an official certificate to each recognized physician or physician group.

## **Duration of Recognition**

For DCL recognitions achieved on or before December 31, 2010, Recognition status remains in effect for **3 years** from the date on which a PAO awards recognition. Beginning January 1, 2010, the DCL recognition duration will be shortened to **2 years** from the date on which a PAO awards recognition. For continuously assessed applicants who maintain their current level of recognition, new begin and end recognition dates will be assigned at the time of the most recent assessment. For applicants achieving recognition through the one-time retrospective sampling option, Recognition status remains in effect for 1 year from the date on which a PAO awards recognition. Recognition determinations are made on the basis of a specific patient population. Recognition status remains in effect for the duration of recognition as long as the physician maintains his or her current practice and patient base. Physicians are responsible for informing the data aggregator within 30 days who will inform the PAO if they move or change practices. Since the program is new, BTE plans to re-evaluate the program after the first year of operation. Requirements for new applicants are likely to change after the reevaluation.

## **Changes in Recognition Levels**

Continuous data submission applicants are eligible for changes in recognition level. Physicians who achieve at least Level I DCL recognition will maintain their DCL program recognition for the duration of recognition outlined above. However, during this time it is possible for the recognition status to move between program levels (I, II and III) based on changes in clinical data from quarter to quarter. Changes to program level and recognition dates occur according to the following rules:

- Physicians who achieve a higher level of recognition for two consecutive assessment periods will have their recognition status changed effective the date of the most recent assessment.
- Physicians recognized at Level II or III can drop in levels of recognition based on lower scoring results for two consecutive assessment periods.
- Each time a physician's recognition status changes levels in either direction a new begin recognition date is assigned for the date of the most recent assessment and a new end recognition date is calculated.
- Physicians who drop below Level I for two consecutive quarterly assessments will be assigned or maintain Level I DCL recognition status and maintain their current begin and end recognition dates.

PAOs are responsible for managing changes to physician's start and end recognition date and submitting updated recognition level and recognition dates to the BTE Recognition Data Exchange (RDE) on a monthly basis. PAOs are responsible for alerting data aggregators when applicants' assessment scores drop in level for one quarter. Data aggregators are responsible for alerting applicants that a second consecutive lower score will result in a change to their recognition level.

## **Terms of Recognition**

When communicating with patients, third-party payers, managed care organizations (MCO) and others, physicians or groups who receive BTE DCL Recognition may represent themselves as BTE-recognized and meeting NQF/AQA quality measure requirements; however, physicians or groups may not characterize themselves as “NQF/AQA-Approved” or “NQF/AQA-Endorsed.” The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

## **Revoking Recognition**

PAOs may revoke a Recognition decision if any of the following occurs:

- The physician or group submits false data or does not collect data according to the procedures outlined in this manual, as determined by discussion with the physician or group or audit of application data and materials.
- The physician or group misrepresents the credentials of any of its physicians.
- The physician or group misrepresents its Recognition status.
- The physician or any of the group's physicians experience a suspension or revocation of medical licensure.
- The physician or group has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the physician or group's operations.
- BTE identifies a significant threat to patient safety or care.

## **Data Use Terms**

Data use terms are outlined in the data use agreement that the applicant signs with the selected data aggregator partner.

## **BTE DCL Clinical Measures**

The following examples illustrate the format used for clinical measures.

### **Evaluation Program Title: Diabetes Care Link Program**

#### **Clinical Measures (CM)**

Clinical measures (CM) are specific numerical values with a numerator and denominator that reflect performance across a sample of eligible patients based on medical record documentation.

The following items are listed for each clinical measure.

**Description:** A statement of what is being measured specifically.

**Data source:** The data source for clinical measures is the medical record.

**Explanation:** The explanation provides additional information about the clinical measure.

**Numerator:** A description of patients in the applicant's sample of eligible patients (denominator) who qualify to be counted for the numerator of the measure.

**Denominator:** A description of the patients in the applicant's sample of eligible patients for whom the measure is relevant.

**Exclusions:** The criteria for patients who may be excluded from the denominator.

**Frequency:** Time frames associated with the numerator requirements.

**Scoring:** **100%:** Performance level (percentage of denominator) needed to earn the total possible points.

**0%:** Performance level (percentage of denominator) that results in no points.

## **REQUIREMENTS FOR DIABETES CARE LINK RECOGNITION PROGRAM**

### **Diabetes Care Link Measurement Set**

#### *Clinical Measures Specifications:*

1. Hemoglobin A1c Control (HbA1c) :

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c level in poor control (greater than 9.0%).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data only for HbA1c test information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend a treatment goal of 7% or lower for HbA1c for adult patients with a diagnosis of diabetes. A HbA1c level greater than 9% is considered poor control and calls for treatment to improve glycemic control. This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients with most recent hemoglobin A1c (HbA1c) level > 9.0% aged 18-75 years old with a diagnosis of diabetes. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Electronic Collection:*** The patient is numerator compliant if the most recent electronic HbA1c result is missing, is > 9.0% , or if the test was not done during the reporting period (i.e. last 12 calendar months from the last day of the reporting period <sup>6</sup>). The patient is NOT numerator compliant if the result for the most recent HbA1c test during the reporting period is ≤ 9.0.

***Medical Record Collection:*** The patient is numerator compliant if the most recent HbA1c level is missing, is >9.0, or was not done during the reporting period (i.e. last 12 calendar months from the last day of the reporting period). The patient is NOT numerator compliant if the result of the most recent HbA1c test during the reporting period is ≤ 9.0.

---

<sup>6</sup> The last day of the reporting period is anchored to the last day of the current quarter.

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. The following is not acceptable documentation of HbA1c results: Fructosamine, HgB, Hemoglobin, Hb and Hg (without reference to either “glycated,” “glycosylated,” and “A1” or “A1c”), or findings reported on progress notes or other non-laboratory documentation.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on p.XXX labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes, during the reporting period. Exclude patients with gestational or steroid induced diabetes during the reporting period.

**Frequency:** Most recent test result over the last 12 calendar months from the last day of the reporting period.

**Scoring:** **100%:** ≤ 20% Patients aged 18-75 years with the diagnosis of diabetes have a HbA1c value of > 9.0 %.

**0%:** > 20% Patients aged 18-75 years with the diagnosis of diabetes have a HbA1c value of > 9.0%.

## 2. Hemoglobin A1c Superior Control (HbA1c):

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c under superior control (less than 7.0%).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data only for HbA1c test information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend a treatment goal of 7% or lower for HbA1c for adult patients with a diagnosis of diabetes. This is a superior control measure. A higher rate indicates better performance (e.g., high rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients with most recent hemoglobin A1c (HbA1c) level < 7.0 aged 18-75 years old with a diagnosis of diabetes. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Electronic Collection:*** The patient is numerator compliant if the result of the most recent HbA1c test during the reporting period is <7.0%. The patient is NOT numerator compliant if the most recent HbA1c test is missing, is ≥ 7.0%, or the test was not done.

