mercy care advantage HMO SNP

Comprehensive Diabetes Care – CDC

HEDIS – Medical record review documentation guidelines

Description: Members age 18-75 years of age with diabetes (Type 1 and Type 2)* that had all of the following:
*Exclusions may apply

A. **Eye Exam**
B. **Kidney Disease Monitoring or Medical Attention for Nephropathy**
C. **Blood Sugar Controlled - HbA1c screening**
D. **BP Control**

A. Eye Exam: Screening or monitoring for diabetic retinal disease.

Requested Medical Record Documentation:

- **2018 - 2019** All Eye Care Consult Reports/Correspondence and/or documentation of Retinal or dilated eye exam; Documentation must include date of exam, results of exam and must show exam performed by a qualified eye care professional (Ophthalmologist/Optometrist)
- **Any Year** Evidence of two unilateral eye enucleations or bilateral eye enucleation anytime during the member's history through December 31, 2019
- **2019** Evidence the member was in hospice

Specific items that will meet compliance:

- A retinal or dilated eye exam, by a qualified eye care professional, with or without evidence of retinopathy in 2019
    1. A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results
    2. A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist
- A negative retinal or dilated eye exam (no evidence of retinopathy) by a qualified eye care professional in 2018 (Send all eye exams from 2018-2019 and we can determine if negative)
    1. Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in 2018, where results indicate retinopathy was not present (e.g., documentation of normal findings)
        a. Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicated "diabetes without complications" **does not** meet criteria
- Two unilateral eye enucleations or bilateral eye enucleation anytime in the member's history through December 31, 2019

Specific requirements for documentation:

- All records **must** include the patient's name on **every** page, and the patient's date of birth and sex on at least **one** page
- Documentation in the **medical record must make it clear** that the patient had a **dilated or retinal exam by an eye care professional** (must state: optometrist or ophthalmologist)
- Documentation in the medical record must **provide** the **date** when the procedure was performed and the **results** of the exam

B. Kidney Disease Monitoring or Medical Attention for Nephropathy: A nephropathy screening or monitoring test, treatment of nephropathy or evidence of nephropathy during 2019.

Requested Medical Record Documentation:

- **2019** All Problem lists, medication lists, health maintenance flow sheets, progress/visit notes
- **2019** All labs and urine tests: Documentation **must include** the **date of service** and **results** of the tests
- **2019** All Nephrologist, Endocrinologist, and Cardiologist Reports/Correspondences
- **2019** All Medication Lists; Documentation must include evidence that the prescription was **written**, was **filled** or the **member took** the medication
- **2019** Evidence the member was in hospice

Specific items that will meet compliance:

Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy:

- A urine test for albumin or protein in 2019. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the results or finding. Any of the following meet the criteria:
    1. 24-hour urine for albumin or protein
    2. Timed urine for albumin or protein
    3. Spot urine (e.g., urine dipstick or test strip) for albumin or protein
    4. Urine for albumin/creatinine ratio
    5. 24-hour urine for total protein
    6. Random urine for protein/creatinine ration
- Documentation of a visit to a nephrologist in 2019
- Documentation of a renal transplant in 2019
- Documentation of medical attention for any of the following in 2019 (no restriction on provider type):
    1. Diabetic nephropathy
    2. End Stage Renal Disease (ESRD)
    3. Chronic Renal Failure (CRF)
    4. Renal Insufficiency (RI)
    5. Proteinuria
    6. Albuminuria
    7. Renal dysfunction
    8. Acute Renal Failure (ARF)
    9. Dialysis, hemodialysis or peritoneal dialysis
- Evidence of ACE inhibitor/ARB therapy in 2019
    1. Documentation in the medical record must include evidence that the member received ACE Inhibitor/ARB therapy during 2019. Any of the following meet criteria:
        - Documentation that a prescription for an ACE inhibitor/ARB was written during 2019
        - Documentation that a prescription for an ACE inhibitor/ARB was filled during 2019
        - Documentation that the member took an ACE inhibitor/ARB during 2019

Specific requirements for documentation:

- All records **must** include the patient's name on **every** page, and the patient's date of birth and sex on at least **one** page
- Documentation in the medical record must **provide** the **date** when the urine test was performed and the **results** or findings of the test
- A medical history of any of the nephropathy findings **does not** meet compliance. (It must be current for 2019)

- Documentation must include evidence that the prescription was **written**, was **filled** or the **member took** the medication during 2019

C. Blood Sugar Controlled - HbA1c screening: The most recent HbA1c level performed in 2019.

Requested Medical Record Documentation:

- **2019** All Problem lists, medication lists, health maintenance flow sheets, progress/visit notes
- **2019** All labs tests: Documentation **must** include the date of service **and** results of the tests
- **2019** All Nephrologist, Endocrinologist, and Cardiologist Reports/Correspondences
- **2019** Evidence the member was in hospice

Specific items that will meet compliance:

HbA1c Testing

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

HbA1c Poor Control >9%

- At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is compliant if the result for the most recent HbA1c level during 2019 is >9% or is missing, or was not done during the measurement year

HbA1c Control <8%

- At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is compliant if the result for the most recent HbA1c level during 2019 is <8%.

Specific requirements for documentation:

- All records **must** include the patient's name on **every** page, and the patient's date of birth and sex on at least **one** page
- Notation of the following in the medical record meet criteria for HbA1c tests:
  - A1c
  - HbA1c
  - HgbA1c
  - Hemoglobin A1c
  - Glycohemoglobin A1c
  - Glycohemoglobin
  - Glycated hemoglobin
  - Glycosylated hemoglobin
- Ranges and thresholds **do not** meet criteria for this indicator. A distinct numeric result is required for compliance.

D. BP Control <140/90 mm Hg: The most recent BP taken during 2019.

Requested Medical Record Documentation:

- **2019** All Problem lists, medication lists, health maintenance flow sheets, progress/visit notes
- **2019** All Nephrologist, Endocrinologist, and Cardiologist Reports/Correspondences
- **2019** All BP readings
- **2019** Evidence the member was in hospice

Specific items that will meet compliance:

- The most recent BP measurement taken in 2019 is <140/90 mm Hg

Specific requirements for documentation:

- All records **must** include the patient's name on **every** page, and the patient's date of birth and sex on at least **one** page
- Documentation in the medical record must **provide** the **date** when the blood pressure measurement was performed and the **complete** reading.
- When multiple BP measurements are recorded for a single date, the lowest systolic and lowest diastolic BP on that date is the representative BP. The systolic and diastolic results do not need to be from the same reading when

multiple readings are recorded for a single date

- BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure **are eligible for use.** For example, the following procedures are considered common low-intensity or preventive procedures (this list is for reference, and is not exhaustive):
    - Vaccinations
    - Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone)
    - TB test
    - IUD insertion
    - Eye exam with dilating agents
    - Wart or mole removal
- BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider
- **Do not** include BP readings that meet the following criteria:
    - Taken during an acute inpatient stay or an ED visit
    - Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests
    - Reported by or taken by the member
- When excluding BP readings, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example, this list is for reference, and is not exhaustive:
    - A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon)
    - Dialysis, infusions and chemotherapy are all therapeutic procedures that require a medication regimen
    - A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol)
- A patient forgetting to take regular medications on the day of the procedure **is not** considered a required change in medication, and therefore the BP reading is eligible
- Member-reported results to the provider from a remote monitoring device are not acceptable