2014 PQRS OPTIONS FOR MEASURES GROUPS:

2014 PQRS MEASURES IN DIABETES MEASURES GROUP:
#1. Diabetes: Hemoglobin A1c Poor Control
#2. Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)
#117. Diabetes: Eye Exam
#119. Diabetes: Medical Attention for Nephropathy
#163. Diabetes: Foot Exam

INSTRUCTIONS FOR REPORTING:
• It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G8485: I intend to report the Diabetes Measures Group

• Report the patient sample method:
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2014 OR July 1 through December 31, 2014).

• Patient sample criteria for the Diabetes Measures Group are patients aged 18 through 75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter:

The following diagnosis codes indicating diabetes:
ICD-9-CM [for use 1/1/2014 – 9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.00, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 362.41, 648.00, 648.01, 648.02, 648.03, 648.04


Accompanied by:
One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

• Report a numerator option on all measures within the Diabetes Measures Group for each patient within the sample.
Instructions for qualifying numerator option reporting for each of the measures within the Diabetes Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G8494:** All quality actions for the applicable measures in the Diabetes Measures Group have been performed for this patient

This measures group contains one or more inverse measures. An inverse measure is a measure that represents a poor clinical quality action as meeting performance for the measure. For these measures, a lower performance rate indicates a higher quality of clinical care. Composite codes for measures groups that contain inverse measures are only utilized when the appropriate quality clinical care is given.

The composite code for this measures group may be reported when codes in the summary table below are applicable for reporting of each measure within the measures group.

<table>
<thead>
<tr>
<th>Measure</th>
<th>#1*</th>
<th>#2</th>
<th>#117</th>
<th>#119</th>
<th>#163</th>
</tr>
</thead>
<tbody>
<tr>
<td>QDC options for acceptable use of the composite QDC</td>
<td>3044F or 3045F</td>
<td>3048F</td>
<td>2022F or 2024F or 2026F or 3072F</td>
<td>3060F or 3061F or 3062F or 3066F or G8506</td>
<td>G9226</td>
</tr>
</tbody>
</table>

*Indicates an inverse measure

To report satisfactorily the Diabetes Measures Group requires all measures for each patient within the eligible professional’s patient sample to be reported a minimum of once during the reporting period.

Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.

**NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option.
Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

   Numerator Instructions: Patient is numerator compliant if most recent HbA1c level is > 9.0% or is missing a result or if an HbA1c test was not done during the measurement year.

   NUMERATOR NOTE: The performance period for this measure is 12 months from date of encounter. A lower calculated performance rate for this measure indicates better clinical care or control.

   Numerator Options:
   Most recent hemoglobin A1c level > 9.0% (3046F)
   OR
   Hemoglobin A1c level was not performed during the performance period (12 months) (3046F with 8P)
   OR
   Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F)
   OR
   Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% (3045F)
**Measure #2 (NQF 0064): Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)**

**DESCRIPTION:**
Percentage of patients aged 18-75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the measurement period

**NUMERATOR:**
Patients whose most recent LDL-C < 100 mg/dL during the measurement period

**NUMERATOR NOTE:** The performance period for this measure is 12 months from the date of encounter. The patient is not numerator compliant if the result for the most recent LDL-C test during the measurement period is ≥ 100 mg/dL, or is missing, or if an LDL-C test was not performed during the measurement period.

**Numerator Options:**
- Most recent LDL-C < 100 mg/dL (3048F)
  
  OR
  - Most recent LDL-C 100-129 mg/dL (3049F)
    
    OR
    - Most recent LDL-C ≥ 130 mg/dL (3050F)
      
      OR
      - LDL-C was not performed during the performance period (12 months) (3048F with 8P)
**Measure #117 (NQF 0055): Diabetes: Eye Exam**

**DESCRIPTION:**
Percentage of patients 18-75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period.

**NUMERATOR:**
Patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement period. For retinal or dilated eye exams performed 12 months prior to the measurement period, an automated result must be available.

- **Definition:**
  - Automated Result – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

- **Numerator Options:**
  - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed (2022F)
  - OR
  - Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed (2024F)
  - OR
  - Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed (2026F)
  - OR
  - Low risk for retinopathy (no evidence of retinopathy in the prior year) (3072F)*
    - *NOTE: This code can only be used if the encounter was during the measurement period because it indicates that the patient had “no evidence of retinopathy in the prior year”. This code definition indicates results were negative, therefore an automated result is not required.
  - OR
  - Dilated eye exam was not performed, reason not otherwise specified (2022F or 2024F or 2026F with 8P)
Measure #119 (NQF 0062): Diabetes: Medical Attention for Nephropathy

DESCRIPTION:
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

NUMERATOR:
Patients with a screening for nephropathy or evidence of nephropathy during the measurement period

Numerator Instructions: This measure is looking for a nephropathy screening test or evidence of nephropathy.