***Medical Record Collection:*** The patient is NOT numerator compliant if the result of the most recent HbA1c test during the reporting period is < 7.0. The patient is NOT numerator compliant if the most recent HbA1c level is missing, is ≥ 7.0, or was not done.

At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.

The following is not acceptable documentation of HbA1c results: fructosamine, HgB, Hemoglobin, Hb and Hg (without reference to either “glycated,” “glycosylated,” and “A1” or “A1c”), or findings reported on progress notes or other non-laboratory documentation.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician

group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

- Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.
- Frequency:** Most recent test result over the last 12 calendar months from the last day of the reporting period.
- Scoring:** **100%:**  $\geq 40\%$  Patients aged 18-75 years with the diagnosis of diabetes have a HbA1c value of  $< 7.0\%$ .
- 0%:**  $< 40\%$  Patients aged 18-75 year with the diagnosis of diabetes have a HbA1c value of  $< 7.0\%$ .

### 3. Blood Pressure Control:

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent blood pressure in poor control (greater than or equal to 140/90 mm Hg).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data only for blood pressure information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend treatment for adult patients with diabetes who have blood pressure  $\geq 140/90$ mmHg. This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patient with most recent systolic blood pressure measurement of  $\geq 140$ mm Hg OR a diastolic blood pressure of  $\geq 90$ mm Hg for all patients aged 18-75 years with the diagnosis of diabetes. The following steps should be followed below to determine the representative blood pressure reading.

1. *Identify the most recent visit to the doctor's office or clinic in which a BP reading was noted.* Patient is numerator compliant if the representative BP was obtained during a visit to the practitioner's office or non-emergency outpatient facility, such as clinic or urgent care center. The patient is NOT numerator compliant if the representative BP was obtained:
  - a. During an outpatient visit for the sole purpose of having a diagnostic test or surgical procedure performed.OR
  - b. The same day as a major diagnostic or surgical procedure or at an emergency room visit.
2. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure 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.

The following are not acceptable forms of documentation of blood pressure: patient self-report and use of terms “VS within normal limits.” “VS WNL” or “Vital signs normal.”

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last

12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from last day of the reporting period.

**Scoring:** **100%:**  $\leq 35\%$  Patients aged 18-75 years with the diagnosis of diabetes have blood pressure  $\geq 140/90$ mmHg.

**0%:**  $> 35\%$  Patients aged 18-75 years with the diagnosis of diabetes have blood pressure  $\geq 140/90$ mmHg.

4. Blood Pressure Superior Control:

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent blood pressure under superior control (less than 130/80 mm Hg).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data only for blood pressure information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend blood pressure of <130/80mmHg as a treatment goal for adults with diabetes. This is a superior control measure. A higher rate indicates better performance (e.g., higher rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patient with most recent systolic blood pressure measurement of < 130mm Hg and a diastolic blood pressure of < 90mm Hg for all patients aged 18-75 years with the diagnosis of diabetes. The following steps should be followed below to determine the representative blood pressure reading.

3. *Identify the most recent visit to the doctor's office or clinic in which a BP reading was noted.* Patient is numerator compliant if the representative BP was obtained during a visit to the practitioner's office or non-emergency outpatient facility, such as clinic or urgent care center. The patient is NOT numerator compliant if the representative BP was obtained:

a. During an outpatient visit for the sole purpose of having a diagnostic test or surgical procedure performed.

OR

b. The same day as a major diagnostic or surgical procedure or at an emergency room visit.

4. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure 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.

The following are not acceptable forms of documentation of blood pressure: patient self-report and use of terms “VS within normal limits.” “VS WNL” or “Vital signs normal.”

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters for diabetes care in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last

12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from the last day of the reporting period.

**Scoring:** **100%:**  $\geq 35\%$  Patients aged 18-75 year with the diagnosis of diabetes have blood pressure  $< 130/80\text{mmHg}$ .

**0%:**  $< 35\%$  Patients aged 18-75 years with the diagnosis of diabetes have blood pressure  $< 130/80\text{mmHg}$ .

5. Lipid Control:

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent LDL-C level under poor control (greater than or equal to 130 mg/dl).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data only for LDL-C test information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend treatment for patients with diabetes with an LDL-C level of  $\geq 130$  mg/dl. This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients with most recent LDL-C level  $\geq 130$  mg/dl for all patients aged 18-75 years with the diagnosis of diabetes.

**Electronic Collection:** The patient is numerator compliant if the result for the most recent LDL-C test is  $\geq 130$ mg/dl, is missing, or was not done. The patient is NOT numerator compliant if the most recent electronic LDL-C test result is  $< 130$ mg/dl.

**Medical Record Collection:** The patient is numerator compliant if the result of the most recent LDL-C test is  $\geq 130$ mg/dl, is missing, or was not done. The patient NOT is numerator compliant if the most recent LDL-C level is  $< 130$ mg/dl.

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are  $\leq 400$ mg/dl:

$$\text{LDL-C} = (\text{total cholesterol}) - (\text{HDL}) - (\text{Triglycerides}/5)$$

The following is not acceptable documentation of LDL-C test results:

- 1) Patient self-reporting or self-monitoring
- 2) LDL-to-HDL ratio
- 3) Findings reported on a progress notes or other non-laboratory documentation.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters for diabetes care in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two

face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from last day of the reporting period.

**Scoring:** **100%:**  $\leq 37\%$  Patients aged 18-75 years with the diagnosis of diabetes with an LDL-C level  $\geq 130\text{mg/dl}$ .

**0%:**  $> 37\%$  Patients aged 18-75 years with the diagnosis of diabetes with an LDL-C level  $\geq 130\text{mg/dl}$ .

6. Lipid Superior Control:

**Description:** Percentage of patients aged 18 through 75 years with diabetes who had most recent LDL-C level under superior control (less than 100 mg/dl).

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and laboratory or medical record data only for LDL-C test information for the numerator.

**Explanation:** American Diabetes Association (ADA) guidelines recommend an LDL-C treatment goal of < 100 mg/dl for patients with diabetes. This is a superior control measure. A higher rate indicates better performance (e.g., higher rates of superior control indicate better care). It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients with most recent LDL-C level < 100 mg/dl for all patients aged 18-75 years with the diagnosis of diabetes.

**Electronic Collection:** The patient is numerator compliant if the result for the most recent LDL-C test is < 100mg/dl. The patient is NOT numerator compliant if the most recent electronic LDL-C test result is missing, is  $\geq 100$ mg/dl, or if the test was not done.

**Medical Record Collection:** The patient is numerator compliant if the result of the most recent LDL-C test is < 100mg/dl. The patient NOT is numerator compliant if the most recent LDL-C level is missing, is  $\geq 100$ mg/dl, or was not done

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are  $\leq 400$ mg/dl:

$$\text{LDL-C} = (\text{total cholesterol}) - (\text{HDL}) - (\text{Triglycerides}/5)$$

The following is not acceptable documentation of LDL-C test results:

- 1) Patient self-reporting or self-monitoring
- 2) LDL-to-HDL ratio
- 3) Findings reported on a progress notes or other non-laboratory documentation.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters diabetes care in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two

face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from last day of the reporting period.

**Scoring:** **100%:**  $\geq 36\%$  Patients aged 18-75 years with a diagnosis of diabetes with an LDL-C level of  $< 100\text{mg/dl}$ .

**0%:**  $< 36\%$  Patients aged 18-75 years with a diagnosis of diabetes with an LDL-C level of  $< 100\text{mg/dl}$ .

7. Ophthalmologic Examination:

**Description:** Percentage of patients aged 18-75 years with a diagnosis of diabetes who had an eye screening exam for diabetic retinal disease over the reporting period.

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter or medical record data only indicate whether an eye screening exam for diabetic retinal disease was performed.

**Explanation:** American Diabetes Association (ADA) guidelines recommend that patients with diabetes have an annual dilated retinal examination to screen for diabetic retinal disease. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients aged 18-75 years with the diagnosis of diabetes with documentation of having received an eye screening exam for diabetic retinal disease performed over the last 12-24 calendar months from the last day of the reporting period (Appropriate timeframe defined below under “Medical Record”).

***Electronic Collection:***

Claims/Encounter data: A patient is numerator compliant if he or she has an eye screening exam for diabetic retinal disease as identified by administrative data. This includes those patients with diabetes who had one of the following:

1. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) over the last 12 months from the last day of the reporting period. The following codes may be used to identify eye exams

CPT Codes: 67028, 67038-67040, 67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245;

HCPCS: S0620, S0621, S0652, S3000;

ICD-9-CM Codes: 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0.

2. A negative retinal exam (no evidence of retinopathy) by an eye care professional over the last 24 months from the last day of the reporting period.

**Medical Record Collection:** A patient is numerator compliant if he or she has an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:

- a. A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) over the last 12 calendar months from the last day of the reporting period.
- b. A negative retinal exam (no evidence of retinopathy) by an eye care professional over the last 24 calendar months from the last day of the reporting period.

Documentation in the medical record of retinal eye exam over the last 12 calendar months from the last day of the reporting period or a negative retinal eye exam over the last 24 calendar months from last day of the reporting period must include:

- a. A note or letter from the care professional summarizing the date on which the procedure was performed and the results of a retinal eye evaluation.  
OR
- b. A chart or photograph of retinal abnormalities.  
OR
- c. A note, which may be prepared by a primary care provider, indicating the date on which the procedure was performed, and that an ophthalmoscopic exam was completed by an eye care professional, with the results of the exam.

The following is not acceptable documentation for eye examination:

- Referral for an eye exam or referral with no documentation that an eye exam was completed.
- An eye exam that simply states the eyes were within normal limits (WNL)
- Primary care physician notes state only that the fundi were normal without specifically stating that the eyes were dilated.
- Visits to the eye care professionals where it is clear that a dilated exam was not performed.
- Patient self-reported of an eye examination.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12

months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** If patient with positive diagnosis of retinopathy: most recent test result over the last 12 calendar months from last day of the reporting period.

If patient with negative retinal exam (i.e. no evidence of retinopathy): most recent test result over the last 24 calendar months from last day of the reporting period.

Note: If no new data on the measure is available during a particular data collection/submission cycle, the pre-existing numerator and denominator values remain valid unless the data does not meet the appropriate timeframe listed above (i.e., 12 months from last day of the reporting period; if patient has a diagnosis of retinopathy, 24 months if not.)

**Scoring:** **100%:**  $\geq 50\%$  Patients aged 18-75 years with the diagnosis of diabetes who had an eye screening exam for diabetic retinal disease over the accepted timeframe (see “Frequency” above for details).

**0%:**  $< 50\%$  Patients aged 18-75 years with the diagnosis of diabetes who had an eye screening exam for diabetic retinal disease over the accepted timeframe (see “Frequency” above for details).

8. Nephropathy Assessment:

**Description:** Percentage of patients aged 18-75 years with a diagnosis of diabetes who had a screening for nephropathy or evidence of nephropathy documented over the past 12 months from the last day of the reporting period.

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter pharmacy, laboratory or medical record data for documentation of nephropathy testing or medical treatment.

**Explanation:** American Diabetes Association (ADA) guidelines recommend routine urinalysis and microalbuminuria testing for adult patients with diabetes to detect nephropathy. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients aged 18-75 years with the diagnosis of diabetes with documentation of screening for nephropathy or evidence of nephropathy with medical attention over the past 12 months, from the last day of the reporting.

***Electronic Collection:** A patient is numerator compliant if he or she has a screening for nephropathy or evidence of nephropathy, as documented thru administrative data.*

Nephropathy Screening: must include administrative date documentation for a microalbuminuria and/or macroalbuminuria test. The following CPT codes may be used to identify these tests.

*Microalbuminuria Test: 82042, 82043, 82044, 83518, 84156, 84160\*, 84166\*, 84165\*. Codes marked by an asterisk (\*) must be accompanied by CPT code 81050 to indicate test was a urinalysis.*

*Macroalbuminuria Test: 81000-81003\*, 81005\*. Codes marked by an asterisk (\*) must be confirmed by a positive result for macroalbuminuria test identified thru the administrative data.*

Evidence of Nephropathy: may include documentation of nephropathy by using the following CPT codes for nephropathy diagnosis or treatment:

CPT Codes : 36145,36800, 36810, 36815, 36818, 36819, -36821,36831-36833, 50300, 50320 50340, 50360,50365, 50370, 50380, 90920, 90921, 90924,90925,

90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512;

ICD-9-CM Codes: 38/95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0;

V-Codes: V42.0, V45.1, V56, UB-92;

Revenue Codes: 0367, 080X, 082X-085X, 088X;

DRGs: 316, 317.

***Medical Record Collection:*** A patient is numerator compliant if he or she has documented screening for nephropathy or evidence of nephropathy.

