2023 CMS Web Interface

DM-2 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Measure Steward: NCQA

Contents

INTRODUCTION

There are a total of 10 individual measures included in the 2023 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The measure documents are being provided to allow organizations an opportunity to better understand each of the 10 individual measures included in the 2023 CMS Web Interface data submission method. Each measure document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the 2023 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

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

IMPROVEMENT NOTATION:
Lower score indicates better quality

INITIAL POPULATION:
Patients 18 - 75 years of age with diabetes with a visit during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:

Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period
OR
Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period
OR
Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period

Table: Dementia Exclusion Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Galantamine Rivastigmine
Miscellaneous central nervous system agents	Memantine

DENOMINATOR EXCEPTIONS:
None

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

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITIONS:
None

GUIDANCE:
Patient is numerator compliant if most recent HbA1c level is > 9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. Do not include HbA1c

levels reported by the patient. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR

  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR

  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country or did not have Fee-for-Service (FFS) Medicare as their primary payer select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance ***Patient Confirmation***

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, *the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.*

If "Not Qualified for Sample" is selected and the date is unknown, *you may enter the last date of the measurement period (i.e., 12/31/2023).*

The Measurement Period is defined *as January 1 – December 31, 2023.*

NOTE:

- ***In Hospice****: Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- ***Moved out of Country:*** *Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- ***Deceased:*** *Select this option if the patient died during the measurement period*
- ***Non-FFS Medicare:*** *Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient has an active diagnosis of diabetes during the measurement period OR an active diagnosis of diabetes during the year prior.
  - If the patient has an active diagnosis of diabetes in the medical record select "Yes"

  OR

  - If you are unable to confirm the diagnosis of diabetes for the patient select "Not Confirmed - Diagnosis"

  OR

  - If there is a denominator exclusion for patient disqualification from the measure select "Denominator Exclusion"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Denominator, Denominator Exclusion and Denominator Exclusion Drug codes can be found in the 2023 CMS Web Interface DM Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance ***Denominator***

If "Not Confirmed – Diagnosis" or "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected, *the patient will be "skipped" and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.*

Other CMS Approved Reason *is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.*

To submit a skip request, follow these steps:

1. *After confirming the beneficiary for the sample, scroll to the measure you would like to skip.*
2. *When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.*
3. *In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary's condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.*

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

The intent of the exclusion *for individuals age 66 and older residing in long-term care facilities, including nursing homes is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measure's process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life*

expectancy. To assess the age for exclusions, the patient's age on the date of the encounter should be used.

NOTE:

- ***Active Diagnosis** is defined as a diagnosis that is either on the patient's problem list, a diagnosis code description listed on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the measurement period*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient had one or more HbA1c tests performed during the measurement period
  - If the patient had one or more HbA1c tests documented select "Yes"

    IF YES

    - Record the most recent date the blood was drawn for the HbA1c in **MM/DD/YYYY** format

    AND

    - Record the most recent HbA1c value OR if test was performed but result is not documented, record "0" (zero) value

  OR

  - If the patient did not have one or more HbA1c tests documented select "No"

Numerator codes can be found in the 2023 CMS Web Interface DM Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

***If "No" is selected**, do not provide Date Drawn and HbA1c Value.*

NOTE:

- ***Synonyms for HbA1c testing may include** Glycohemoglobin A1c, HbA1c, Hemoglobin A1c, HgbA1c, A1c*
- ***Use the following priority ranking:***
  Lab report draw date
  Lab report date
  Flow sheet documentation
  Practitioner notes
  Other documentation
- ***Ranges and thresholds do not meet criteria** for this indicator. A distinct numeric result is required for numerator compliance*
- ***At a minimum**, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. If the day is unknown enter 01 i.e. 05/01/2023*
- ***Documentation of most recent HbA1c result** may be completed during a telehealth encounter*
- ***HbA1c finger stick tests** administered by a healthcare provider at the point of care are allowed*

DOCUMENTATION REQUIREMENTS

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

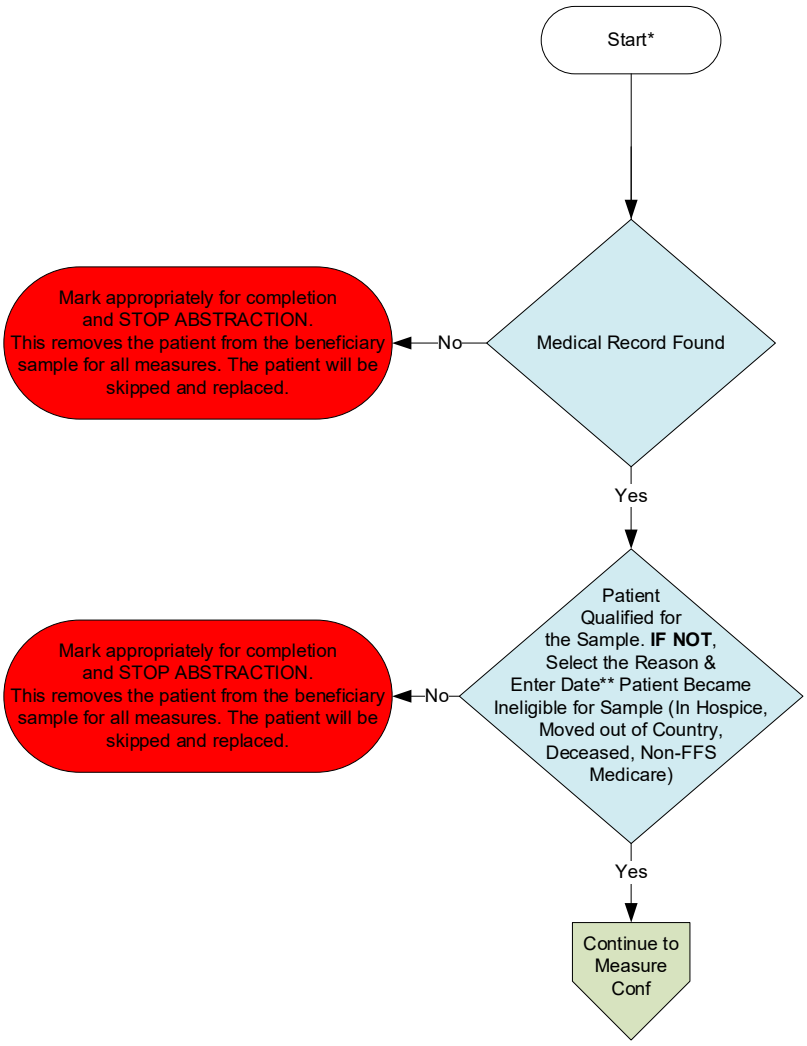
Claims data cannot be used to confirm a diagnosis (DM, HTN, etc.) used for sampling purposes as claims are the original source of the diagnosis sampling. Claims data can be used to prepare the CMS Web Interface Excel, but supporting medical record documentation will be required to substantiate what is reported in the event of an audit.

