

**2009**  
**Diabetes Recognition Program**  
**Requirements**



No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without the written permission of NCQA.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA encourages and promotes the use of the performance measures HEDIS comprises.

© 2009 by the National Committee for Quality Assurance

1100 13<sup>th</sup> Street, NW, Suite 1000

Washington, DC 20005

[www.ncqa.org](http://www.ncqa.org)

All rights reserved. Printed in the U.S.A.

NCQA Customer Support: 888-275-7585

Revised April 1, 2011

Effective August 1, 2009

## **Acknowledgments**

Dear Colleague:

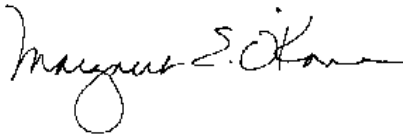
Thank you for your interest in the Diabetes Recognition Program (DRP). The DRP is designed to recognize clinicians and groups that deliver excellent care to people with diabetes. Program participation has grown steadily since the first release in 1997 and as of June 2009 over 7,300 clinicians across the country are recognized. Between 1999 and 2008, the percentage of patients with good cholesterol control treated by Recognized clinicians increased from 27 percent to 58 percent. Blood pressure control also had a notable improvement, increasing from 56 percent to 74 percent in the same time frame.

This program and others like it represent the future of the healthcare quality movement. Data about care provided at the practitioner-level yields information of enormous power for consumers, clinicians and employers. Consumers use the data to help them select a clinician; clinicians use reports about their performance to deliver better care and employers have shown support for financially rewarding recognized clinicians as a means of improving their employees' health.

This release of the program has been updated with guidance and feedback from NCQA's Diabetes Expert Panel and the Committee on Physician Programs. These committees have representation from both generalists and specialists with expertise in the medical management of diabetes. We thank both committees for their input.

Please visit the NCQA Web Site ([www.ncqa.org/recognition](http://www.ncqa.org/recognition)) for additional information about NCQA's recognition programs and to see the listing of Recognized clinicians who are at the forefront of quality in diabetes care. We look forward to your participation in this program and we welcome your comments and suggestions on how we might further advance our collective efforts to improve the quality of health care.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret E. O'Kane". The signature is fluid and cursive, with a large loop at the end of the last name.

Margaret E. O'Kane  
President  
NCQA

## Table of Contents

<b>Overview</b> .....	1
About DRP .....	1
Why Recognition?.....	1
DRP features .....	1
Benefits of Recognition.....	2
Development of DRP .....	2
Contributors.....	3
<b>Policies and Procedures</b> .....	4
Eligibility for Participation .....	4
Individual applicants .....	4
Group Practice applicants .....	4
What Recognition Requires .....	4
Table 1: DRP Adult Standards, Performance Criteria and Scoring.....	5
Table 2: DRP Pediatric Standards, Performance Criteria and Scoring .....	6
Readiness Evaluation .....	7
Readiness evaluation reports and results .....	7
Data Collection Tool .....	7
Applying for Recognition .....	8
The Evaluation Process .....	9
Audit.....	9
Computing results.....	9
Scoring an element.....	9
Preliminary results .....	9
Final decision and status .....	9
Reporting results.....	10
Certificates.....	10
Duration of Recognition .....	10
Use of NCQA Logo and Recognition Seals .....	10
Policies .....	11
Discretionary Survey .....	12
Change in status.....	12
Revoking Recognition.....	12
Mergers, Acquisitions and Consolidations .....	13
Revisions to Policies and Procedures.....	13
<b>Requirements for Diabetes Recognition</b>	
Clinical Measures	
CM 1: Glycated Hemoglobin (HbA1c) Control.....	15
CM 2: Blood Pressure Control.....	21
CM 3: Eye Examination .....	25
CM 4: Smoking Status and Cessation Advice or Treatment .....	29
CM 5: Lipid Control.....	31
CM 6: Nephropathy Assessment.....	32
CM 7: Foot Examination .....	35
<b>Appendices</b>	
Appendix 1—American Diabetes Association Standards of Care for Patients With Diabetes Mellitus	
Appendix 2—Patient Eligibility Criteria, Patient Identification and Sample Size Requirements	
Appendix 3—Optional Patient Survey	
Appendix 4—Glossary	

## Overview

National Committee for Quality Assurance (NCQA) is pleased to present the 2009 Diabetes Recognition Program (DRP) Requirements. The program recognizes clinicians and group practices for the delivery of quality ambulatory care to persons who have diabetes. To earn Recognition, applicants submit data documenting their delivery of care to patients with diabetes.

Program performance requirements were tested in a feasibility study that analyzed over 1,900 patient records in 29 specialty and general practice sites, leading to standards of performance for both adult and pediatric patients. These requirements were selected based on the scientific evidence supporting their relevancy to improved care for people with diabetes, as supported by the *ADA Standards of Medical Care for People with Diabetes Mellitus* (Appendix 1). Clinicians who demonstrate high-quality performance based on these key standards are expected to have fewer patients who develop the serious complications of diabetes, such as kidney disease, heart disease, stroke, amputations and blindness. NCQA publishes specifications for the DRP requirements, evaluates individual clinicians and group practices that voluntarily apply for Recognition and publicly recognizes those that meet the standards.

In 2008, results from ACCORD (Action to Control Cardiovascular Risk in Diabetes) and ADVANCE (Action in Diabetes and Vascular Disease) studies suggested that aggressive HbA1c management could cause patient safety issues in certain patients. As a result, a new HbA1c < 8% measure has been added to the DRP. While guidelines continue to recommend a general HbA1c goal of <7% for most adults with diabetes, goals should be individualized and less stringent glycemic goals are appropriate for certain patients. NCQA's expert panels also emphasized that significantly lowering the A1c (even if not reaching the target HbA1c) provides a benefit for patients and this benefit could be recognized by adding an HbA1c<8% measure.

### About DRP

#### Why Recognition?

Concern over the cost and quality of health care services in the United States is driving demand for development of initiatives using performance standards to encourage the delivery of high-quality health care. This demand and activity led the NCQA to create the Diabetes Recognition Program to encourage standardization of performance measurement for diabetes care and to acknowledge clinicians who demonstrate high levels of performance.

The NCQA believes that by maintaining this program and encouraging clinicians to achieve Recognition, care given to patients with diabetes will improve. The DRP's primary goal is to help recognized clinicians gain visibility for the high-quality care they are providing. Secondary goals are to support use of national performance standards, document the effectiveness of intervention programs and encourage implementation of effective intervention programs.

#### DRP features

DRP requirements were selected based on scientific evidence supporting their relevancy to improved care for people with diabetes. Clinicians who demonstrate high-quality performance based on these key requirements will help their patients avoid additional complications from diabetes.

The program focuses on care for people with diabetes, defined as the following categories of diagnoses.

- Diabetes Mellitus
- Diabetic Polyneuropathy
- Diabetic Retinopathy
- Diabetic Cataract

Individual clinicians and group practices voluntarily apply for Recognition by submitting information on their patients for the following requirements.

- Glycated Hemoglobin (HbA1c) Control
- Blood Pressure Control
- Eye Examination
- Smoking Status and Cessation Advice or Treatment
- Lipid Control
- Nephropathy Assessment
- Foot Examination

Clinicians who demonstrate high-quality performance based on these key requirements earn Recognition.

### **Benefits of Recognition**

Many national health plans and other sponsors of provider directories are including Recognition status in the information they offer to consumers.

- Clinicians can demonstrate to the public and to their professional peers that they meet requirements for providing quality diabetes care through a press release and by having their achievement posted on the ADA and NCQA Web sites.
- Clinicians can use Recognition status to demonstrate that they meet requirements for providing quality diabetes care when contracting with health organizations and purchasers of health services.
- .
- Clinicians can identify areas where their practice varies from the performance criteria and take steps to improve quality of care.
- Where applicable, clinicians who are recognized may also meet the requirements of other performance measurement entities and may establish eligibility for pay-for-performance bonuses or differential reimbursement from payers and health plans (e.g. Physician Quality Reporting Initiative (PQRI) or Bridges to Excellence).

### **Development of DRP**

Since its inception in 1997, the DRP has resulted in clinicians documenting their delivery of quality diabetes care in various ambulatory settings, including solo practices, group practices, hospital-based programs and managed care across the United States. The DRP performance requirements are consistent with NCQA's comprehensive diabetes care measures, part of the Health Care Effectiveness Data and Information Set (HEDIS<sup>®</sup>) Technical Specifications for Physician Measurement. Refer to Tables 1 and 2 for a list of DRP standards.

Individual clinicians and group practices voluntarily apply for Recognition based on a sample of self-abstracted medical records. To attain Recognition, clinicians must demonstrate that they meet specific performance thresholds for the DRP standards.

## Contributors

NCQA is grateful to the members of the NCQA Committee on Physician Programs and the Diabetes Expert Panel for their contributions to this program update.

### Committee on Physician Programs (CPP)

**Colleen Conry, MD**

American Academy of Family Physicians

**Francois de Brantes, MS, MBA**

Bridges to Excellence

**Joyce Dubow**

AARP Office of Policy and Strategy

**Sheldon Greenfield, MD**

University of California, Irvine

**Ron Harris, MD**

Geisinger Medical Group

**George Isham, MD, MS**

Health Partners

**Susan Nedza, MD, MBA**

American Medical Association

**Frank Opelka, MD, FACS**

American College of Surgeons

**Lee Partridge**

National Partnership for Women and Families

**Louise Probst, RN, MBA**

St. Louis Area Business Health Coalition

**Martin A. Quan, MD**

American Board of Family Medicine, Inc.

**Dick Salmon, MD, PhD**

CIGNA HealthCare

**Christine Sinsky, MD, FACP**

Medical Associates Clinic and Health Plans

**Samuel “Woody” Warburton, MD**

Duke University Medical Center

**William Charles Watters, III, MD**

American Association of Orthopedic Surgeons

**Janet Wright, MD, FACC**

American College of Cardiology

### Diabetes Expert Panel

**Richard M. Bergenstal, MD**

International Diabetes Center

**Lawrence Blonde, MD, FACP**

Ochsner Clinic

**Colleen Conry, MD**

American Academy of Family Physicians

**Sheldon Greenfield, MD**

University of California, Irvine

**Francine Ratner Kaufman, MD**

Children’s Hospital of Los Angeles

**Donald Stangler, MD**

Oxford Health Plans

## Policies and Procedures

### Eligibility for Participation

An individual physician, nurse practitioner, physician assistant or group practice (i.e., physicians, nurse practitioners, physician assistants) may apply for DRP Recognition. To be eligible, applicants must meet the following criteria.

- Applicants must hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), nurse practitioner (NP) or physician assistant
- Applicants must provide continuing care for people with diabetes
- Applicants must submit data documenting their delivery of care for a sample of patients with diabetes
- Applicants must use NCQA-supplied or approved materials to submit data electronically

<b>Individual applicants</b>	An individual applicant represents one physician or nurse practitioner or physician assistant who provides continuing care for patients with diabetes in any ambulatory setting. Individual applicants must have had face-to-face contact with and submit data on care delivered for a 12-month period to at least 25 different eligible patients with diabetes.
<b>Group Practice applicants</b>	A group practice represents clinicians (i.e., physicians, nurse practitioners, physician assistants) who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location.
<b>Documenting Delivery of Care</b>	Individual and group practice applicants must identify the patient sample using the DRP patient selection methodology described in Appendix 2 or through an alternative selection methodology approved in advance by NCQA.

### What Recognition Requires

To seek Recognition, applicants must submit information that demonstrates they meet specific performance criteria for the standards comprising the DRP. Tables 1 and 2 show the program requirements and the associated point values for scoring an applicant's performance.

The 2009 DRP requirements focus on clinical measures only. Unlike previous versions, this update does not include the optional patient survey measures. The patient survey is being re-evaluated for effectiveness and value to the overall program and an updated version is expected to be included in the next edition of the DRP requirements.

Applicants choose either the Adult or Pediatric evaluation option to seek Recognition.

*To achieve Recognition for the adult requirements, applicants must score at least 75 points out of a total of 100 points available.*

*To achieve Recognition for the pediatric requirements, applicants must score at least 30 out of a total of 40 points available.*

The participating individual applicant or lead clinician in a participating group practice is responsible for appropriate patient identification and data accuracy, but does not have to complete each task required for data submission on their own. One or more individuals within the applicant's practice may do the following:

- Serve as a liaison between the site and NCQA
- Identify eligible patients, following the DRP instructions, until the required sample size is met



- Abstract data from medical records and administrative data systems

**Table 1: DRP Adult Standards, Performance Criteria and Scoring**

<b>Clinical Measures (Required)</b>	<b>Criteria</b>	<b>Points</b>
HbA1c Poor Control >9.0%*	≤15% of patients in sample	12.0
HbA1c Control <8.0%	60% of patients in sample	8.0
HbA1c Control <7.0%	40% of patients in sample	5.0
Blood Pressure Control ≥ 140/90 mm Hg*	≤35% of patients in sample	15.0
Blood Pressure Control <130/80 mm Hg	25% of patients in sample	10.0
Eye Examination	60% of patients in sample	10.0
Smoking Status and Cessation Advice or Treatment	80% of patients in sample	10.0
LDL Control ≥130 mg/dl*	≤37% of patients in sample	10.0
LDL Control <100 mg/dl	36% of patients in sample	10.0
Nephropathy Assessment	80% of patients in sample	5.0
Foot Examination	80% of patients in sample	5.0
<b>Total Points</b>		<b>100.0</b>
<b>Points Needed to Achieve Recognition</b>		<b>75.0</b>
<b>Patient Survey Measures (Optional)</b>	<b>Criteria</b>	<b>Points</b>
Self-Management Education	90% of patients in sample	10.0
Medical Nutrition Therapy	90% of patients in sample	10.0
Self-Monitoring of Blood Glucose:		
• Non-Insulin Treated Patients	50% of patients in sample	1.0
• Insulin Treated Patients	97% of patients in sample	4.0
Patient Satisfaction With:		
• Diabetes Care Overall	58% of patients in sample	1.0
• Answers to Diabetes Questions	56% of patients in sample	1.0
• Emergency Access	46% of patients in sample	1.0
• Explanation of Laboratory Results	50% of patients in sample	1.0
• Courtesy/Personal Manner	77% of patients in sample	1.0
<b>Total Points (including Required Clinical Measures)</b>		<b>130.0</b>
<b>Points Needed to Achieve Recognition</b>		<b>95.0</b>

\*Denotes poor control

Adult Age Requirement: Patients must be between the ages of 18 and 75.

**Table 2: DRP Pediatric Standards, Performance Criteria and Scoring**

<b>Clinical Measures (Required)</b>	<b>Criteria</b>	<b>Points</b>
HbA1c Test	93% of patients in sample	10.0
HbA1c Control <8.0%	34% of patients in sample	2.5
HbA1c Control <10.0%	84% of patients in sample	2.5
Blood Pressure Test	97% of patients in sample	10.0
Diastolic Blood Pressure Control ≤90 mm Hg	96% of patients in sample	0.0
Eye Exam	40% of patients in sample	10.0
Smoking Status and Cessation Advice or Treatment	76% of patients in sample	5.0
<b>Total Points</b>		<b>40.0</b>
<b>Points To Achieve Recognition</b>		<b>30.0</b>
<b>Patient Survey Measures (Optional)</b>	<b>Criteria</b>	<b>Points</b>
Self-Management Education	90% of patients in sample	10.0
Medical Nutrition Therapy	90% of patients in sample	10.0
Self-Monitoring of Blood Glucose: <ul style="list-style-type: none"> <li>• Non-Insulin Treated Patients</li> <li>• Insulin Treated Patients</li> </ul>	50% of patients in sample 97% of patients in sample	10.0
Patient Satisfaction With: <ul style="list-style-type: none"> <li>• Diabetes Care Overall</li> <li>• Answers to Diabetes Questions</li> <li>• Emergency Access</li> <li>• Explanation of Laboratory Results</li> <li>• Courtesy/Personal Manner</li> </ul>	58% of patients in sample 56% of patients in sample 46% of patients in sample 50% of patients in sample 77% of patients in sample	1.0 1.0 1.0 1.0 1.0
<b>Total Points (including Required Clinical Measures)</b>		<b>75.0</b>
<b>Points to Achieve Recognition</b>		<b>55.0</b>

Pediatric Age Requirement: Patients must be between the ages of 5 and 17.

## Readiness Evaluation and Business Associate Agreement

Applicants can use the DRP Data Collection Tool (DCT) to perform a readiness evaluation using the DRP performance criteria without submitting an official application to NCQA. However, prior to entering any patient level data into the DCT which may include Protected Health Information (as defined in C.F.R. Section 160.103) that is subject to protection under the federal privacy regulations (the "Privacy Regulations") and the federal security regulations (the "Security Regulations") established at 45 C.F.R. Parts 160 and 164, as amended from time to time, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 11-5 and its implementing regulations ("ARRA"), applicant must agree to the terms of the Business Associate Agreement (the "Business Associate Agreement") contained in the DCT and submit their electronic signature on the Business Associate Agreement to NCQA. Once the applicant has submitted the Business Associate Agreement to NCQA, the applicant can perform the readiness evaluation at their own pace and estimate their scores on the performance requirements to identify strengths and opportunities for improvement in their care delivery.

While an applicant conducts the readiness evaluation, NCQA has access to the applicant's data, but does not review the data. All information is secure and confidential and for the sole use of the applicant during readiness evaluation.

Following the readiness evaluation, clinicians or group practices may elect to apply for Recognition by submitting data to NCQA using the DCT. Applicants must make sure they are using a current version of the DCT. This submission begins the formal survey process by NCQA.

### Readiness evaluation reports and results

Reports and numeric results generated or otherwise received from the access and use of the DCT are preliminary and do not constitute a final score or Recognition decision from NCQA. DRP reports and numeric results are not final until NCQA makes the final Recognition decision.

A clinician or group practice may only use the reports and numeric results for internal purposes to examine, review and otherwise analyze its operations; and may not use, disclose, represent or otherwise communicate reports or numeric results to any third party for any other purpose. The applicant may not represent that it is recognized based on reports or numeric results without a final DRP decision on the reports and numeric results.

### Data Collection Tool (DCT)

The following activities are prohibited in connection with the DCT.

- No individual or entity may purchase from NCQA or use the DCT, regardless of its source, to evaluate another individual clinician or group practice against DRP requirements. This prohibition does not apply to individuals or entities that are assisting the clinician or group practice with its readiness evaluation and preparation for applying for Recognition under the DRP.
- The individual clinician or group practice may not use the DCT to evaluate another clinician or group practice against DRP requirements.
- The individual clinician or group practice may not allow a third party to use the DCT it has purchased to evaluate another individual or group practice against DRP requirements.

## Applying for Recognition

- Step 1 Order Free Application Packet.** Call NCQA Customer Support at 888-275-7585 or visit [www.ncqa.org/drp](http://www.ncqa.org/drp).
- Step 2 Purchase the Data Collection Tool (DCT) and Requirements.** The DCT is a Web-based program that enables you to collect and submit your data for evaluation. It is available to purchase online or through NCQA Customer Support.
- Step 3 Complete Business Associate Agreement.** The 2009 Business Associate Agreement must be signed electronically or downloaded and mailed to NCQA.
- Step 4 Identify Patient Sample, Enter Data into the DCT, and Evaluate Your Performance.** Abstract data for your patient sample (selected following the instructions provided in Appendix 2) and enter it into the DCT. The DCT automatically scores your performance and lets you know if you meet the Diabetes Recognition Program requirements.
- Step 5 Mail in Signed and Dated Recognition Review Agreement and Application Fees.** Review and mail in two signed copies of the NCQA Recognition Review Agreement.
- Step 6 Submit Data.** NCQA is notified electronically once the application information and data are completed online and submitted.
- Step 7 NCQA Review and Notification.** NCQA evaluates your data and, when complete, sends you notification of the results within 60 days. If you pass, your name and your practice are then posted to the NCQA Web site as Recognized.

## The Evaluation Process

DRP staff review and assess the completeness of application data and other materials and notify you if additional information is required. Completed applications are processed for compliance with performance criteria, and applicant-specific results for all DRP measures are determined.

NCQA makes its final scoring decision within 60 days of receiving a complete application that includes appropriate fees, signed Recognition Review Agreement, attestations and DRP data collection tool.

**Audit** NCQA reserves the right to complete an audit of your application for Recognition. NCQA conducts audits of five percent of applicants, either on the basis of specific criteria or randomly, prior to making a final decision about whether the applicant has met DRP requirements. DRP audits are completed by mail.

NCQA will notify you if your application is chosen for audit and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. Failure to pass an audit results in no further consideration for the DRP for six months from the date of submission of the DCT.

**Computing results** NCQA makes a decision on whether to award Recognition on the basis of applicants' overall performance against the criteria. Decisions are based on a numeric score. The scoring for applicants' performance is built into the DCT and is described below.

**Scoring an element** NCQA evaluates performance against each applicable element within a standard, and assigns a scoring level to the element of Met (element has been Met = 100%) or Not Met (element *has not* been met = 0%). The DCT multiplies the scoring level for the element by the element's points to determine the element score.

**Example** For *CM 1: Glycated Hemoglobin (HbA1c) Control*, there is a total of 12 points for Element A (HbA1c Poor Control >9.0%). If 15 percent or less of the patient sample has this level of HbA1c poor control, then the clinician has met the criteria for the element and receives 100 percent of the 12 points. If the applicant's performance on Element A is more than 15 percent of the patient sample with this level of HbA1c poor control, then the applicant receives 0 points.

**Preliminary results** Preliminary results of DRP scoring decisions are provided in the DCT.

**Final decision and status** NCQA completes reviews and makes Recognition status determinations.

The scoring threshold is shown in the table below. For the DRP, there are two statuses: *Recognized* and *Not Recognized*.

DRP Status	Adult Patient Sample	Pediatric Patient Sample
Recognized	75–100 points	30–40 points
Not Recognized	0–74 points	0–29 points

**Recognized** indicates the applicant meets or exceeds the criteria acceptable for the requirements and that three-year Recognition has been achieved.

**Not Recognized** indicates that the applicant does not meet the criteria acceptable for the requirements. NCQA does not release names of individual clinicians or group practices who do not achieve Recognition.

<b>Reporting results:</b>	As part of its mission to identify and promote quality, DRP reports results to the following:
<b>...to the individual clinician or group practice</b>	NCQA provides you with your final DRP status.
<b>...to the public</b>	Individual clinicians and group practices that achieve Recognition are added to the list of DRP-Recognized clinicians on the NCQA ( <a href="http://www.ncqa.org/DRP">www.ncqa.org/DRP</a> ) Web site. DRP only reports the names of individual clinicians and group practices that achieve Recognition. DRP also provides the list of recognized clinicians to health plans and others for use in provider directories.
	Individual clinicians or group practices who achieve Recognition receive <i>Guidelines for Marketing and Advertising Recognition</i> , which provides guidelines and sample language to illustrate how recognition may be advertised or communicated. The guidelines are also available at <a href="http://www.ncqa.org/marketing.aspx">www.ncqa.org/marketing.aspx</a> . All marketing and advertising materials, including press releases must be submitted to <a href="mailto:marketing@ncqa.org">marketing@ncqa.org</a> for review and approval. If you are in doubt about compliance with advertising guidelines, contact NCQA at 202-955-5194 or e-mail <a href="mailto:marketing@ncqa.org">marketing@ncqa.org</a> .
	Recognized clinicians and group practices can ask NCQA Communications to prepare a press release about their Recognition to be distributed by NCQA. To receive this benefit, complete and submit the information requested in the media kit sent with your Recognition notification letter or contact <a href="mailto:communications@ncqa.org">communications@ncqa.org</a> .
<b>Certificates</b>	NCQA issues an official certificate of Recognition to clinicians and group practices who achieve recognition.
<b>Duration of Recognition</b>	Recognition status remains in effect for three years from the date of the award. You will receive a notice with renewal information six months prior to the end of your three-year Recognition period.

### Use of NCQA Logo and Recognition Seals

<b>Use of NCQA logo</b>	Without NCQA's consent, the use and reproduction of NCQA's logo is strictly prohibited. Individuals and organizations that have received NCQA Accreditation, Certification, Recognition or other distinction are prohibited from using the NCQA logo in any marketing and advertising materials, including e-mails, Web sites and other Web-based applications.  If you want to provide a link to NCQA's Web site, use <a href="http://www.ncqa.org">www.ncqa.org</a> .
<b>Recognition seals</b>	Only individual clinicians and group practices that have received notification from NCQA about their Recognition status may display and use seals for marketing and advertising purposes. Refer to guidelines for marketing and advertising recognition for instructions on using program seals. Seals can be downloaded from the NCQA Web site at <a href="http://www.ncqa.org/marketing.aspx">www.ncqa.org/marketing.aspx</a> .
<b>Link to NCQA Web site</b>	NCQA encourages clinicians and group practices that have received Recognition to use the NCQA Web site as a resource. You may provide a link to the NCQA Web site. E-mail <a href="mailto:marketing@ncqa.org">marketing@ncqa.org</a> if you have questions.

## Policies

By submitting the application to NCQA the applicant agrees to:

- Release to NCQA the information that NCQA deems pertinent.
- Hold NCQA, its employees, directors, officers, contractors, surveyors and agents harmless from any claims the clinician or group practice may have relating to the DRP Recognition review, all review and reconsideration processes, any determinations made by NCQA relating thereto and publication of the DRP status of individual applicants and aggregated performance results for all applicants.
- Abide by the terms of the signed Recognition Review Agreement, the Guidelines for Marketing and Advertising the Diabetes Recognition Program, these procedures and instructions for Recognition and all other published NCQA policies, procedures and rules.
- Notify NCQA of the final determination by a state or federal agency with respect to an investigation, request for corrective action, imposition of sanctions or changes in licensure or qualification status. Such notification must be sent to NCQA no later than 30 days after the clinician or group practice receives notice of such action.
- Accept all DRP determinations regarding the applicant's status.
- Agree that NCQA makes no representations to others about the quality of applicant's care and that the provision of health care advice is solely the responsibility of the clinician or group practice or a third party.
- Agree that Recognition by NCQA does not constitute a warranty or any other representation by NCQA to any third parties (including, but not limited to, employers, consumers or payers) regarding the quality or nature of the health-related services provided or arranged for by the clinician or group practice.
- Agree that any information created as a part of the DRP evaluation of the clinician or group practice by NCQA shall be kept confidential, except as indicated in the section *Reporting results*, above, unless otherwise agreed to by NCQA.
- Agree that Recognition is not a replacement for a clinician or group practice evaluation, assessment and monitoring of its own services and programs.
- Not misrepresent its DRP status (including, but not limited to, the scope and meaning of such status as defined herein) or suggest that it has received DRP Recognition when such representation is not accurate.
- Notify NCQA of any material changes in the structure or operation of the individual clinician or group practice, including merger, acquisition or consolidation in accordance with these policies within 30 days.
- Notify NCQA of any change in address and agree that recognition is not transferable to another office location.

If NCQA identifies a deficiency in a clinician or group practice's operations that poses a threat to patient or public health or safety, it may notify the applicable regulatory agencies, following notice to the individual clinician or the chief executive officer or clinical director of the group practice.



## Discretionary Survey

**Discretionary Surveys** are specifically targeted to address issues related to an individual clinician or group practice's continuing to meet DRP requirements in effect at the time the Recognition was received. The scope and content of the survey are determined by NCQA. Discretionary Surveys, which are rare, may consist of an offsite document review and an onsite review or a teleconference.

NCQA may, at its discretion, review an individual or group practice during the period that Recognition is in effect. The purpose of such a review is to validate the appropriateness of an existing Recognition decision. The decision to initiate a Discretionary Survey is made by NCQA's Vice President for Product Delivery and General Counsel. NCQA conducts an onsite review within 60 calendar days of its notification of intent to conduct a Discretionary Survey.

**Change in status** When NCQA notifies the individual clinician or group practice of its intent to conduct a Discretionary Survey, it removes the party from the DRP Web site. NCQA conducts the review against requirements that were in effect at the time of the clinician or group practice achieving Recognition from DRP. Following completion of the Discretionary Survey, DRP will either restore the listing on the DRP Web site or will not. The Discretionary Survey does not extend the length of the existing Recognition.

The clinician or group practice has the right to a Reconsideration of the determination should its Recognition status change as a result of the Discretionary Survey.

### Revoking Recognition

NCQA may revoke a Recognition decision if any of the following happens.

- The clinician or group practice submits false data or does not collect data according to the procedures outlined in this manual, as determined by documented discussion with the clinician or group practice or audit of application data and materials
- The clinician or group practice misrepresents the credentials of any of its clinicians
- The clinician or group practice misrepresents its Recognition status
- The clinician or any of the group practice's clinicians experience a suspension or revocation of licensure
- The clinician or group practice has been placed in receivership or rehabilitation and is being liquidated
- State, federal or other duly authorized regulatory or judicial action restricts or limits the clinician or group practice's operations
- Results of a Discretionary Survey do not validate the Recognition decision
- NCQA Identifies a significant threat to patient safety or care

When communicating with patients, third-party payers, health plans and others, clinicians or group practices who receive DRP Recognition may represent themselves as meeting NCQA DRP requirements; however, they may not characterize themselves as "NCQA-Approved" or "NCQA-Endorsed." The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

### **Mergers, Acquisitions and Consolidations (MAC)**

Recognized clinicians and group practices must report to NCQA any merger, acquisition or consolidation (MAC) activity in which they are involved. Based on the circumstances, NCQA makes a determination about the need for additional information and the need for a MAC Survey.

### **Revisions to Policies and Procedures**

At its sole discretion, NCQA may amend any Recognition policy and procedure. Notice of and information about modifications or amendments are sent to individuals or group practices that have purchased this manual 30 calendar days before the effective date of the modifications or amendments.

# **Requirements for Diabetes Recognition**

## CM 1: Glycated Hemoglobin (HbA1c) Control

Patients with diabetes are in glycemic control.

### Intent

The clinician or group practice works with patients to control their glycated hemoglobin and avoid further complications of diabetes.

### Element A: HbA1c Poor Control

12.0 points

No more than 15 percent of patients in the sample have an HbA1c >9 percent.

Scoring	Met (100%)	Not Met (0%)
	No more than 15% of patients have an HbA1c value >9.0%	>15% of patients have an HbA1c value >9.0%

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** American Diabetes Association (ADA) guidelines recommend a treatment goal of 7 percent or lower for HbA1c for adult patients with diabetes. An HbA1c greater than 9 percent is considered poor control and calls for treatment to improve glycemic control. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample whose most recent HbA1c result during the 12-month abstraction period is greater than 9 percent with date and value of the measurement documented. Patients are included in the numerator in the following circumstances:

- The result of the most recent HbA1c test during the 12-month abstraction period is >9%.
- The most recent HbA1c result is missing.
- An HbA1c test was not done during the 12-month abstraction period.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation of HbA1c results.

- Fructosamine
- Hgb
- Hemoglobin
- Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”

**Element B: HbA1c Control <8.0%** **8.0 points**

At least 60 percent of patients in the sample have an HbA1c <8 percent.

Scoring	Met (100%)	Unmet (0%)
	At least 60% of patients have an HbA1c value of <8%	>60% of patients have an HbA1c value of <8%

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** The American Diabetes Association's position, reaffirmed in their January 2009 paper integrating the results of the ACCORD<sup>1</sup>, ADVANCE<sup>2</sup>, VADT and UKPDS follow-up studies<sup>3</sup>, recommends a general A1C goal of <7% for most adults with diabetes. The ADA states that A1C targets should be individualized and less stringent glycemic goals are appropriate for certain patients. NCQA's expert panels also emphasized that significantly lowering the A1C (even if not reaching the target A1C) provides a benefit for patients and this benefit could be recognized by adding an A1c<8% measure. The A1c <8% measure should not be construed as encouraging the use of less stringent goals than <7% for patients other than those suggested by ADA guidelines and informed clinical judgment. An A1C >9% remains as a marker of poor control. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample whose most recent HbA1c result during the 12-month abstraction period was less than 8 percent, with date and value of the measurement documented.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation of HbA1c results.

- Fructosamine
- Hgb
- Hemoglobin
- Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”

<sup>1</sup> The Action to Control Cardiovascular Risk in Diabetes Study Group. 2008. Effects of intensive glucose lowering in type 2 diabetes. *New England Journal of Medicine* 358:2545-59.  
<sup>2</sup> The Advance Collaborative Group. (2008). Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. *New England Journal of Medicine* 358:2560-72.  
<sup>3</sup> Karalliedde, Janaka and Luigi Gnudi. 2008. ACCORD and ADVANCE: A tale of two studies on the merits of glycemic control in type 2 diabetic patients. *Nephrology Dialysis Transplant* 23:1796-98.

**Element C: HbA1c Control <7.0%** **5.0 points**

At least 40 percent of patients in the sample have an HbA1c <7 percent.

	<b>Met (100%)</b>	<b>Unmet (0%)</b>
<b>Scoring</b>	At least 40% of patients have an HbA1c value of <7%	>40% of patients have an HbA1c value of <7%

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** ADA guidelines recommend a treatment goal of less than 7 percent for HbA1c for most adult patients with diabetes. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample whose most recent HbA1c result during the 12-month abstraction period was less than 7 percent, with date and value of the measurement documented.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation of HbA1c results.

- Fructosamine
- Hgb
- Hemoglobin
- Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”

## CM 1: Glycated Hemoglobin (HbA1c) Testing and Control— Pediatric Patients

Patients with diabetes are in glycemic control.

### Intent

The clinician or group practice works with patients to control their glycated hemoglobin and avoid further complications of diabetes.

### Element A: HbA1c Test

10.0 points

At least 93 percent of patients in the sample have an HbA1c test during the abstraction period.

Scoring	Met (100%)	Not Met (0%)
	At least 93% of patients have an HbA1c test with documentation of date and result	<93% of patients have an HbA1c test with documentation of date and result
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines indicate that glycemic control in children is critical and recommend routine HbA1c testing for patients with diabetes. Refer to Appendix 1 for the risk criteria and guidelines.	
<b>Numerator</b>	The number of patients in the sample who have documentation of date and result for the most recent HbA1c test during the 12-month abstraction period	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	
<b>Exclusions</b>	The following is not acceptable documentation of HbA1c testing. <ul style="list-style-type: none"> <li>• Fructosamine</li> <li>• Hgb</li> <li>• Hemoglobin</li> <li>• Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”</li> </ul>	

**Element B: HbA1c <8%**

**2.5 points**

At least 34 percent of patients in the sample have an HbA1c <8 percent.

	<b>Met (100%)</b>	<b>Not Met (0%)</b>
<b>Scoring</b>	At least 34% of patients have an HbA1c value of <8%	<34% of patients have an HbA1c value of <8%
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines indicate that glycemic control is critical and recommend routine HbA1c testing for pediatric patients with diabetes. Refer to Appendix 1 for the guidelines.	
<b>Numerator</b>	The number of patients in the sample whose most recent HbA1c result during the 12-month abstraction period is less than 8 percent, with date and value of the test documented.	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	
<b>Exclusions</b>	The following is not acceptable documentation of HbA1c results. <ul style="list-style-type: none"> <li>• Fructosamine</li> <li>• Hgb</li> <li>• Hemoglobin</li> <li>• Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”</li> </ul>	

**Element C: HbA1c <10**

**2.5 points**

At least 84 percent of patients in the sample have an HbA1c <10 percent.

	<b>Met (100%)</b>	<b>Not Met (0%)</b>
<b>Scoring</b>	≥84% of patients in the sample have an HbA1c value of <10%	<84% of patients in the sample have an HbA1c value of <10%
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines indicate that glycemic control is critical and recommend routine HbA1c testing for pediatric patients with diabetes. Refer to Appendix 1 for the guidelines.	
<b>Numerator</b>	The number of patients in the sample whose most recent HbA1c result during the 12-month abstraction is less than 10 percent, with date and value of the test documented.	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	



**Exclusions**

The following is not acceptable documentation of HbA1c results.

- Fructosamine
- Hgb
- Hemoglobin
- Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c”

## CM 2: Blood Pressure Control

Patients with diabetes have their blood pressure in control.

### Intent

The clinician or group practice works with patients to control their blood pressure and avoid further complications of diabetes.

### Element A: Blood Pressure 140/90

15.0 points

No more than 35 percent of patients in the sample have blood pressure  $\geq 140/90$  mm Hg.

	Met (100%)	Not Met (0%)
<b>Scoring</b>	No more than 35% of patients have blood pressure $\geq 140/90$ mm Hg	>35% of patients have blood pressure $\geq 140/90$ mm Hg
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines recommend treatment for adult patients with diabetes who have blood pressure $\geq 140/90$ mm Hg. Refer to Appendix 1 for the guidelines. Patients exceeding this target are considered to be in poor control.	
<b>Numerator</b>	<p>The number of patients in the sample whose most recent blood pressure result during the 12-month abstraction period is <math>\geq 140/90</math> mm Hg with date and value of the measurement documented. Patients are included in the numerator in the following circumstances:</p> <ul style="list-style-type: none"> <li>• The result of either the systolic or diastolic measurement meets or exceeds the threshold of 140/90 mm Hg.</li> <li>• The most recent blood pressure measurement result is missing.</li> <li>• A blood pressure measurement was not done during the 12-month abstraction period.</li> </ul>	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	
<b>Exclusions</b>	<p>The following is not acceptable documentation of blood pressure.</p> <ul style="list-style-type: none"> <li>• Patient self-report</li> <li>• Use of terms “VS within normal limits” or “Vital signs normal” without recording the numeric result</li> </ul>	

**Element B: Blood Pressure 130/80**

**10.0 points**

At least 25 percent of patients in the sample have blood pressure <130/80 mm Hg.

<b>Scoring</b>	<b>Met (100%)</b>	<b>Not Met (0%)</b>
	At least 25% of patients have blood pressure <130/80 mm Hg	<25% of patients have blood pressure <130/80 mm Hg

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** ADA guidelines recommend blood pressure <130/80 mm Hg as a treatment goal for adult patients with diabetes. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample whose most recent blood pressure result during the 12-month abstraction period is <130/80 mm Hg, with date and value of the measurement documented. Both the systolic and diastolic readings must be below the threshold of 130/80 mmHg to count in the numerator.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation of blood pressure.

- Patient self-report
- Use of terms “VS within normal limits” or “Vital signs normal” without recording the numeric result

## CM 2: Blood Pressure Control—Pediatric Patients

Patients with diabetes have their blood pressure in control.

### Intent

The clinician or group practice works with patients to control their blood pressure and avoid further complications of diabetes.

### Element A: Blood Pressure Test

10.0 points

At least 97 percent of patients in the sample have a blood pressure test within the 12-month abstraction period.

	Met (100%)	Not Met (0%)
<b>Scoring</b>	At least 97% of patients have a blood pressure test with documentation of date and result	<97% of patients have a blood pressure test with documentation of date and result

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** ADA guidelines indicate that control of hypertension in children is critical and recommend routine testing of blood pressure. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample with documentation of date and diastolic result for the most recent blood pressure test during the 12-month abstraction period.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation of blood pressure.

- Patient self-report
- Use of terms “VS within normal limits” or “Vital signs normal” without recording the numeric result

**Element B: Diastolic Blood Pressure <90 0.0 points**

At least 96% of patients in the sample have diastolic blood pressure ≤90 mm Hg.

	<b>Met (100%)</b>	<b>Not Met (0%)</b>
<b>Scoring</b>	At least 96% of patients have diastolic blood pressure ≤90 mm Hg	<96% of patients have diastolic blood pressure ≤90 mm Hg
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines recommend a diastolic blood pressure of ≤90 mm Hg for pediatric patients with diabetes. Refer to Appendix 1 for the guidelines.	
<b>Numerator</b>	The number of patients in the sample whose most recent diastolic blood pressure during the 12-month abstraction period is ≤90 mm Hg.	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	
<b>Exclusions</b>	The following is not acceptable documentation of blood pressure.	
	<ul style="list-style-type: none"> <li>• Patient self-report</li> <li>• Use of terms “VS within normal limits” or “Vital signs normal” without recording the numeric result</li> </ul>	

## CM 3: Eye Examination

Patients with diabetes have a recent screening for diabetic retinal disease.

### Intent

The clinician or group practice screens patients for retinopathy, a complication of diabetes.

### Element A: Retinal Screening

10.0 points

At least 60 percent of patients in the sample have retinal screening with documentation of date.

Scoring	Met (100%)	Not Met (0%)
	At least 60% of patients have retinal screening with documentation of date	<60% of patients have retinal screening with documentation of date
Data source	Records or files	
Scope of review	Each clinician or group practice seeking Recognition	
Explanation	<p>ADA guidelines recommend that patients with diabetes have an annual dilated retinal examination or retinal photograph by an ophthalmologist or optometrist. Refer to Appendix 1 for the guidelines.</p> <p><i>No exam documented during abstraction period.</i> If an eye exam is not performed during the abstraction period, an exam performed in the 12 months prior to the abstraction period is acceptable if the patient showed no evidence of retinopathy.</p>	
Numerator	<p>The number of patients in the sample with date and result of a retinal or dilated eye examination documented:</p> <ul style="list-style-type: none"> <li>• During the 12-month abstraction period or</li> <li>• During the 12 months prior to the abstraction period if the patient showed no evidence of retinopathy</li> </ul> <p><i>Codes to identify eye exams</i></p> <ul style="list-style-type: none"> <li>• <u>CPT Codes:</u> 67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245</li> <li>• <u>ICD-9-CM Codes:</u> 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16</li> </ul>	
Denominator	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	

**Exclusions**

The following is not acceptable documentation for eye examination.

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

## CM 3: Eye Examination—Pediatric Patients

Patients with diabetes have a recent screening for diabetic retinal disease.

### Intent

The clinician or group practice screens patients for retinopathy, a complication of diabetes.

### Element A: Retinal Screening

10.0 points

At least 40 percent of patients in the sample have retinal screening with documentation of date.

Scoring	Met (100%)	Not Met (0%)
	At least 40% of patients have retinal screening with documentation of date	<40% of patients have retinal screening with documentation of date

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** ADA guidelines recommend a dilated retinal examination or retinal photograph every year for all patients who have had diabetes for five years or more. Refer to Appendix 1 for the guidelines.

*No exam documented during abstraction period.* If an eye exam is not performed during the abstraction period, an exam performed in the 12 months prior to the abstraction period is acceptable if the patient showed no evidence of retinopathy.

**Numerator** The number of patients in the sample with date and result of a retinal or dilated eye examination documented:

- During the 12-month abstraction period or
- During the 12 months prior to the abstraction period if the patient showed no evidence of retinopathy

*Codes to Identify Eye Exams*

- CPT Codes: 67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
- ICD-9-CM Codes: 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.



**Exclusions**

The following is not acceptable documentation for eye examination.

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

## CM 4: Smoking Status and Cessation Advice or Treatment

Patients with diabetes discuss smoking status with their clinician and cessation or treatment, if they are a smoker.

### Intent

The clinician or group practice determines the smoking status of patients and encourages cessation or treatment for those who are smokers.

### Element A: Smoking Status and Cessation Advice

5.0 points

At least 80 percent of patients in the sample have documentation of smoking status and cessation counseling or treatment during the abstraction period if they are a smoker.

	Met (100%)	Not Met (0%)
<b>Scoring</b>	At least 80% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker	<80% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines recommend that patients with diabetes do not smoke and that those who do smoke receive cessation counseling or treatment.	
<b>Numerator</b>	The number of patients in the sample with documentation of smoking status and if the patient currently smokes, documentation of the date of cessation counseling or treatment during the 12-month abstraction period.	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	

## CM 4: Smoking Status and Cessation Advice or Treatment— Pediatric Patients

Patients with diabetes discuss smoking status with their clinician and cessation or treatment, if they are a smoker.

### Intent

The clinician or group practice determines the smoking status of patients and encourages cessation or treatment for those who are smokers.

### Element A: Smoking Status and Cessation Advice

5.0 points

At least 76 percent of patients in the sample have documentation of smoking status and cessation counseling or treatment during the abstraction period if they are a smoker.

	Met (100%)	Not Met (0%)
<b>Scoring</b>	At least 76% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker	<76% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines recommend that patients with diabetes do not smoke and that those who do smoke receive cessation counseling or treatment.	
<b>Numerator</b>	The number of patients in the sample with documentation of smoking status and if the patient currently smokes, documentation of the date of cessation counseling or treatment during the 12-month abstraction period.	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	

## CM 5: Lipid Control

Patients with diabetes have their low-density lipoprotein in control.

### Intent

The clinician or group practice evaluates patient lipid levels to prompt treatment, work with patients to reach or maintain LDL control and help patients avoid further complications of diabetes.

### Element A: LDL $\geq$ 130

10 points

No more than 37 percent of patients in the sample have an LDL  $\geq$ 130 mg/dl.

Scoring	Met (100%)	Not Met (0%)
	No more than 37% of patients have an LDL $\geq$ 130 mg/dl	>37% of patients have an LDL $\geq$ 130 mg/dl
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	ADA guidelines recommend treatment for patients with diabetes with an LDL >130 mg/dl, with an LDL of <100 mg/dl as a treatment goal. Refer to Appendix 1 for the guidelines.	
<b>Numerator</b>	<p>The number of patients in the sample whose most recent LDL result during the 12-month abstraction period is <math>\geq</math>130 mg/dl, with date and value documented. Patients are counted in the numerator in the following circumstances:</p> <ul style="list-style-type: none"> <li>• The result of the most recent LDL test during the 12-month abstraction period is <math>\geq</math>130 mg/dl.</li> <li>• The most recent LDL result is missing.</li> <li>• An LDL test was not done during the 12-month abstraction period.</li> </ul>	
<b>Denominator</b>	The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.	
<b>Exclusions</b>	<p>The following is not acceptable documentation of LDL.</p> <ul style="list-style-type: none"> <li>• Patient self-report or self-monitoring</li> <li>• LDL-to-HDL ratio</li> </ul>	

**Element B: LDL <100** **10 points**

At least 36 percent of patients in the sample have an LDL of <100 mg/dl.

	<b>Met (100%)</b>	<b>Not Met (0%)</b>
<b>Scoring</b>	At least 36% of patients have an LDL <100 mg/dl	<36% of patients have an LDL <100 mg/dl

<b>Data source</b>	Records or files
<b>Scope of review</b>	Each clinician or group practice seeking Recognition
<b>Explanation</b>	American Diabetes Association guidelines recommend a treatment goal of less than 100 mg/dl for patients with diabetes. Refer to Appendix 1 for the guidelines.
<b>Numerator</b>	The number of patients in the sample with an LDL completed during the 12-month abstraction period with date and a LDL value of less than 100 mg/dl documented.
<b>Denominator</b>	The total patient sample, based on and the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.
<b>Exclusions</b>	The following is not acceptable documentation of LDL. <ul style="list-style-type: none"> <li>• Patient self-report or self-monitoring</li> <li>• LDL-to-HDL ratio</li> </ul>

## CM 6: Nephropathy Assessment

Patients with diabetes have a recent nephropathy assessment.

### Intent

The clinician or group practice assesses patients for nephropathy to help them avoid progression of their diabetes to end stage renal disease.

### Element A: Nephropathy Assessment

10.0 points

At least 80 percent of patients in the sample have documentation of assessment for nephropathy during the abstraction period.

Scoring	Met (100%)	Not Met (0%)
	At least 80% of patients have microalbuminuria testing or positive urinalysis or medical attention for nephropathy with documentation of date	<80% of patients have microalbuminuria testing or positive urinalysis or medical attention for nephropathy with documentation of date
<b>Data source</b>	Records or files	
<b>Scope of review</b>	Each clinician or group practice seeking Recognition	
<b>Explanation</b>	<p>ADA guidelines recommend routine urinalysis and microalbuminuria testing for adult patients with diabetes to detect nephropathy. Refer to Appendix 1 for the guidelines.</p> <p>Documentation of a nephropathy assessment must include one of the methods below.</p> <ul style="list-style-type: none"> <li>• Microalbuminuria test (including a microalbumin/creatinine ratio, a 24-hour urine for microalbuminuria, timed urine for microalbuminuria or spot urine for microalbuminuria)</li> <li>• Positive urinalysis for protein (microalbuminuria) test</li> <li>• Medical attention for nephropathy, including any of the following:                             <ul style="list-style-type: none"> <li>— any nephrologist visit or</li> <li>— documentation of arterionephrosclerosis, azotemia, chronic renal disorder, chronic renal insufficiency, diabetic kidney disease, diabetic nephropathy, diffuse diabetic or nodular glomerulosclerosis, end stage renal disease (ESRD), Kimmelstiel-Wilson lesion, microalbuminuria, papillary necrosis, proteinuria, renal insufficiency, acute renal failure, and renal dialysis, or</li> <li>— evidence of ACE inhibitor/ARB therapy.</li> </ul> </li> </ul>	
<b>Numerator</b>	The number of patients in the sample with microalbuminuria testing, positive urinalysis for protein or medical attention for nephropathy during the 12-month abstraction period, with date of the assessment documented.	

*Codes to Identify Microalbuminuria Test*

- CPT Codes: 82042, 82043, 82044, 83518, 84156, 84160\* 84166\*, 84165\*

\* Codes marked by an asterisk (\*) must be accompanied by CPT code 81050 to indicate the test was urinalysis.

*Codes to Identify Macroalbuminuria Test*

- CPT Codes: 81000–81003\*, 81005\* Codes marked by an asterisk (\*) must be confirmed as a positive result for a macroalbuminuria test identified through administrative data.

*Codes to Identify Diagnosis of or Treatment for Nephropathy*

- CPT Codes: 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512
- ICD-9-CM Codes: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0,
- V Codes: V42.0, V45.1, V56
- Revenue Codes: 0367, 080x, 082x-085x, 088x
- DRGs: 316, 317

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following is not acceptable documentation.

- Patient self-report or self-monitoring

## CM 7: Foot Examination

Patients with diabetes have a recent foot examination.

### Intent

The clinician or group practice identifies patients who have or who are at high risk for foot problems and screen for the presence of clinically significant neuropathy or vascular disease.

### Element A: Foot Examination

5.0 points

At least 80 percent of patients in the sample have documentation of a foot examination with shoes and socks removed during the abstraction period.

	Met (100%)	Not Met (0%)
<b>Scoring</b>	At least 80% of patients have a foot examination with documentation of date	<80% of patients have a foot examination with documentation of date

**Data source** Records or files

**Scope of review** Each clinician or group practice seeking Recognition

**Explanation** American Diabetes Association guidelines recommend foot examination, with shoes and socks removed, for adult patients with diabetes to avoid lower extremity amputations, foot ulcers and other foot problems. Refer to Appendix 1 for the guidelines.

**Numerator** The number of patients in the sample with a foot examination during the 12-month abstraction period with date of the exam documented.

**Denominator** The total patient sample, based on the number of clinicians seeking Recognition. Patient eligibility criteria are provided in Appendix 2.

**Exclusions** The following are not acceptable documentation of a foot exam.

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



**APPENDIX 1**  
**ADA STANDARDS OF CARE FOR PATIENTS**  
**WITH DIABETES MELLITUS**

*ADA Standards of Medical Care in Diabetes-2009, Diabetes Care, Volume 32, Supplement 1, January 2009.*



## APPENDIX 2

### PATIENT ELIGIBILITY CRITERIA, PATIENT SELECTION AND SAMPLE SIZE REQUIREMENTS

#### Patient Eligibility

##### Criteria for eligibility

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

1. Is between 5 and 75 years of age.
  - Pediatric patients (5–17 years of age)
  - Adult patients (18–75 years of age)
2. Has had a diagnosis of diabetes (as defined in Table 1 below) or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics (as defined in Table 2 below) for at least 12 months.
3. Has been under the care of the applicant clinician or group practice for at least 12 months. This is defined by documentation of a face-to-face visit for diabetes care between the clinician and the patient that *predates* the most recent visit by at least 12 months.

#### DRP Coding Conventions

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

**Table 1. Codes and Descriptions to Identify a Patient With a Diagnosis of Diabetes**

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

**Table 1. Codes and Descriptions to Identify a Patient With a Diagnosis of Diabetes**  
(continued)

Diagnosis Codes			
ICD-9 Code and Criteria	Definition	Synonyms	Exclusions
<b>362.0 Diabetic retinopathy</b>	Any mention of a diagnosis of diabetic retinopathy in the medical record	Diabetic eye changes: <ul style="list-style-type: none"> <li>• Proliferative diabetic retinopathy</li> <li>• New vessels on the disc (NVD)               <ul style="list-style-type: none"> <li>– New vessels elsewhere in iris or retina</li> <li>– Preretinal or vitreous hemorrhage</li> <li>– Fibrosis rubeosis diabetic retinal changes</li> <li>– Macular lesion</li> <li>– Background retinopathy</li> </ul> </li> <li>• Preproliferative retinopathy               <ul style="list-style-type: none"> <li>– Venous beading/looping</li> <li>– Large retinal blot hemorrhages</li> <li>– Multiple cotton wool spots</li> <li>– Multi-preintoretinal microvascular abnormalities</li> <li>– Diabetic macular edema</li> </ul> </li> <li>• Nonproliferative diabetic retinopathy               <ul style="list-style-type: none"> <li>– Microaneurysms</li> <li>– Blot hemorrhage</li> <li>– Hard exudates</li> <li>– 1-2 soft exudates</li> </ul> </li> </ul>	Rule out or R/O diabetic retinopathy
<b>366.41 Diabetic cataract</b>	Any mention of a diagnosis of diabetic cataract in the medical record	NA	Patients with congenital cataract, senile cataract, traumatic cataract, cataract secondary to ocular disorders or after-cataract

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

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

## Patient Identification

**Overview** To begin, applicants must establish a “start date” and identify eligible patients. Once the patient sample is identified, applicants abstract the required data and complete the DRP Data Collection Tool (DCT). **Applicants must submit the completed DCT to NCQA within 180 calendar days of the start date.**

**Guidelines for Identifying the Patient Sample**

The DRP patient sample:

1. Is identified using the DRP patient selection methodology or an alternative selection methodology approved in advance by NCQA.
2. Is selected across the entire patient population regardless of the patient's method of payment (e.g., health plan, Medicare, Medicaid, employer, self-pay or other payment mechanism.)
3. Includes all eligible patients (i.e., eligible patients must not be excluded from the sample).

### Patient Selection Methodology

Action	Process	Example												
<b>Step 1 - Establish a Start Date</b>	Applicants must first select a <b>start date</b> . The start date is the date applicants begin to identify eligible patients for the sample.	An applicant establishes May 1, 2009 as the start date.												
<b>Step 2 - Identify eligible patients moving backwards from the start date</b>	<p>On each day moving backward from the start date, consecutively evaluate the eligibility of each patient seen for an office visit.</p> <p>Patients meeting the 3 eligibility criteria are selected for the sample until the required sample size is met. (Refer to Sample Size Requirements in the next section.)</p> <p>Applicants may not go back more than 12 months from the start date to select patients.</p> <p>Applicants may review patient medical records or set up a query of the administrative data system for patients who meet the eligibility requirements and who have had a visit with a clinician prior to the selected start date.</p> <p>Administrative data sources include medical encounters, medical claims and ambulatory pharmacy records.</p>	<p>Moving consecutively <i>backward</i> from 5/1/09, an applicant identifies 25 eligible patients who had office visits on the following dates:</p> <table border="1"> <thead> <tr> <th>Visit Date Identified as Eligible</th> <th>Number of Patients identified</th> </tr> </thead> <tbody> <tr> <td>4/30/10</td> <td>3</td> </tr> <tr> <td>4/29/10</td> <td>6</td> </tr> <tr> <td>4/22/10</td> <td>5</td> </tr> <tr> <td>3/26/10</td> <td>7</td> </tr> <tr> <td>3/04/10</td> <td>4</td> </tr> </tbody> </table>	Visit Date Identified as Eligible	Number of Patients identified	4/30/10	3	4/29/10	6	4/22/10	5	3/26/10	7	3/04/10	4
Visit Date Identified as Eligible	Number of Patients identified													
4/30/10	3													
4/29/10	6													
4/22/10	5													
3/26/10	7													
3/04/10	4													

	<p>In some practices or organizations, a separate diabetes patient database exists for this purpose.</p> <p>Determination of patient eligibility may be based on an administrative data system, but must be supported by documentation found in the medical record.</p>																			
<p><b>Step 3 - Determine Abstraction Period</b></p>	<p>When moving backward from the start date, the visit date that a patient is identified as eligible establishes that patient's 12-month abstraction period.</p> <p>After determining each patient's 12-month abstraction period, abstract data for care completed for each patient in the sample.</p>	<p>12-month abstraction periods for the 25 patients identified :</p> <table border="1" data-bbox="932 579 1419 1045"> <thead> <tr> <th>Visit Date Identified as Eligible</th> <th>12-month Abstraction Period</th> <th>Number of Patients</th> </tr> </thead> <tbody> <tr> <td>4/30/10</td> <td>4/30/10 – 4/29/09</td> <td>3</td> </tr> <tr> <td>4/29/10</td> <td>4/29/10 – 4/28/09</td> <td>6</td> </tr> <tr> <td>4/22/10</td> <td>4/22/10 – 4/21/09</td> <td>5</td> </tr> <tr> <td>3/26/10</td> <td>3/26/10 – 3/25/09</td> <td>7</td> </tr> <tr> <td>3/04/10</td> <td>3/04/10 – 3/03/09</td> <td>4</td> </tr> </tbody> </table>	Visit Date Identified as Eligible	12-month Abstraction Period	Number of Patients	4/30/10	4/30/10 – 4/29/09	3	4/29/10	4/29/10 – 4/28/09	6	4/22/10	4/22/10 – 4/21/09	5	3/26/10	3/26/10 – 3/25/09	7	3/04/10	3/04/10 – 3/03/09	4
Visit Date Identified as Eligible	12-month Abstraction Period	Number of Patients																		
4/30/10	4/30/10 – 4/29/09	3																		
4/29/10	4/29/10 – 4/28/09	6																		
4/22/10	4/22/10 – 4/21/09	5																		
3/26/10	3/26/10 – 3/25/09	7																		
3/04/10	3/04/10 – 3/03/09	4																		
<p><b>Step 4 – Complete the DCT</b></p>	<p>Completion of the DCT requires the following:</p> <ul style="list-style-type: none"> <li>• Review of consecutive patients seen based on a start date.</li> <li>• Response to eligibility criteria questions to confirm eligibility for the patient sample.</li> <li>• Entry of clinical data for the DRP measures for eligible patients.</li> </ul> <p>After completion of data entry in the DCT, results on the Preliminary Results screen helps applicants determine if they are ready to apply for recognition.</p>																			

**Sample Size Requirements**

**Overview**

Applicants must determine the required patient sample size, as outlined below.

**Individual clinician applicants**

An individual applicant represents one clinician (physician, nurse practitioner or physician assistant) practicing in any ambulatory setting who provides continuing care for patients with diabetes. Individual clinician applicants must have had face-to-face contact with and submit data on care delivered for a 12-month period to at least 25 different eligible patients with diabetes.<sup>4</sup> The sample must be identified using the DRP patient selection methodology described in the section above.

**Group Practice applicants**

Group practice applicants represent 2 or more clinicians (i.e., physicians, nurse practitioners, physician assistants) who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location.

<b>Number of Clinicians in Practice</b>	<b>Sample Size (per site)</b>
2	50
3	75
4	100
5	125
6	150
7	175
8	200
9 or more	200*

\* An alternate sampling methodology is available for group practices of 9 or more. Contact DRP staff for details via email at [DRP@NCQA.ORG](mailto:DRP@NCQA.ORG).





---

## **APPENDIX 3**

### **STANDARDS FOR THE OPTIONAL PATIENT SURVEY**

The patient survey is temporarily suspended for the 2009 DRP Standards. The survey will be examined for effectiveness and value during the overall program re-evaluation scheduled for 2009-2010.

## APPENDIX 4

### GLOSSARY

<b>abstraction time frame</b>	The relevant 12-month period for each eligible patient from which the applicant abstracts required data for an application for Recognition.
<b>applicant</b>	One clinician or a group of individuals affiliated with a practice who are applying for Recognition.
<b>business associate</b>	A person or organization that on behalf of a covered entity (health plan, health care clearinghouse or health care provider) or organized health care arrangement (which includes a covered entity) performs or assists in the performance of (but not in the capacity of a workforce member) functions or activities involving the use or disclosure of individually identifiable health information from the covered entity or organized health care arrangement.
<b>element</b>	The scoreable component of a standard. A standard comprises elements, which can be separately assessed and which provide details about performance expectations.
<b>evidence based</b>	Clinical practice guidelines that are known to be effective in improving health outcome. Effectiveness is determined by scientific evidence, or, in the absence of scientific evidence, professional standards, or, in the absence of professional standards, expert opinion.
<b>records or files</b>	Actual patient medical records, patient registry data or administrative files that document an action taken.
<b>registry</b>	A searchable list of patient data that the practice actively uses to assist in patient care.
<b>sample</b>	A statistically valid representation of the applicant's patient population, which is identified using the instructions for identification of eligible patients for the Recognition program.
<b>standard</b>	A description of clinical outcome and performance expectation.
<b>start date</b>	The self-selected date that an applicant for Recognition uses to begin identification of eligible patients for its sample of patients. Going forward or backward from this date, each patient seen must be consecutively assessed for eligibility for the patient sample.