Nephropathy Screening: must include documentation of date on which the urine micro albumin test was performed, and the test result. Notation of the following may count in the medical record for urine micro albumin test:

- 24-hour urine for micro albumin
- Timed urine for micro albumin
- Spot urine for micro albumin
- Microalbumin/Creatine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Documentation of a positive result on urine dipstick over the past 12 months, from the last day of the reporting period, reflects proteinuria which is considered evidence of nephropathy. See “Evidence of nephropathy” section below for further details.

Note: A negative result on urine dipstick is insufficient for numerator compliance under “nephropathy screening.” See “nephropathy screening” section above for further details.

Evidence of Nephropathy: may include diagnosis and medical attention for nephropathy, which would require documentation in the medical record indicating medical attention over the past 12 months, from the last day of the reporting period, for 1 or more of the following:

- Diabetic nephropathy
- Diabetic kidney disease
- Diffuse diabetic or nodular glomerular sclerosis

- Kimmesstiel-Wilson lesion
- Papillary necrosis
- Arterionephrosclerosis
- End-stage renal disease (ESRD)
- Chronic renal failure (CRF)
- Chronic Renal insufficiency
- Chronic renal disorder
- Renal Dialysis
- Acute renal failure
- Proteinuria
- Azatemia
- Microalbuminuria

Medical attention for nephropathy may include documentation of a patient dispensed or prescribed an Angiotensin-Converting Enzyme (ACE) Inhibitor or ACE Receptor Blocker (ARB) over the past 12 months, from the last day of the reporting period.

The following is not acceptable documentation:

- Patient self-reporting or self-monitoring
- Findings reported in progress notes or other non-laboratory documentation

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

**Pharmacy data:** Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from the last day of the reporting period.

Note: If no new data on the measure is available during a particular data submission cycle, the pre-existing numerator and denominator values remain valid unless such data is dated over 12 calendar months from the last day of the reporting period.

**Scoring:** **100%:**  $\geq 70\%$  Patients aged 18-75 years with the diagnosis of diabetes with a microalbuminuria test or positive urinalysis or medical attention for

nephropathy over the last 12 calendar months from the last day of the reporting period.

**0%:** < 70% Patients aged 18-75 years with the diagnosis of diabetes with a microalbuminuria test or positive urinalysis or medical attention for nephropathy over the last 12 calendar months from the last day of the reporting period.

9. Podiatry Examination:

**Description:** Percentage of patients aged 18-75 years with a diagnosis of diabetes who had a foot exam performed over the past 12 months, from the last day of the reporting period.

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and claims/encounter and medical record data for documentation of foot exam.

**Explanation:** American Diabetes Association (ADA) guidelines recommend foot examination, with shoes and socks removed, for adult patients with diabetes to avoid lower extremity amputations, foot ulcers and other foot problems. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients aged 18-75 years with diagnosis of diabetes with documentation of having received a foot exam (which includes visual inspection and documentation of sensitivity to position, vibration, and light touch and skin integrity) over the past 12 months, from the last day of the reporting period.

***Electronic Collection:*** The patient is numerator compliant if he or she has received a foot examination (visual inspection and sensory exam with monofilament as described above) in the past 12 months (from the last day of the reporting period), as documented by administrative data. CPT II Code 2028F may be used to identify a foot examination was performed.

***Medical Record Collection:*** The patient is numerator compliant if he or she has received a foot examination (visual inspection and sensory exam with monofilament as described above) in the past 12 months, from the last day of the reporting period. Indication of a test result and date must be documented. Documentation of a “diabetic foot exam” is acceptable and considered numerator compliant.

The following are not acceptable documentation of a foot exam.

1. Documentation of general extremity exam without mention of the foot, such as extremities—no edema or Doppler.
2. Range of motion or ROM exams
3. Patient self-report of foot condition

Documentation of bilateral foot amputation is acceptable and considered numerator compliant.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis

in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from last day of the reporting period.

Note: If no new data on the measure is available during a particular data submission cycle, the pre-existing numerator and denominator values remain valid unless such data is dated over 12 calendar months from the last day of the reporting period.

**Scoring:** **100%:**  $\geq 70\%$  Patients aged 18-75 years with the diagnosis of diabetes with a foot examination documented over the last 12 calendar months from the last day of the reporting period.

**0%:**  $< 70\%$  Patients aged 18-75 years with the diagnosis of diabetes with a foot examination documented over the last 12 calendar months from the last day of the reporting period.

10. Smoking Status and Cessation Advice and Treatment:

**Description:** Percentage of patients aged 18-75 years with a diagnosis of diabetes who have documentation of smoking status over the past 12 months (from the last day of the reporting period) and if a smoker, received cessation counseling or treatment over the past 12 months, from the last day of the reporting period.

**Data source:** Electronic data (visit, lab, encounter data, or claims) and or medical record data (paper based or EHR). This measure requires the use of claims/encounter pharmacy or medical record data for identification of patients with diabetes for the denominator, and medical record data only for documentation of smoking status, and if a smoker, cessation counseling or treatment.

**Explanation:** American Diabetes Association (ADA) guidelines recommend that diabetics do not smoke and that those who do smoke received cessation counseling and treatment. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

**Numerator:** Patients aged 18-75 years with the diagnosis of diabetes with documentation of smoking status over the past 12 months (from the last day of the reporting period), and if smoker, date of cessation counseling or treatment over the past 12 months, from the last day of the reporting period.

**Medical Record Collection:** The patient is numerator compliant if he or she has smoking status documented over the past 12 months (from the last day of the reporting period) AND if smoker has documented date of receipt of cessation counseling and/or treatment over the past 12 months, from the last day of the reporting period.

The patient is NOT numerator compliant if:

- 1) His or her smoking status documentation is missing
- 2) His or her status was not asked.
- 3) His or her smoking status documentation is dated > 12 months ago, from the last day of the reporting period.

If the patient is a smoker the patient is NOT numerator compliant if:

- 1) His or her documentation is missing  
OR
- 2) He or she did not receive cessation counseling and/or treatment over the past 12 months, from the last day of the reporting period.

**Denominator:** Patients aged 18-75 with a documented diagnosis of diabetes (as defined by criteria listed on page 55 labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

***Electronic Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or claims/encounter data.

Pharmacy data: Patient is denominator compliant if he or she was dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Claims/Encounter data: Patient is denominator compliant if he or she has had at least two face to face encounters, for diabetes care, in an ambulatory setting: one within 12 months of the last day of the reporting period and that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information on codes to identify patients with diabetes.

***Medical Record Collection:*** Two methods are provided to identify patients with diabetes: pharmacy data or medical record data.

Pharmacy data: Patient is denominator compliant if he or she was prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis over the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. Prescriptions to identify patients with diabetes include insulin prescriptions and oral hypoglycemics/antihyperglycemics prescriptions. See “Patient Eligibility Criteria” on page 55 for further information on list of eligible drugs to identify patients with diabetes.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of diabetes listed on the problem list in the last 12 months or at least two face to face visits with diabetes listed as the diagnosis in the last 12 months AND has been under the care of the applicant physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one

within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See “Patient Eligibility Criteria” on page 55 for further information.

**Exclusions:** Exclude patients with diagnosis of polycystic ovaries who did not also have a primary or secondary diagnosis of diabetes. Exclude patients with gestational or steroid induced diabetes.

**Frequency:** Most recent test result over the last 12 calendar months from the last date of the reporting period.

Note: If no new data on the measure is available during a particular data submission cycle, the pre-existing numerator and denominator values remain valid unless such data is dated over 12 calendar months from the last date of the reporting period.

**Scoring:** **100%:**  $\geq 80\%$  Patients aged 18-75 years with the diagnosis of diabetes who have documentation of smoking status over the past 12 months (from the last date of the reporting period) and if a smoker, received cessation counseling or treatment over the last 12 calendar months from the last date of the reporting period.

**0%:**  $< 80\%$  Patients aged 18-75 years with the diagnosis of diabetes who have documentation of smoking status over the past 12 months (from the last date of the reporting period) and if a smoker, received cessation counseling or treatment over the last 12 calendar months from the last date of the reporting period.

## Patient Eligibility Criteria

An **eligible** diabetes patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.<sup>7</sup>
2. Has had a diagnosis of diabetes (as defined in Table 1 below) and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics (as defined in Table 2 below) for at least 12 months, from the last date of the reporting period.
3. Has been under the care of the applicant’s physician or physician group for at least 12 months. This is defined by documentation of two face-to-face visits for diabetes care between the physician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

**DCL Coding Conventions:** Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x," which represents a required digit: for example, ICD-9-CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.

**Table 1: Codes and Descriptions to Identify a Patient with a Diagnosis of Diabetes**

Diagnosis Codes			
ICD-9 Code and Criteria	Definition	Synonyms	Exclusions
<b>250 or 648.0</b> <i>Diabetes mellitus</i>	The need for diet management, insulin or oral hypoglycemic agent, report of home urine or home blood glucose testing or the presence of an insulin pump anywhere in the medical record	Insulin-dependent diabetes mellitus (IDDM), non-insulin dependent diabetes (NIDDM), Type I, Type II, DM, AODM, sugar diabetes, maturity onset diabetes, diet controlled diabetes	Documentation of a family history of diabetes without personal diagnosis, steroid-induced diabetes, gestational diabetes (ICD-9 code 648.8), R/O diabetes, diabetes insipidus, questionable or “?” diabetes mellitus, or hyperglycemia, glucose intolerance, borderline diabetes
<b>357.2</b> <i>Diabetic polyneuropathy</i>	Any mention of a diagnosis of diabetic polyneuropathy in the medical record	Neuropathy or peripheral neuropathy, decreased or altered sensation, extremity numbness or tingling, paresthesia in the lower extremity, foot ulcers, distal symmetric polyneuropathy, loss of sensation (vibration/touch) in the feet, loss of ankle reflexes, Charcot’s joints, malperforans ulcer, loss of light touch and pin prick, knife-like or burning pain of feet, sensory loss or pain in	Rule out or R/O neuropathy, extremity weakness, or probable or “?” neuropathy

<sup>7</sup> As of the last date of the reporting period. Patients known to be deceased should be excluded.

		hands, or mononeuropathy	
<b>362.0 Diabetic retinopathy</b>	Any mention of a diagnosis of diabetic retinopathy in the medical record	<p>Diabetic eye changes:</p> <ul style="list-style-type: none"> <li>- Proliferative diabetic retinopathy</li> <li>- New vessels on the disc (NVD)</li> <li>- New vessels elsewhere in iris or retina</li> <li>- Preretinal or vitreous hemorrhage</li> <li>- Fibrosis rubeosis diabetic retinal changes</li> <li>- Macular lesion</li> <li>- Background retinopathy</li> <li>- Proliferative retinopathy</li> <li>- Venous beading/looping</li> <li>- Large retinal blot hemorrhages</li> <li>- Multiple cotton wool spots</li> <li>- Multi-preintoretinal microvascular abnormalities</li> <li>- Diabetic macular edema</li> <li>- Nonproliferative diabetic retinopathy</li> <li>- Microaneurysms</li> <li>- Blot hemorrhage</li> <li>- Hard exudates</li> <li>- 1-2 soft exudates</li> </ul>	Rule out or R/O diabetic retinopathy
<b>366.41 Diabetic cataract</b>	Any mention of a diagnosis of diabetic cataract in the medical record	N/A	Patients with congenital cataract, senile cataract, traumatic cataract, cataract secondary to ocular disorders or after-cataract

**Table 2: Descriptions to Identify Patients With Notation of Prescribed Insulin or Oral Hypoglycemics/Antihyperglycemics**

Criteria	Definition	Synonyms	Exclusions
<b>Insulin</b>	Any mention of routine insulin use during the past 12 months in the medical record	Any insulin, including regular insulin, insulin pump, insulin pen, 70/30, CSII (continuous subcutaneous infusion of insulin), Humalog, Humulin, Lente, Lispro, MDI (multiple daily injections), Novolin, Novolin Penfill, NPH Novo Nordisk, Semilente, Ultralente, Velosulin	Insulin given only during hospitalization, or briefly to help a patient through an acute illness, such as with steroid treatment or active infection does not constitute documentation of insulin use for diabetes
<b>Oral hypoglycemics/anti-hyperglycemics</b>	Any mention of oral hypoglycemic or antihyper-glycemic use during the past 12 months	Acarbose, Acetohexamide, Amaryl, Chlorpropamide, Diabeta, Diabinase, Dymelor, Glipizide, Glipizide XL, Glucamide, Glucophage, Glucotrol, Glucotrol	N/A

	in the medical record	XL, Glyburide, Glynase, Metformin, Micronase, Orinase, Orimide, Prandin (Repaglinide), Precose, Tolazamide, Tolamide, Tolbutamide, Tolinase, Troglitazone	
--	-----------------------	---	--

## **Minimum Patient Requirements**

Applicants must abide by the minimum patient panel requirements as outlined below. Physicians must elect and inform their data aggregator whether they are applying as an individual physician or a physician group. Physicians are prohibited from applying as both individuals and part of a physician group.

***Individual physician applicants:*** Individual physician applicants must submit data on a minimum of 25 different eligible patients with diabetes.

***Physician group applicants:*** For physician group applicants, the total number of diabetic patients submitted must include:

- A minimum of 10 diabetic patients per individual physician
- A minimum group average of 25 diabetic patients per physician

*Example 1:* Physician Group A

- Physician 1 has 25 eligible patients.
- Physician 2 has 55 eligible patients.
- Physician 3 has 10 eligible patients.
- Total number of eligible patients for Physician Group A is 90.
- Group average per physician for Physician Group A is 30.

Each physician in Physician Group A meets the individual minimum of 10 diabetic patients. Physician Group A also meets the minimum group average of 25 diabetic patients per physician.

*Example 2:* Physician Group B

- Physician 1 has 25 eligible patients.
- Physician 2 has 30 eligible patients.
- Physician 3 has 7 eligible patients.
- Physician 4 has 18 eligible patients.
- Total number of eligible patients for Physician Group A is 80.
- Group average per physician for Physician Group A is 20.

Physician 3 in Physician Group B does not meet the individual minimum of 10 diabetic patients. Additionally, Physician Group B does not meet the minimum group average of 25 diabetic patients per physician.

See “Patient Eligibility Criteria” on page 55.

## **Retrospective Sampling Methodology**

The following sampling methodology should be used by physicians applying for the one-year preliminary DCL recognition through the one-time retrospective patient sampling option.

Step 1: Establish a start date within the last 12 months. A start date is an arbitrary date set at the convenience of the applicant. The start date is the date applicants begin to identify eligible patients for the sample. Applicants must identify patients who have already been seen (moving backward), in relationship to a start date.

For example, a practice selects July 1, 2006, as the start date. On each day, going backward from July 1, the practice consecutively evaluates each patient seen and identifies diabetes patients who meet the eligibility criteria, until the required sample size of 25 patients per physician is met.

Step 2: Identify eligible patients. Applicants may review patient medical records or set up a query of the administrative data system for patients who meet the eligibility requirements for having diabetes and who have had a visit with a physician prior to the selected start date.

Administrative data sources include medical encounters, medical claims and ambulatory pharmacy records. In some practices or organizations, a separate diabetes patient database exists for this purpose.

Determination of patient eligibility may be based on an administrative data system, but must be supported by documentation found in the medical record.

The sampling methodology for the one-time preliminary DCL assessment requires:

- Review of consecutive patients seen based on a start date
- Entry of clinical care data for the DCL standards for eligible patients

## **Appendix A: Audit Methodology**

The PAO is responsible for conducting three levels of audit pertaining to applicant submissions for BTE DCL recognition:

- Level 1: Data Aggregator (DA) Data Extraction code review
- Level 2: Data Validation (Load Summary)
- Level 3: Physician Chart Audit

### **Level 1 Audit – Data Aggregator Data Extraction**

The PAO will conduct an audit of each data aggregator’s DCL data extraction process prior to accepting applications. The PAO will review the code that the data aggregator is using to extract the physician data and verify that all eligible patients are accurately included in the denominator. Each data aggregator needs to pass the extraction audit before numerator data is abstracted for submission to the PAO. This level of review will also be conducted annually and upon any changes to the data aggregator data extraction code. Data aggregators are responsible for informing the PAO when any changes are made.

Data aggregators are required to supply the PAO with the following information in order for the PAO to certify the denominators submitted by the data aggregator:

- Patient lists produced by following the clinical measures specifications and patient eligibility requirements outlined in this document
- Source code used to produce denominator lists
- Patient attribution methodology documentation
- Exclusion criteria

### **Level 2 Audit – Data Validation (Load Summary)**

The PAO runs and provides the data aggregator with a file load summary for each file submission within 3 days of receipt of the file, ensuring that each data field contains a valid data value that meets the data field specifications and makes sense in relation to itself and related data fields. The load summary will identify which records contain incomplete or invalid data values. There is a zero tolerance policy for errors on required data fields and data values that do not meet data field specifications. It is the data aggregator’s responsibility to correct or remove the problematic data and resubmit the file to the PAO. Files will not be rejected for invalid data values in clinical measures fields, but will be counted as a numerator miss for scoring purposes (with the exception of the poor control measures for which it will be counted as a numerator hit). Invalid data values in clinical measures fields are however identified in the load summary to the data aggregator, which is responsible for reporting this information back to the applicant in order to improve data collection.

The following data validation checks are used in creating the load summary provided to the data aggregator after each data file submission to identify any missing or invalid data values:

Data Validation Checks for Clinical Measures Data Fields			
Data field	Data field specifications	Acceptable Data Value Range	Notes
<b>Resp. Provider ID</b>	<b>(Required Field)</b> Alphanumeric value up to 26 characters in length		
<b>Chart ID</b>	<b>(Required Field)</b> Alphanumeric value		
<b>Last Visit Date</b>	<b>(Required Field)</b> Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Patient Year/Date of Birth</b>	<b>(Required Field)</b> Numeric value: YYYY or MM/DD/YYYY	(Current Year/Date -75 years) - (Current Year/Date -18 years)	Current year/date anchored to end of measurement period (last day of current quarter)
<b>HbA1c</b>	Numeric value	4.0-16.0	
<b>HbA1c Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Systolic Blood Pressure</b>	Numeric value	60-300	
<b>Diastolic Blood Pressure</b>	Numeric value	40-150 <i>Data submitted is INVALID if:</i> <i>Diastolic Blood Pressure ≥ Systolic Blood Pressure</i>	
<b>Blood Pressure Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Retinopathy Diagnosis</b>	Alpha value	“YES”, “NO”, “NOT KNOWN”	
<b>Retinal Exam Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)

<b>Smoking Status</b>	Alpha value	“SMOKER”, “NON-SMOKER”, “NOT KNOWN”	
<b>Smoking Status Assessment Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Smoking Cessation and/or Treatment Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>LDL Level (mg/dl)</b>	Numeric Value	30-500	
<b>LDL Level Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Nephropathy Diagnosis</b>	Alpha value	“YES”, “NO”	
<b>ACE-I or ARB Therapy</b>	Alpha value	“YES”, “NO”	
<b>Microalbumin Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)
<b>Bilateral Amputation</b>	Alpha value	“YES”, “NO”	
<b>Podiatry Exam Date</b>	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if:</i> 1. It is the same date as that of the most current data submission. 2. A future date based upon the date of the most current data submission.	Date of most current data submission anchored to end of measurement period (i.e. last day of current quarter)

<b>Data Validation Checks for Physician Identifier Data Fields</b>			
<b>Data field</b>	<b>Data field specifications</b>	<b>Acceptable Data Value Range</b>	<b>Notes</b>
<b>Resp. Provider ID</b>	<b>(Required field)</b> Alphanumeric value up to 26 characters in length		

<b><i>NPI/UPIN</i></b>	NPI: Numeric value 10 characters in length; UPIN: single alpha value followed by 5 numeric values		
<b><i>DEA Number</i></b>	Alphanumeric value 9 characters in length	First letter must be “A”, “B” or “F”.	
<b><i>Medical License Number</i></b>	Alphanumeric value up to 10 characters in length		
<b><i>Physician Last Name</i></b>	<b><i>(Required field)</i></b> Alpha value up to 50 characters in length		Leading abbreviations like “DR” or “Dr” must be dropped. Generational suffixes (e.g., Sr, Jr, II, III, etc.) should be included in the Last Name field without any punctuation. Suffix should be separated from the last name by a blank (e.g., Smith Jr).
<b><i>Physician First Name</i></b>	<b><i>(Required field)</i></b> Alpha value up to 50 characters in length		
<b><i>Physician Middle Name</i></b>	Alpha value up to 30 characters in length		
<b><i>Physician Degree</i></b>	<b><i>(Required field)</i></b> Numeric value	“01”, “02”	01 = MD 02 = DO
<b><i>Physician/Practice Address 1</i></b>	<b><i>(Required field)</i></b> Alphanumeric value up to 100 characters in length		Should include the street name and number only.
<b><i>Physician/Practice Address 2</i></b>	Alphanumeric value up to 100 characters in length		Should include additional information such as suite, room, floor, building, etc.
<b><i>Physician/Practice City</i></b>	<b><i>(Required field)</i></b> Alpha value up to 100 characters in length		
<b><i>Physician/Practice State</i></b>	<b><i>(Required field)</i></b> Alpha value 2 characters in length	U.S. Postal Service abbreviation representing the state of the physician’s or practice’s address	
<b><i>Physician/Practice Zip Code</i></b>	<b><i>(Required field)</i></b> Numeric value 5 (#####), 9 (#####) or 10 characters (#####-####) in length		
<b><i>Physician/Practice Phone</i></b>	Alphanumeric value up to 30 characters in length		Area code is required. Telephone number may be entered with or without punctuation.
<b><i>Physician Date of Birth</i></b>	Numeric value: MM/DD/YYYY		

<b>Physician Gender</b>	Alpha value	“F”, “M”, “U”	F = Female M = Male U = Unknown
<b>Physician Specialty</b>	Numeric value	01-29	01 = Allergy/Immunology 02 = Cardiology 03 = Critical Care Services 04 = Dermatology 05 = Endocrinology 06 = Gastroenterology 07 = Gen/Fam Practice 08 = Geriatric Medicine 09 = Hematology 10 = Infectious Disease 11 = Internal Medicine 12 = Nephrology 13 = Neurology 14 = Neurosurgery 15 = Obstetrics/Gynecology 16 = Occ. Medicine 17 = Oncology 18 = Ophthalmology 19 = Orthopedics 20 = Otolaryngology 21 = Pediatrics 22 = Phys/Rehab Medicine 23 = Psychiatry 24 = Psychopharmacology 25 = Pulmonary Medicine 26 = Rheumatology 27 = Surgery 28 = Urology 29 = Other – not listed
<b>Practice ID</b>	<i>(Required field for group applicants only)</i> Alphanumeric value up to 26 characters in length		
<b>Practice Name</b>	<i>(Required field for group applicants only)</i> Alpha value up to 100 characters in length		
<b>Full Patient Panel</b>	Alpha value	“Y”, “N”	Y = Yes N = No Blank fields will default to “N”.
<b>Data Submission through CCHIT-certified System</b>	Alpha value	“Y”, “N”	Y = Yes N = No Blank fields will default to “N”.

### Level 3 Audit – Physician Chart

BTE reserves the right to complete an audit of any individual or group application for recognition. PAOs or specified local organization subcontractors conduct audits of at least 5 percent of applicants from each data aggregator partner each year. DCL audits may be completed by fax, mail, electronically or on site. Any data identified by the PAO as irregular through a pre-determined list of chart audit triggers is subject to audit. The remainder of the 5 percent is selected through a random sampling methodology. Once selected for an audit, an applicant submitting data continuously cannot be reselected for a subsequent audit through the random sampling methodology for a period of at least one year.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission.

The following chart identifies the components of the physician chart audit depending on the data source of the patient information (whether the information is housed in an electronic medical record (EMR)/electronic health record (EHR), patient registry or paper chart).

<i>Patient data source / Purpose</i>	<i>EMR/EHR</i>		<i>Registry</i>		<i>Paper Chart</i>	
	<i>All patients</i>	<i>Sample</i>	<i>All patients</i>	<i>Sample</i>	<i>All patients</i>	<i>Sample</i>
1. Verification of data submitted in comparison to data in patient chart	Y	Y	Y	Y	Y	Y
2. Verification of patient selection for entry in electronic system (denominator certification)	N	Y	Y	Y	Y	Y
3. Verification of sampling methodology	N	Y	N	Y	N	Y

For each applicant selected for audit, the PAO will identify and notify the data aggregator of 25 charts selected for review. For those physicians chosen for audit due to an audit trigger, the patient charts containing the irregular data identified are included in the review. For all other audits the patient charts are identified through a random sampling methodology. For applicants using an EMR/EHR system, if a selected patient has a more recent encounter at the time of audit and the auditor is unable to review the historical encounter, then the patient in question will be eliminated from the audit list and the PAO will select an alternate patient.

The auditor reviews all data fields submitted to the PAO in the clinical measures data file for each patient chart selected. The auditor is required to audit all the way through the 25 charts regardless of early findings to determine the final audit score. Errors are counted at the data field level. Applicants with 85 percent or greater accuracy on the audit will receive a Pass for the audit, and final recognition status will be determined. Failure to pass an audit results in no further consideration for the DCL program for a pre-determined period of time from the date of submission of the application. Applicants with an audit score of 50 to 84 percent will be prohibited from resubmitting data to a PAO for a period of six months. Applicants with an audit score less than 50 will be prohibited from resubmitting data to a PAO for assessment for a period of two years.

<b>Audit Score</b>	<b>Audit Determination</b>	<b>Lockout from Reconsideration</b>
85-100	Pass	None
50-84	Fail	6 months
0-49	Fail	2 years

Applicants with an audit determination of “Fail” are automatically subject to re-audit upon their next data submission to any PAO after the completion of the lockout period. All audit decisions are considered final.

Detailed audit processes and procedures will be provided to data aggregators and selected applicants by the PAO.

## Appendix B: Sample Results Report

### Diabetes Care Link Program

#### Sample Data Set Calculation

Clinical Measures	BTE						
	HgBA1c	BP	LDL	Ophtho Exam	Nephro Assess	Foot Exam	Smoking Status Cessation & Tx
Patient 1	8.6	125/75	122	NO	YES	YES	NO
Patient 2	6.4	128/70	124	YES	YES	NO	NO
Patient 3	8.3	135/85	95	YES	YES	YES	YES
Patient 4	6.5	135/80	88	NO	NO	YES	NO
Patient 5	7.7	155/100	118	YES	YES	YES	YES
Patient 6	6.3	120/75	146	NO	NO	YES	YES
Patient 7	6.6	125/70	120	NO	NO	YES	YES
Patient 8	9.5	165/95	174	NO	YES	YES	YES
Patient 9	6.4	130/75	127	YES	YES	YES	YES
Patient 10	6.8	132/85	82	NO	YES	YES	YES
Patient 11	8.4	132/80	115	NO	YES	NO	NO
Patient 12	6.9	124/85	92	YES	NO	YES	YES
Patient 13	7.3	120/70	98	NO	YES	YES	NO
Patient 14	6.5	165/90	155	NO	NO	YES	NO
Patient 15	8.8	135/85	128	NO	YES	NO	NO
Patient 16	10.3	168/100	168	NO	YES	YES	YES
Patient 17	7.4	130/70	124	YES	YES	YES	YES
Patient 18	8.3	124/78	94	NO	YES	YES	NO
Patient 19	7.5	135/85	116	YES	YES	YES	YES
Patient 20	6.2	120/65	98	NO	YES	YES	YES
Patient 21	6.1	110/75	110	NO	NO	YES	YES
Patient 22	6.3	115/70	90	NO	YES	YES	YES
Patient 23	8.1	125/75	114	YES	YES	YES	NO
Patient 24	8.3	138/85	120	YES	YES	YES	YES
Patient 25	7.4	120/80	84	NO	NO	YES	NO

Level 1 Certification

**Clinical Measures**

*Poor control measures*

HgBA1c Control

Blood Pressure Control

LDL Control

*Superior control measures*

HgBA1c Superior Control

Blood Pressure Superior Control

LDL Superior Control

*Process measures*

Ophthalmologic exam

Nephropathy Assessment

Podiatry Exam

Smoking Status and Cessation Advice & Tx

**TOTAL POINTS**

**POINTS NEEDED TO ACHIEVE RECOGNITION**

<b><u>Threshold</u></b>	<b><u>Criteria</u></b>	<b><u>Sample Meeting Criteria</u></b>	<b><u>Available Points</u></b>	<b><u>Points Earned</u></b>	<b><u>Required</u></b>
> 9.0	≤ 20% of pts in sample	2/25 = 8%	15	<b>15</b>	YES
≥ 140/90	≤ 35% of pts in sample	4/25 = 16%	15	<b>15</b>	YES
≥ 130 mg/dl	≤ 37% of pts in sample	4/25 = 16%	10	<b>10</b>	YES
< 7.0	≥ 40% of pts in sample	11/25 = 44%	10	<b>10</b>	NO
< 130/80	≥ 35% of pts in sample	10/25 = 40%	10	<b>10</b>	NO
< 100 mg/dl	≥ 36% of pts in sample	9/25 = 36%	10	<b>10</b>	NO
N/A	≥ 50% of pts in sample	9/25 = 36%	10	<b>0</b>	NO
N/A	≥ 70% of pts in sample	18/25 = 72%	5	<b>5</b>	NO
N/A	≥ 70% of pts in sample	22/25 = 88%	5	<b>5</b>	NO
N/A	≥ 80% of pts in sample	15/25 = 60%	10	<b>0</b>	NO
			<b>100</b>	<b>80</b>	
			<b>75</b>	<b>75</b>	

Level 2 Certification

**Clinical Measures**

*Poor control measures*

HgBA1c Control

Blood Pressure Control

LDL Control

*Poor control composite measure*

HgBA1c Control

Blood Pressure Control

LDL Control

*Superior control measures*

HgBA1c Superior Control

Blood Pressure Superior Control

LDL Superior Control

*Process measures*

Ophthalmologic Exam

Nephropathy Assessment

Podiatry Exam

Smoking Status and Cessation Advice & Tx

**TOTAL POINTS**

**POINTS NEEDED TO ACHIEVE RECOGNITION**

<b>Threshold</b>	<b>Criteria</b>	<b>Sample Meeting Criteria</b>	<b>Available Points</b>	<b>Points Earned</b>	<b>Required</b>
> 9.0	≤ 20% of pts in sample	2/25 = 8%	0	0	YES
≥ 140/90	≤ 35% of pts in sample	4/25 = 16%	0	0	YES
≥ 130 mg/dl	≤ 37% of pts in sample	4/25 = 16%	0	0	YES
> 9.0	<b>≤ 20% of pts in sample meet thresholds for any 1 of the 3 poor control measures on a per patient basis</b>	5/25 = 20%	40	40	YES
≥ 140/90					
≥ 130 mg/dl					
< 7.0	≥ 40% of pts in sample	11/25 = 44%	10	10	YES
< 130/80	≥ 35% of pts in sample	10/25 = 40%	10	10	YES
< 100 mg/dl	≥ 36% of pts in sample	9/25 = 36%	10	10	YES
N/A	≥ 50% of pts in sample	9/25 = 36%	10	0	NO
N/A	≥ 70% of pts in sample	18/25 = 72%	5	5	NO
N/A	≥ 70% of pts in sample	22/25 = 88%	5	5	NO
N/A	≥ 80% of pts in sample	15/25 = 60%	10	0	NO
			<b>100</b>	<b>80</b>	
			<b>75</b>	<b>75</b>	

Level 3 Certification

**Clinical Measures**

*Poor control measures*

HgBA1c Control

<b>Threshold</b>	<b>Criteria</b>	<b>Sample Meeting Criteria</b>	<b>Available Points</b>	<b>Points Earned</b>	<b>Required</b>
> 9.0	≤ 20% of pts in sample	2/25 = 8%	0	0	YES
≥ 140/90	≤ 35% of pts in sample	4/25 = 16%	0	0	YES
≥ 130 mg/dl	≤ 37% of pts in sample	4/25 = 16%	0	0	YES
<i>Poor control composite measure</i>					
> 9.0	<b>≤ 20% of pts in sample meet thresholds for any 1 of the 3 poor control measures on a per patient basis</b>	5/25 = 20%	40	40	YES
≥ 140/90					
≥ 130 mg/dl					
<i>Superior control measures</i>					
< 7.0	≥ 40% of pts in sample	11/25 = 44%	0	0	YES
< 130/80	≥ 35% of pts in sample	10/25 = 40%	0	0	YES
< 100 mg/dl	≥ 36% of pts in sample	9/25 = 36%	0	0	YES

