Comprehensive Diabetes Care — HbA1c Control

Topic	Explanation
Measure Type	Dynamic Star Measure
Description of the Measure	The percentage of members with diabetes who received at least one HbA1c screening during the measurement year and whose last HbA1C test for the measurement year was reported as ≤ 9.0%.
Eligible Population	Diabetic members age 18–75 years as of December 31 of the measurement year who were identified as diabetic using the following criteria: • Pharmacy data — Members who were dispensed insulin or hypoglycemic/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. – Regardless of indication, diabetic medications when used to treat a condition other than diabetes, will cause the member to fall into the diabetes denominator. Example is prescribing Victoza® for weight loss. **OR** • Claim encounter data — Members who had: – At least two outpatient settings including outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, ED visits, or non-acute inpatient encounters (without telehealth) on different dates of service with a diagnosis of diabetes, during the measurement year or year prior to the measurement year. Visit type need not be the same for the two visits. – At least one encounter in an acute inpatient setting, with diagnosis of diabetes, during the measurement year or the year prior to the measurement year. • Members are identified as diabetic by medical claims and pharmacy claims data as described above. – If you believe a member may be erroneously identified as a diabetic through submitted medical claims diagnosis coding, then document in the member's medical record that the member is not diabetic and identify claims that have been erroneously coded to replace and remove the incorrect diagnosis. Members will remain in the eligible population until claims data identifying them as diabetic are no longer in member claim history for measurement year and year prior. **Exclusions:** • Members dispensed Glucophage®/metformin when used as monotherapy are not included because it is used to treat conditions other than diabetes. • Members who did not have a diagnosis of diabetes, in any setting, and who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during measurement year or the year prior to the measurement year. • Diagnosis of polycystic ovarian syndrome during the measurement year or the year prior to the measurement year.

<table>
<tr><th>Topic</th><th>Explanation</th></tr>
<tr><td>Eligible Population
(continued)</td><td>

Advanced Illness and Frailty Exclusion: Members 66 years of age and older as of December 31st of the measurement year with frailty AND advanced illness diagnosis (exclusions applied based on processed claims data only).
Members receiving palliative care (as defined by the HEDIS value sets) during the measurement year.

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<tr><td>Compliant Member</td><td>The member is compliant if the most recent HbA1c level is ≤ 9.0% (during the measurement year).</td></tr>
<tr><td>How to Submit to Highmark Inc.</td><td>

Submit a zero charge claim (CPTII code) to report the value of the result:

<table>
<tr><th>HbA1c Level</th><th>CPT II Code</th></tr>
<tr><td>< 7%</td><td>3044F</td></tr>
<tr><td>≥ 7 to < 8%</td><td>3051F</td></tr>
<tr><td>≥ 8 to ≤ 9%</td><td>3052F</td></tr>
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When submitting a CPT II code for an HbA1c result, the date of service must match the date that the HbA1c test was performed.
Submit lab values either by normal claim processing, submission of NaviNet®* 1500 claim form, or Clinical Quality Feedback Loop. Allow at least 45 days for claims to process before submitting through the CQF Loop.

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<tr><td>Best Practices</td><td>

Identify non-compliant patients and outreach to scheduling lab testing during the measurement year.
Determine reason for non-compliance.

Value is > 9.0% (CPTII code 3046F).
Ensure that lab was ordered.
Lab was ordered but not drawn.
Lab was drawn but value not resulted via claim or Clinical Quality Feedback Loop (CQF).

Review chart note for exclusion — submit via CQF.
Review chart note to locate value — submit CPT II code via claim or value in CQF.
Assure HbA1c result and date of testing is recorded within the patient's EMR.
Ensure that practice submits the appropriate CPT II code to Highmark.
Implement care coordination to manage patients with > 9.0% levels. Review with member current diabetes plan, including adherence, diet, medication regimen, and exercise routine.
Provide ongoing outreach to non-compliant members.

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Topic	Explanation
Best Practices (continued)	• Review quarterly Suspicious Diagnosis Report for members meeting the eligibility for denominator inclusion by way of a questionable diagnosis, e.g., an inpatient diagnosis for diabetes, with no previous or follow-up diabetes diagnosis. • Utilize Highmark's predesigned member letter templates and other informational resources that are located on the Provider Resource Center. • Be proactive. Evaluate practice processes for opportunities to close gaps every time the patient is seen rather than reacting to gap closure reports.
Other	• Be aware that labs can be ordered by other providers (specialists, ED, Urgent Care, community screenings, etc.). **The value of the last HbA1c test completed in the measurement year is required for this measure.** Establish a process for obtaining lab results from lab processing facilities.

*NaviNet is a registered mark of NaviNet, Inc., a separate company that provides a secure, web-based portal between providers and health care insurance plans.

Key Additional Resources

Additional information can be found on the Provider Resource Center under Value-Based Reimbursement Programs Overview, in the Medicare Advantage Stars section.