Numerator Options:
Positive microalbuminuria test result documented and reviewed (3060F)
OR
Negative microalbuminuria test result documented and reviewed (3061F)
OR
Positive macroalbuminuria test result documented and reviewed (3062F)
OR
Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) (3066F)
OR
Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8506)
OR
Nephropathy screening was not performed, reason not otherwise specified (3060F or 3061F or 3062F with 8P)
Measure #163 (NQF 0056): Diabetes: Foot Exam

DESCRIPTION:
Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period

NUMERATOR:
Patients who received a foot exam (i.e., visual inspection, sensory exam with monofilament AND pulse exam) during the measurement period

NUMERATOR NOTE: Patients who received a foot exam at least once within the prior 12 months.

Numerator Options:
- Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when all of the 3 components are completed) (G9226)
- Documentation of medical reason for not performing foot exam (e.g., patient with bilateral foot/leg amputation) (G9224)
- Foot exam was not performed, reason not otherwise given (G9225)
Measure #1 – Diabetes: Hemoglobin A1c Poor Control

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al., 1995).

CLINICAL RECOMMENDATION STATEMENTS:
American Geriatrics Society (Brown et al. 2003):
For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Quality of Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):
Lowering A1c to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1c goal for non-pregnant adults in general is < 7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of < 7% appears reasonable for many adults for macrovascular risk reduction. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial suggest a small but incremental benefit in microvascular outcomes with A1c values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1c goals than the general goal of < 7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (Level of Evidence: B)

Conversely, less stringent A1c goals than the general goal of < 7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (Level of Evidence: C)
Measure #2 - Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor cholesterol, specifically lipoprotein (LDL). Clinical guidelines recommend lifestyle modifications that include reducing intake of saturated fat, trans fat and cholesterol, weight loss, and increased physical activity (American Diabetes Association 2009). Statin therapy is suggested for eligible patients whose levels are consistently and significantly higher (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (2009): In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (LDL cholesterol < 100 mg/dL, HDL cholesterol > 50 mg/dl, and triglycerides < 150 mg/dl), lipid assessments may be repeated every 2 years.

American Association of Clinical Endocrinologists (2007): Aggressive management of dyslipidemia in patients with diabetes mellitus is critical; treat patients to achieve the following goal: LDL-C < 100 mg/dL (< 70 mg/dL is recommended for patients with diabetes mellitus and coronary artery disease).

Measure #117 - Diabetes: Eye Exam

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative) (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (ADA) (2009):
• Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
• Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
• Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
• Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
• Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
• Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
• Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
• The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)

Measure #119 - Diabetes: Medical Attention for Nephropathy

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin (National Institute of Diabetes and Digestive and Kidney Diseases 2011). It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Diabetes may cause life-threatening, life-ending or life-altering complications, including end-stage kidney disease. Diabetes is the primary cause of kidney failure, accounting for 44 percent of newly diagnosed cases in 2005 (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Clinical guidelines recommend regular testing to evaluate urine albumin excretions and serum creatinine and the estimated glomerular filtration rate derived from serum creatinine, in addition to comparing measurements when screening for chronic kidney disease (American Diabetes Association 2009; American Association of Clinical Endocrinologists 2007).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (2009):
• Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of >= 5 years and in all type 2 diabetic patients, starting at diagnosis. (Level of Evidence E)
• Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (Level of Evidence E)
• In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (Level of Evidence A)

American Association of Clinical Endocrinologists (2007): Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with Type 1 diabetes mellitus (T1DM) and at the time of diagnosis in patients with Type 2 diabetes mellitus (T2DM). Testing includes:
• Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine

The following are diagnostic criteria for chronic kidney disease:
• Estimated glomerular filtration rate < 60 mL/min/1.73 m2 or albumin-to-creatinine ratio >= 30 mg albumin/g creatinine
• Microalbuminuria >= 30 mg albumin/g creatinine
• Macroalbuminuria >= 300 mg albumin/g creatinine (Grade A)
• Prescribe an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker in the antihypertensive regimen in the absence of contraindications. (Grade A)

California Healthcare Foundation/American Geriatrics Society (2003): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes mellitus. After the initial screening and in the absence of
previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Level III, Grade A)

Measure #163 - Diabetes: Foot Exam

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage. The consensus among established clinical guidelines is that patients with diabetes should have a foot exam soon after diagnosis and annually thereafter. Comprehensive foot care programs can lower amputation rates by 45-85 percent (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (2009) Guidelines/Recommendations: Perform annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold).