HEDIS® 2014
Technical Specifications for Physician Measurement

Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)
Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
Comprehensive Ischemic Vascular Disease Care (IVD)
Comprehensive Adult Diabetes Care (CDC)
Use of Appropriate Medications for People with Asthma (ASM)
Colorectal Cancer Screening (COL)

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NCQA is proud to release the HEDIS 2014 *Technical Specifications for Physician Measurement.* This publication includes the contributions of many stakeholders, external and internal to NCQA.

Improvements and enhancements to this volume are the result of a team effort of staff from the NCQA Analysis Department, Policy Department, Performance Measurement Department and Product Development Department.

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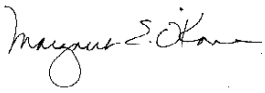
Sincerely,



Margaret E. O'Kane
President

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Revised the patient inclusion criteria.
- Revised the age criterion to women 50–74 years of age.
- Revised the numerator time frame.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- Includes the Medical Record Specification for the numerator, from the HEDIS 2005 Hybrid Specifications.
- Patient inclusion criteria for use by non-health plans.
- Require eligibility exclusion criteria.

Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Eligible Population

Age	Women 52–74 years as of December 31 of the measurement year.
Patient inclusion criteria	**Health plan.** Continuous medical benefit enrollment from October 1 two years prior to the measurement year through December 31 of the measurement year, with no more than one gap in continuous enrollment of up to 45 days during each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may not be more than a 1-month gap in coverage during each year of continuous enrollment. The patient must be enrolled as of December 31 of the measurement year. No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year. **Non-health plan.** Any enrollment, claim or encounter transaction any time during the measurement year and the year prior to the measurement year.
Event/diagnosis	None.
Exclusion	Patients who had a bilateral mastectomy (Table BCS-B) and for whom electronic data do not indicate that a mammogram was performed. Look for evidence of a bilateral mastectomy as far back as possible in the patient's history, using electronic data or medical record review. Any of the following meet criteria for bilateral mastectomy: • A bilateral mastectomy code (Bilateral Mastectomy Value Set). • A unilateral mastectomy code (Unilateral Mastectomy Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).

- Two unilateral mastectomy codes (Unilateral Mastectomy Value Set) on different dates of service.
- Both of the following (on the same or a different date of service):
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same date of service).
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same date of service).

Electronic Specification

Denominator The eligible population.

Numerator One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Medical Record Specification

Denominator A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerator One or more mammograms any time between October 1 two years prior to the measurement year and December 31 of the measurement year. The medical record must include the following documentation:

- A note indicating the date when the mammogram was performed, ***and***
- The result or finding.

Note

- *The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.*

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- The Hybrid Specification is located in the *General Guidelines;* retained the Medical Record Specification for the numerator.
- Patient inclusion criteria for use by non-health plans.
- Require eligibility exclusion criteria.

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Eligible Population

Age	Women 24–64 years as of December 31 of the measurement year.
Patient inclusion criteria	**Health plan.** The patient must be enrolled as of December 31 of the measurement year. ***Commercially insured*.** Continuous medical benefit enrollment for the measurement year and two years prior to the measurement year, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. ***Medicaid insured.*** Continuous enrollment for the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may not be more than a 1-month gap in coverage (i.e., a patient whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). **Non-health plan.** Any enrollment, claim or encounter transaction any time during the measurement year *and* the year prior to the measurement year.
Event/ diagnosis	None.
Exclusion	None.

Exclusion Patients who had a hysterectomy with no residual cervix and for whom the electronic data do not indicate that a Pap test was performed. The hysterectomy must have occurred by December 31 of the measurement year. Refer to the Hysterectomy Value Set for codes to identify a hysterectomy. Look for evidence of a hysterectomy as far back as possible in the patient's history, using electronic data or medical record review.

Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix has been removed.

Electronic Specification

Denominator The eligible population.

Numerator The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.

Step 1 Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.

Step 2 From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set), with service dates four or less days apart during the measurement year or the four years prior to the measurement year *and* who were 30 years or older on the date of both tests.

Step 3 Sum the events from steps 1 and 2 to obtain the rate.

Medical Record Specification

Denominator A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerator The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

Step 1 Identify the number of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*

Step 2 From the women who did not meet step 1 criteria, identify the number of women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year *and* who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
- The results or findings.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.

Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*

Step 3 Sum the events from steps 1–2 to obtain the rate.

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Revised the time frame in the event/diagnosis criteria.
- Clarified requirements for AMI and CABG diagnoses in the *Event/diagnosis* section.
- Clarified medical record requirements for the LDL-C Control indicators.
- Added a *Note* section.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- The Hybrid Specification is located in the *General Guidelines;* retained the Medical Record Specification for the numerator.
- Added LDL-C control threshold option for the numerator.
- Patient inclusion criteria for use by non-health plans.

Description

The percentage of patients 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, ***or*** who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had each of the following during the measurement year:

- LDL-C screening.
- LDL-C control.

Eligible Population

Age	18–75 years as of December 31 of the measurement year.
Patient inclusion criteria	**Health plan.** Continuous medical enrollment for the measurement year and the year prior to the measurement year, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may be no more than a 1-month gap in coverage (i.e., a patient whose coverage lapses for 2 months [60 days] is not considered continuously enrolled. The patient must be enrolled as of December 31 of the measurement year. **Non-health plan.** Any enrollment, claim or encounter transaction any time during the measurement year or the year prior to the measurement year.

Event/ diagnosis

Patients are identified for the denominator in one of two ways: event or diagnosis. The organization must use both methods to identify the eligible population, but a patient only needs to be identified by one to be included in the measure.

Claims/ encounter data

Event. Any of the following during the year prior to the measurement year meet criteria;

- *AMI.* Discharged from an inpatient setting with an AMI (AMI Value Set). Use both facility and professional claims to identify AMI.
- *CABG*. Discharged from an inpatient setting with a CABG (CABG Value Set). Use both facility and professional claims to identify CABG.
- *PCI*. Patients who had PCI (PCI Value Set) in any setting.

Diagnosis. Identify patients as having IVD who met at least one of the following criteria during *both* the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).

Medical record data

Documentation of IVD in the medical record includes:

- IVD.
- Ischemic heart disease.
- Angina.
- Coronary atherosclerosis.
- Coronary artery occlusion.
- Cardiovascular disease.
- Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
- Atherosclerosis of renal artery.
- Atherosclerosis of native arteries of the extremities.
- Chronic total occlusion of artery of the extremities.
- Arterial embolism and thrombosis.
- Atheroembolism.

Note: *Use paper logs, patient registries or EMRs to identify the denominator, then use the medical record to confirm patient eligibility.*

Exclusion

None.

Electronic Specification

Denominator The eligible population.

Numerator

LDL-C screening An LDL-C test (LDL-C Tests Value Set) performed any time during the measurement year, as identified by claim/ encounter or electronic laboratory data.

The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

LDL-C control Select the desired LDL-C control threshold.

- *LDL-C Threshold 1:* <100 mg/dL
- *LDL-C Threshold 2:* <130 mg/dL

Use codes in the LDL-C Tests Value Set to identify the *most recent* LDL-C test during the measurement year. The patient is numerator compliant for each threshold selected by using the most recent LDL-C screening test. The patient is not numerator compliant if the automated result for the most recent LDL-C test during the measurement year exceeds the desired threshold or is missing, or if an LDL-C test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes for the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

LDL-C <100 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Not Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

LDL-C <130 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

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Medical Record Specification

Denominator A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerator

LDL-C Screening An LDL-C test performed during the measurement year as determined by either electronic data or medical record review. At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result or finding.

The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

LDL-C Control The number of patients in the denominator whose LDL-C is adequately controlled during the measurement year. Select the desired LDL-C control threshold:

- *LDL-C Threshold 1:* <100 mg/dL.
- *LDL-C Threshold 2:* <130 mg/dL.

To determine compliance, use the *most recent* LDL-C level performed during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result.

A documented range or threshold that indicates the most recent result meets the desired LDL-C control threshold meets criteria.

The patient is noncompliant in the following circumstances:

- The result for the most recent LDL-C test during the measurement year is greater than the desired control threshold.
- The most recent test result is missing.
- An LDL-C test was not done during the measurement year.

LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)

If lipoprotein (a) is measured, this calculation is:

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3 [lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

The Friedewald equation may not be used if a direct or calculated result in present in the medical record for the most recent LDL-C test.

Note

- *If the organization uses a combination of electronic, medical record, or hybrid data, the most recent result must be used for the LDL-C control indicators, regardless of data source.*

Comprehensive Ischemic Vascular Disease Care (IVD)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Revised the time frame in the event/diagnosis criteria.
- Clarified medical record requirements for the LDL-C Control (<100 mg/dL) indicator.
- Clarified the numerator for BP Control indicators in the Medical Record Specification to state when a BP reading is not compliant.
- Clarified in the *Note* section that organizations must use the most recent result for indicators that require it, regardless of data source.

MODIFICATIONS FROM HEDIS 2014VOLUME 2 TECHNICAL SPECIFICATIONS

- Indicators are derived from NCQA's Heart/Stroke Recognition program; they are not based on HEDIS measures.
- Augmented methods to identify patient eligibility and Medical Record specifications from HEDIS specifications, where applicable.
- The Electronic Method specification is based on HEDIS measures *Cholesterol Management for Patients With Cardiovascular Conditions* and *Comprehensive Adult Diabetes Care.*
- Additional cholesterol and blood pressure control threshold options for the respective numerators.

Description

The percentage of patients 18 years of age and older who who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had each of the following during the measurement year:

- Smoking status and cessation advice or treatment.
- Use of aspirin or another antithrombotic.
- Complete lipid profile.
- LDL-C control.
- BP control.

Eligible Population

Age	18 years or older as of December 31 of the measurement year.
Patient inclusion criteria	**Health plan.** Continuous medical enrollment for the measurement year and the year prior to the measurement year, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may not be more than a 1-month gap in coverage (i.e., a patient whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). The patient must be enrolled as of December 31 of the measurement year. **Non-health plan.** Any enrollment, claim or encounter transaction any time during the measurement year.

Event/diagnosis

Diagnosis. Identify patients as having IVD who met at least one of the following criteria below, during *both* the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
- At least one acute inpatient visit (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).

Medical record data

Documentation of IVD in the medical record includes:

- IVD.
- Ischemic heart disease.
- Angina.
- Coronary atherosclerosis.
- Coronary artery occlusion.
- Cardiovascular disease.
- Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
- Atherosclerosis of renal artery.
- Atherosclerosis of native arteries of the extremities.
- Chronic total occlusion of artery of the extremities.
- Arterial embolism and thrombosis.
- Atheroembolism.

Note: *Use paper logs, patient registries or EMRs to identify the denominator, then use the medical record to confirm patient eligibility.*

Exclusion

None.

Electronic Specification

Denominator

The eligible population.

Numerators

Smoking Status and Cessation Advice or Treatment

Patients with documentation of smoking status (e.g., nonsmoker, smoker, not known) ***and*** date of cessation counseling, ***or*** treatment during the measurement year if the patient smokes tobacco.

Refer to for the Tobacco Smoker Value Set the code to identify tobacco smokers. Refer to the Smoking Cessation Services Value Set for codes to identify smoking cessation counseling and treatment.

Use of Aspirin or Another Antithrombotic

Documentation of use of aspirin or another antithrombotic during the measurement year.

Refer to the Oral Anti-Platelet Value Set to identify the codes for prescribed oral anti-platelet therapy. Refer to Table IVD-E to identify medications for oral anti-platelet therapy.

Table IVD-E: Oral Anti-Platelet Therapies

Description	Prescription	
Oral anti-platelet therapies	• Aspirin • Clopidogrel • Aspirin-dipyridamole	• Prasugrel • Ticagrelor • Ticlopidine

Note: *NCQA posted a comprehensive list of medications and NDC codes to www.ncqa.org on November 1, 2013.*

Complete Lipid Profile and LDL-C Control

Complete Lipid Profile

A complete lipid profile performed during the measurement year (Lipid Panel Value Set), as identified by claim/encounter or electronic laboratory data.

LDL-C Control

Select the desired LDL-C control threshold:

- *LDL-C Threshold 1:* <100 mg/dL.
- *LDL-C Threshold 2:* <130 mg/dL.

Use the LDL-C Tests Value Set to identify the *most recent* LDL-C test during the measurement year. The patient is numerator compliant for each threshold selected by using the most recent LDL-C screening test. The patient is not numerator compliant if the automated result for the most recent LDL-C test during the measurement year exceeds the desired threshold or is missing, or if an LDL-C test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

LDL-C <100 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Not Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

LDL-C <130 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

The patient is noncompliant if:

- The electronic result for the most recent LDL-C test exceeds the desired threshold.
- The electronic result for the most recent LDL-C test is missing.
- An LDL-C test was not done during the measurement year.

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BP Control

BP Control <140/80 mm Hg

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

The patient is numerator compliant if the BP is <140/80 mm Hg. The patient is not compliant if the BP is ≥140/80 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80-89 Value Set	Diastolic not compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

BP Control <140/90 mm Hg

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

The patient is numerator compliant if the BP is <140/90 mm Hg. The patient is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

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Medical Record Specification

Denominator

A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerators

Smoking Status and Cessation Advice or Treatment

Patients with documentation of smoking status (e.g., nonsmoker, smoker, not known) ***and*** date of cessation counseling, ***or*** treatment during the measurement year if the patient smokes tobacco. Documentation in the medical record must include a note indicating smoking status and the dates of required services.

The notation of smoker or nonsmoker status may be from a period prior to the 12-month abstraction period, but once a patient is documented as a smoker, the element requires annual counseling and treatment to encourage smoking cessation.

Use of Aspirin or Another Anti-thrombotic

Documentation of use of aspirin or another antithrombotic during the measurement year.

At a minimum, documentation in the medical record must include a note indicating the date when aspirin or another antithrombotic was prescribed or documentation of prescription from another treating physician.

Complete Lipid Profile and LDL-C Control

Complete Lipid Profile

A full lipid profile completed during the measurement year, with the date and result of each component of the profile documented.

Identify the most recent visit to the doctor's office or clinic where a full lipid profile was documented and which occurred during the measurement year (but after the diagnosis of IVD was made).

Each component of the lipid profile (total cholesterol, HDL-C, triglycerides and LDL-C) must be noted with the date of the laboratory test and results.

Exclude patient self-report or self-monitoring, LDL-to-HDL ratio and findings reported on progress notes or other nonlaboratory documentation.

LDL-C Control

The number of patients in the denominator whose LDL-C is adequately controlled during the measurement year. Select the desired LDL-C control threshold:

- *LDL-C Threshold 1:* <100 mg/dL.
- *LDL-C Threshold 2:* <130 mg/dL.

To determine compliance, use the *most recent* LDL-C level performed during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result.

A documented range or threshold that indicates the most recent result meets the desired LDL-C control threshold meets criteria.

The patient is noncompliant in the following circumstances:

- The result for the most recent LDL-C test during the measurement year is greater than the desired control threshold.
- The most recent LDL-C test result is missing.
- An LDL-C test was not done during the measurement year.

LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)

If lipoprotein (a) is measured, this calculation is:

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3 [lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides >400 mg/dL.

BP Control The number of patients in the denominator whose BP is adequately controlled during the measurement year. "Adequately controlled" means that both the systolic and the diastolic BP meet the desired thresholds:

- *BP Threshold 1:* <140/80 mm Hg.
- *BP Threshold 2:* <140/90 mm Hg.

To determine if a patient is adequately controlled, the representative BP must be identified. Follow the steps below.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was made or confirmed.

Do not include readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Taken the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the patient.
- Documentation of "VS within normal limits" or "vital signs normal."

Step 2 Identify the lowest systolic and lowest diastolic reading from the most recent BP notation in the medical record. If there are multiple readings recorded for a single date, use the lowest systolic and lowest diastolic reading on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Note

- *The organization may select the data collection method (e.g., Electronic, Medical Record, Hybrid) at the indicator level, but the method for screening and control rates and for BP control indicators must be consistent.*
- *If a combination of electronic, medical record or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*

Comprehensive Adult Diabetes Care (CDC)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Clarified requirements for a CABG diagnosis in the Required exclusions for HbA1c Control <7% for a Selected Population indicator.
- Added canagliflozin to the description of "Sodium glucose cotransporter 2 (SGLT2) inhibitor" in Table CDC-A.
- Clarified requirements for using the HbA1c Level 7.0–9.0 Value Set for the HbA1c Control (<8.0%) indicator.
- Clarified hybrid requirements for the HbA1c Control indicators.
- Clarified medical record documentation requirements for a negative retinal or dilated eye exam.
- Clarified that a finding (e.g., normal, within normal limits) is acceptable for the LDL-C Screening indicator.
- Clarified hybrid requirements for the LDL-C Control (<100 mg/dL) indicator.
- Clarified step 2 of the numerator for BP Control indicators in the Hybrid Specifications to state when a BP reading is not compliant.
- Clarified in the *Note* section that organizations must use the most recent result for indicators that require it, regardless of data source.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- The Hybrid Specification is located in the *General Guidelines;* retained the Medical Record Specification for the numerator.
- Medical Record Specification for the denominator.
- Added cholesterol and BP Control threshold options for the respective numerators.
- Includes foot exam and smoking status and cessation advice derived from NCQA's Diabetes Recognition Program.
- Patient inclusion criteria for use by non-health plans.
- Require eligibility exclusion criteria.

Description

The percentage of patients 18–75 years of age with type 1 or type 2 diabetes who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- Eye exam (retinal) performed.
- LDL-C screening.
- LDL-C control.
- Medical attention for nephropathy.
- BP control.
- Foot examination.
- Smoking status and cessation advice or treatment.

**Additional exclusion criteria are required for this indicator, which will result in a different eligible population from all other indicators.*

Eligible Population

Age

18–75 years as of December 31 of the measurement year.

Patient inclusion criteria

Health plan. Continuous medical benefit enrollment for the measurement year, with no more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage during each year of continuous enrollment and must be enrolled as of December 31 of the measurement year.

Non-health plan. Any enrollment, claim or encounter transaction any time during the measurement year.

Table CDC-A: Prescriptions to Identify Patients With Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Saxagliptin • Sitagliptin-simvastatin	
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Miscellaneous antidiabetic agents	• Alogliptin • Exenatide • Linagliptin	• Liraglutide • Metforum-repaglinide • Sitagliptin	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canaglifozin		
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	

Note: *Glucophage/metformin is not included because it is used to treat conditions other than diabetes; Patients with diabetes on these medications are identified through diagnosis codes only. NCQA posted a complete list of medications and NDC codes to www.ncqa.org on November 1, 2013.*

Event/ diagnosis

There are three methods for identifying diabetic patients:

1. Pharmacy data.
2. Claim/encounter data.
3. Medical record data.

Use pharmacy and claim/encounter data to identify the eligible population for electronic specifications. Patients must be identified in only one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Patients who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).
- At least one ED visit (ED Value Set) with a diagnosis of diabetes (Diabetes Value Set).

*Pharmacy data***.** Patients who were dispensed or prescribed insulin or hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A).

Medical record data used to confirm diabetes could be any of the following.

- Diagnosis of diabetes on the Problem List.
- Two office visits with diabetes listed as the diagnosis.
- The need for diet management, insulin or hypoglycemic agent, report of home urine or home blood glucose testing or the presence of an insulin pump anywhere in the medical record. Possible notes include:
  - Insulin-dependent diabetes mellitus (IDDM), non-insulin dependent diabetes (NIDDM), type 1, type 2, DM, AODM, sugar diabetes, maturity onset diabetes, diet-controlled diabetes.
- Any mention of a diagnosis of diabetic polyneuropathy in the medical record. Possible notes include:
  - 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 hands, mono-neuropathy.
- Any mention of a diagnosis of diabetic retinopathy in the medical record. Possible notes include:
  - Diabetic eye changes such as proliferative diabetic retinopathy, new vessels on the disc (NVD), new vessels elsewhere in iris or retina, preretinal or vitreous hemorrhage, fibrosis rubeosis diabetic retinal changes, macular lesion, background retinopathy, preproliferative

retinopathy, venous beading/looping, large retinal blot hemorrhages, multiple cotton wool spots, multi-preintroretinal microvascular abnormalities, diabetic macular edema, nonproliferative diabetic retinopathy, microaneurysms, blot hemorrhage, hard exudates, 1–2 soft exudates.

- Any mention of a diagnosis of diabetic cataract in the medical record.

Note: *Use paper logs, patient registries or EMRs to identify the denominator, then use the medical record to confirm patient eligibility.*

Exclusion

Identify patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the patient's history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes (Gestational or Steroid-Induced Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Electronic Specification

Denominator

The eligible population.

Required exclusions for the HbA1c Control <7% for a Selected Population indicator

Exclude patients who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG*. Patients discharged for CABG (CABG Value Set) during the measurement year or the year prior to the measurement year. Use both facility and professional claims to identify CABG and include inpatient claims only.
- *PCI*. Patients who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- *IVD.* Patients who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- *Thoracic aortic aneurysm.* Patients who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).

- Any of the following, in any setting, any time during the patient's history through December 31 of the measurement year.
  - *Chronic heart failure (CHF)*. A diagnosis of CHF (CHF Value Set).
  - *Prior MI*. A diagnosis of MI (MI Value Set).
  - *ESRD*. ESRD (ESRD Value Set; ESRD Obsolete Value Set).
  - *Chronic kidney disease (stage 4)*. Stage 4 chronic kidney disease (CKD Stage 4 Value Set).
  - *Dementia*. A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set).
  - *Blindness*. A diagnosis of blindness (Blindness Value Set).
  - *Amputation (lower extremity).* Lower extremity amputation (Lower Extremity Amputation Value Set).

Hba1c Testing

An HbA1c test (HbA1c Tests Value Set) performed during the measurement year as identified by claim/ encounter or electronic laboratory data.

HbA1c Poor Control >9.0%

Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The patient is numerator compliant if the most recent automated HbA1c level is >9.0% or is missing a result or if an HbA1c test was not done during the measurement year. The patient is not numerator compliant if the automated result for the most recent HbA1c test during the measurement year is ≤9.0%.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value set and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

HbA1c Control <8.0%

Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during the measurement year. The patient is numerator compliant if the most recent automated HbA1c level is <8.0%. The patient is not numerator compliant if the automated result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

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Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant*
HbA1c Level Greater Than 9.0 Value Set	Not compliant

*CPT Category II code (3045F) in this value set indicates most recent hemoglobin A1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For patients with this code, the organization must use other sources (laboratory data, Hybrid Method of reporting) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed.

HbA1c Control <7.0% for a Selected Population

Use codes in the HbA1c Tests Value Set to identify the most recent HbA1c test during the measurement year. The patient is numerator compliant if the most recent automated HbA1c level is <7.0%. The patient is not numerator compliant if the automated result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

Note: *This indicator uses the eligible population with additional eligible population criteria (e.g., removing patients with required exclusions).*

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

Eye Exam

An eye screening for diabetic retinal disease as identified by electronic data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.

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- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

LDL-C Screening

An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/ encounter or automated laboratory data.

The organization may use a calculated or direct LDL for LDL-C Screening and Control indicators.

LDL-C Control

Select the desired LDL-C control thresholds from below.

- *LDL-C Threshold 1:* <100 mg/dL
- *LDL-C Threshold 2:* <130 mg/dL

Use codes in LDL-C Tests Value Set to identify the *most recent* LDL-C test during the measurement year. The patient is numerator compliant for each threshold selected by using the most recent LDL-C screening test. The patient is not numerator compliant if the automated result for the most recent LDL-C test during the measurement year exceeds the desired threshold or is missing, or if an LDL-C test was not done during the measurement year.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant.

LDL-C <100 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Not Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

LDL-C <130 mg/dL

Value Set	Numerator Compliance
LDL-C Level Less Than 100 Value Set	Compliant
LDL-C Level 100-129 Value Set	Compliant
LDL-C Level Greater Than/Equal To 130 Value Set	Not Compliant

Medical Attention for Nephropathy

A nephropathy screening test ***or*** evidence of nephropathy, as documented through electronic data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening test (Nephropathy Screening Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Value Set).
- Evidence of kidney transplant (Kidney Transplant Value Set).

- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- A positive urine macroalbumin test (Positive Urine Macroalbumin Tests Value Set).
- A urine macroalbumin test (Urine Macroalbumin Tests Value Set) where laboratory data indicates a positive result ("trace" urine macroalbumin test results are not considered numerator compliant).
- At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolaprilt
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrocholorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide		• Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan Trandolapril-verapamil	

Note: *NCQA posted a comprehensive list of medications and NDC codes to www.ncqa.org on November 1, 2013.*

BP Control Select the desired BP control threshold:

- *BP Threshold 1:* <140/80 mm Hg.
- *BP Threshold 2:* <140/90 mm Hg.

Use electronic data to identify the most recent BP reading during the measurement year.Calculate a numerator for each threshold selected to determine compliance with the threshold.

An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code to evaluate whether the patient is numerator compliant for both systolic and diastolic levels. If a combination of data from internal electronic databases and CPT Category II codes is being used, search all sources and use the most recent result. If there are multiple readings on the same date of service, use the lowest systolic and lowest diastolic reading on that date as the representative BP.

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BP Control <140/80 The patient is noncompliant if the electronic result for the most recent test exceeds the desired threshold, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

For both BP Control indicators, the BP must be in conjunction with an outpatient visit code (Outpatient Value Set) or nonacute inpatient visit code (Nonacute Inpatient Value Set) during the measurement year.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80-89 Value Set	Diastolic not compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

BP Control <140/90

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

Foot Examination A foot exam (visual inspection with either a sensory exam or a pulse exam) during the measurement year (Foot Exam Value Set).

Smoking Status and Cessation Advice or Treatment Patients with documentation of smoking status (e.g., nonsmoker, smoker, not known) ***and*** date of cessation counseling, ***or*** treatment during the measurement year if the patient smokes tobacco. Refer to the Tobacco Smoker Value Set for codes to identify tobacco smokers. Refer to the Smoking Cessation Services Value Set for codes to identify smoking cessation counseling and treatment.

Medical Record Specification

Denominator

A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Required exclusions for the HbA1c Control <7.0% for a Selected Population indicator

Exclude patients with any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG*. Dated documentation of CABG in the measurement year or the year prior to the measurement year.
- *PCI*. Dated documentation of PCI in the measurement year or the year prior to the measurement year.
- *IVD*. Documentation of an IVD diagnosis. Look as far back as possible in the patient's history through December 31 of the measurement year. Appropriate diagnoses include:
  - IVD.
  - Ischemic heart disease.
  - Angina.
  - Coronary atherosclerosis.
  - Coronary artery occlusion.
  - Cardiovascular disease.
  - Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
  - Atherosclerosis of renal artery.
  - Atherosclerosis of native arteries of the extremities.
  - Chronic total occlusion of artery of the extremities.
  - Arterial embolism and thrombosis.
  - Atheroembolism.
- *Thoracoabdominal or thoracic aortic aneurysm*. Documentation of thoracoabdominal aneurysm or thoracic aortic aneurysm. Look as far back as possible in the patient's history through December 31 of the measurement year.
- *CHF*. Documentation of CHF or cardiomyopathy diagnosis. Look as far back as possible in the patient's history through December 31 of the measurement year.
- *Prior MI*. Documentation of prior MI. Look as far back as possible in the patient's history through December 31 of the measurement year.
- ESRD. Documentation of stage 5 ESRD. Look as far back as possible in the patient's history through December 31 of the measurement year.
- *Chronic kidney disease (stage 4)*. Documentation of stage 4 chronic kidney disease. Look as far back as possible in the patient's history through December 31 of the measurement year.
- *Dementia*. Documentation of dementia. Look as far back as possible in the patient's history through December 31 of the measurement year.

- *Blindness*. Documentation of blindness in one or both eyes. Look as far back as possible in the patient's history through December 31 of the measurement year.
- *Amputation (lower extremity)*. Documentation of lower extremity amputation. Look as far back as possible in the patient's history through December 31 of the measurement year.

Note: *The organization must search the medical record for required exclusions before it searches for a numerator hit.Organizations are not required to search for required exclusions if a patient has an electronic hit for the indicator, but should exclude these patients if they are discovered during medical record review.*

Numerators

HbA1c Testing

An HbA1c test performed during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. Count notation of any of the following in the medical record:

- A1c.
- HbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.
- HgbA1c.

HbA1c Poor Control >9.0%

The *most recent* HbA1c level (performed during the measurement year) is >9.0%, is missing or was not done during the measurement year, as documented through automated laboratory data or medical record review.
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 patient is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The patient is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note: *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

HbA1c Control <8.0%

The *most recent* HbA1c level (performed during the measurement year) is <8.0%, as identified by automated laboratory data or medical record review.

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 patient is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The patient is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <7.0% for a Selected Population

The *most recent* HbA1c level (performed during the measurement year) is <7.0%, as identified by automated laboratory data or medical record review.

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 patient is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The

patient is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥7.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note: *This indicator uses the eligible population with additional criterion (i.e., removing patients with comorbid conditions).*

Eye Exam

An eye screening for diabetic retinal disease as identified by electronic data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

At a minimum, documentation in the medical record must include one of the following:

- 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, the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional meets criteria).

LDL-C Screening

An LDL-C test performed during the measurement year.

At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result or finding. The organization may use a calculated LDL for LDL-C screening and control indicators.

LDL-C Control

The numerator is the number of patients in the denominator whose LDL-C is adequately controlled during the measurement year. Select the desired LDL-C control threshold:

- *LDL-C Threshold 1:* <100 mg/dL.
- *LDL-C Threshold 2:* <130 mg/dL.

To determine compliance, use the *most recent* LDL-C level performed during the measurement year.

At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result. A documented range or threshold that indicates the most recent result meets the desired threshold meets criteria.

LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5)

If lipoprotein (a) is measured, this calculation is:

(LDL-C) = (total cholesterol) – (HDL) – (triglycerides/5) – 0.3[lipoprotein (a)]

These formulae are used when all levels are expressed in mg/dL and may not be used if triglycerides >400 mg/dL.

The Friedewald equation may not be used if a direct or calculated result is present in the medical record for the most recent LDL-C test.

Medical Attention for Nephropathy

A nephropathy screening test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this specification.*

Nephropathy Screening Test

At a minimum, documentation in medical record must include a note indicating the date when a urine microalbumin test was performed, and the result. Notation of the following in the medical record may be counted for urine microalbumin test:

- 24-hour urine for microalbumin.
- Timed urine for microalbumin.
- Spot urine for microalbumin.
- Urine for microalbumin/creatinine ratio.
- 24-hour urine for total protein.
- Random urine for protein/creatinine ratio.

Evidence of Nephropathy

Any of the following meet criteria for evidence of nephropathy:

- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.
- A positive urine macroalbumin test during the measurement year.
  - At a minimum, documentation in medical record must include a note indicating the date when the test was performed and a positive result. Notation of the following in the medical record may be counted for urine macroalbumin:
    - Positive urinalysis (random, spot or timed) for protein.
    - Positive urine (random, spot or timed) for protein.
    - Positive urine dipstick for protein.
    - Positive tablet reagent for urine protein.
    - Positive result for albuminuria.
    - Positive result for macroalbuminuria.

- Positive result for proteinuria.
- Positive result for gross proteinuria.

Note: *"Trace" urine macroalbumin test results are not considered numerator compliant.*

- Evidence of ACE inhibitor/ARB therapy during the measurement year.
  - At a minimum, documentation in medical record must include a note indicating that the patient received an ambulatory prescription for ACE inhibitors/ARBs within the measurement year.

BP Control The number of patients in the denominator whose BP is adequately controlled during the measurement year. "Adequately controlled" means that *both* the systolic and the diastolic pressure meet the desired thresholds.

Select the desired control threshold:

- *BP Threshold 1:* <140/80mm Hg.
- *BP Threshold 2:* <140/90mm Hg.

To determine if a patient's BP is adequately controlled, the representative BP must be identified. Follow the steps below.

Step 1 Identify the most recent reading noted during the measurement year. Do not include readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit that was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Taken the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the patient.

Step 2 Identify the lowest systolic and lowest diastolic reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic reading on that date as 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.

The patient is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Foot Examination Patients who received a foot exam (visual inspection with either a sensory exam or a pulse exam) during the measurement year. Documentation in the medical record must include a note indicating the date and result of the test.

Smoking Status and Cessation Advice or Treatment Patients with documentation of smoking status (e.g., nonsmoker, smoker, not known) ***and*** date of cessation counseling, ***or*** treatment during the measurement year if the patient smokes tobacco.

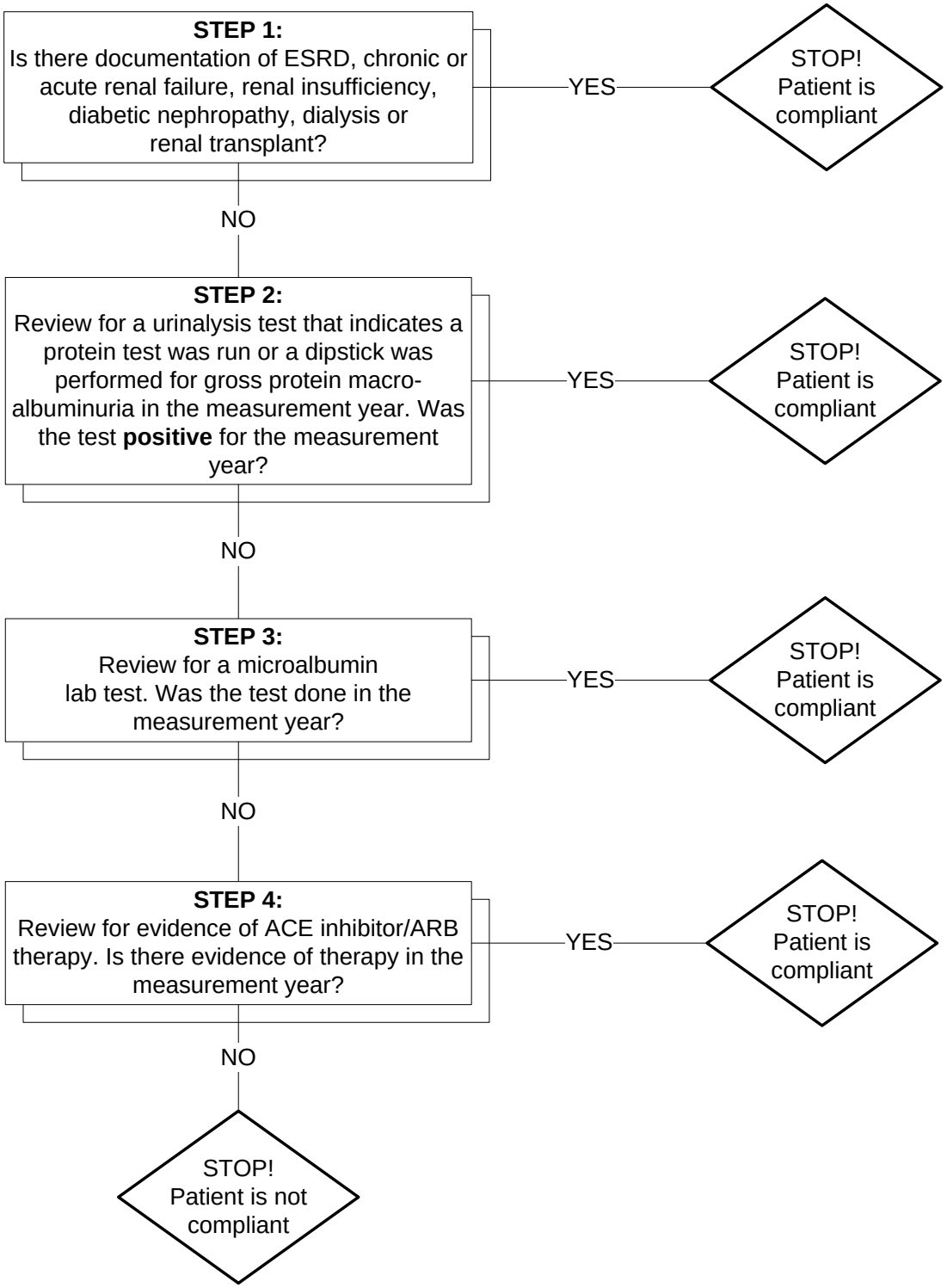
Documentation in the medical record must include a note indicating smoking status and the dates of required services.

The notation of smoker or nonsmoker status may be from a period prior to the measurement year, though once a patient is documented as a smoker, the element requires that there be annual counseling and treatment to encourage smoking cessation.

Note

- *The organization may select the data collection method (e.g., Electronic, Medical Record, Hybrid) at the indicator level, but the method for screening and control rates and for BP Control indicators must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because of the difficulty distinguishing between individuals who are legally blind but who require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *If a combination of electronic, medical record or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*

Monitoring for Diabetic Nephropathy



Use of Appropriate Medications for People With Asthma (ASM)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.
- Revised the definition of *Inhaler dispensing event*.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- Medical Record Specification for the numerator.
- Patient inclusion criteria for use by non-health plans.
- Require eligibility exclusion criteria.

Description

The percentage of patients 5–64 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-days prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date when the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

- *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
- *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaler dispensing event

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a patient received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the NDC list to determine if the medications are the same or different.

Injection dispensing event

Injections count as one dispensing event. Multiple dispensing events of the same or different medications are counted as separate dispensing events. The organization should allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Eligible Population

Age

5–64 years by December 31 of the measurement year. Report two age stratifications and a total rate:

- 5–11 years.
- 12–18 years.
- 19-50 years.
- 51-64 years.
- Total.

The total is the sum of the two age stratifications.

Patient inclusion criteria

Health plan. Continuous medical enrollment for the measurement year and the year prior to the measurement year and continuous pharmacy benefit enrollment for the measurement year, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, there may not be more than a 1-month gap in coverage. The patient must be enrolled as of December 31 of the measurement year.

Non-health plan. Any pharmacy claim or prescription written any time during the measurement year and the year prior to the measurement year.

Event/ diagnosis

Follow the steps below to identify the eligible population for the measure.

Step 1 Identify patients as having persistent asthma who met at least one of the following criteria during *both* the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (ED Value Set), with asthma as the principal diagnosis (Asthma Value Set).
- At least one acute inpatient discharge (Acute Inpatient Value Set), with asthma as the principal diagnosis (Asthma Value Set).
- At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service, with asthma as one of the listed diagnoses (Asthma Value Set) and at least two asthma medication dispensing events (Table ASM-C). Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events (Table ASM-C).

Table ASM-C: Asthma Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	• Triamcinolone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Long-acting, inhaled beta-2 agonists	• Aformoterol • Formoterol	• Salmeterol	
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline • Dyphylline	• Theophylline	
Short-acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol	• Pirbuterol	

Note: *NCQA posted a comprehensive list of medications and NDC codes to www.ncqa.org on November 1, 2013.*

Step 2 A patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Step 3: Exclusion Exclude patients who had any diagnosis from any of the following value sets, any time during the patient's history through December 31 of the measurement year:

- Emphysema Value Set.
- Other Emphysema Value Set.
- COPD Value Set.
- Obstructive Chronic Bronchitis Value Set.
- Chronic Respiratory Conditions Due To Fumes/Vapors Value Set.
- Cystic Fibrosis Value Set.
- Acute Respiratory Failure Value Set.

Electronic Specification

Denominator The eligible population.

Numerator Dispensed at least one prescription for an asthma controller medication during the measurement year (Table ASM-D).

Table ASM-D: Asthma Controller Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	• Triamcinolone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline

Medical Record Specification

Denominator A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerator At least one prescription for an asthma controller medication during the measurement year (Table ASM-D).

The medical record must include a note indicating the date when the prescription was written or filled.

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES FROM HEDIS 2013 TECHNICAL SPECIFICATIONS FOR PHYSICIAN MEASUREMENT

- Removed coding tables and replaced all coding table references with value set references.

MODIFICATIONS FROM HEDIS 2014 VOLUME 2 TECHNICAL SPECIFICATIONS

- The Hybrid Specification is located in the *General Guidelines;* retained the Medical Record Specification for the numerator.
- Patient inclusion criteria for use by non-health plans.
- Require eligibility exclusion criteria.

Description

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer .

Eligible Population

Age	51–75 years as of December 31 of the measurement year.
Patient inclusion criteria	**Health plan.** Continuous medical benefit enrollment for the measurement year and the year prior to the measurement year, with no more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. The patient must be enrolled on December 31 of the measurement year. **Non-health plan.** Any enrollment, claim or encounter transaction any time during the measurement year *and* the year prior to the measurement year.
Event/ diagnosis	None.
Exclusion	A diagnosis of colorectal cancer or total colectomy. Either of the following meet exclusion criteria. • Colorectal cancer (Colorectal Cancer Value Set). • Total colectomy (Total Colectomy Value Set). Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, using electronic data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by December 31 of the measurement year.

Electronic Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Any of the following meet criteria.

- Fecal occult blood test (FOBT Value Set) during the measurement year. For electronic data, assume that the required number of samples was returned.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

Medical Record Specification

Denominator A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the *General Guidelines:*

- *The Medical Record Method.*
- *The Hybrid Method.*
- *Sampling Methods.*

Numerator One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If it is unclear whether the documentation is part of the medical history, then the result or finding must be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine patient compliance.

- If the medical record does not indicate the type of test and there is no indication how many samples were returned, assume the required number was returned. The patient meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the patient would only meet the screening criteria if the number of samples specified is greater than or equal to three samples. If the number of samples is less than three, the patient does not meet the screening criteria for inclusion in the numerator.

- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the patient meets the screening criteria for inclusion in the numerator regardless of the number of returned samples.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The patient meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the patient meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the patient does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.