Appendix I: Performance Calculation Flow

Disclaimer: *Refer to the measure submission document for specific coding and instructions to submit this measure.*

Patient Confirmation Flow

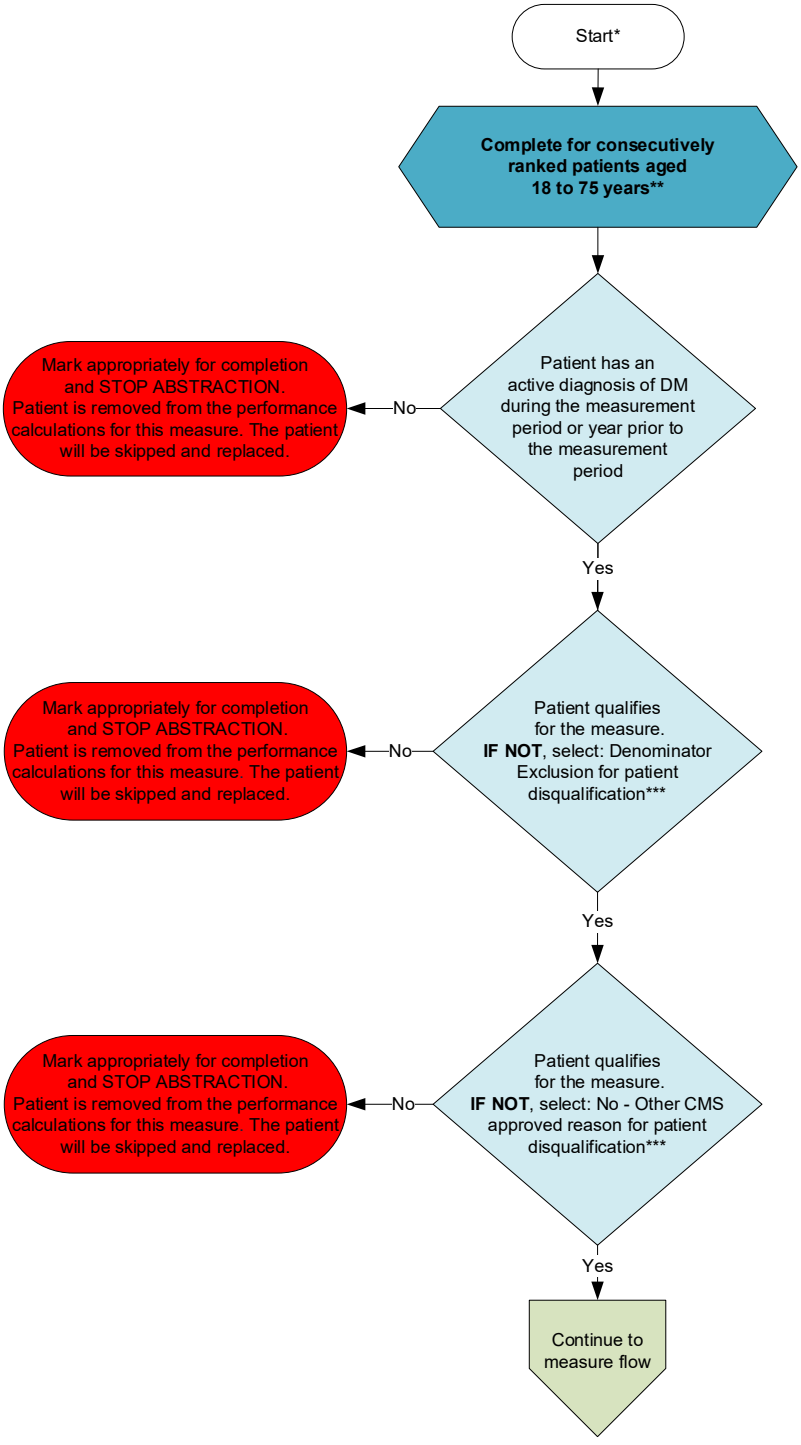
Confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.



*See the posted measure submission document for specific coding and instructions to submit this measure.
** If date is unknown, enter 12/31/2023

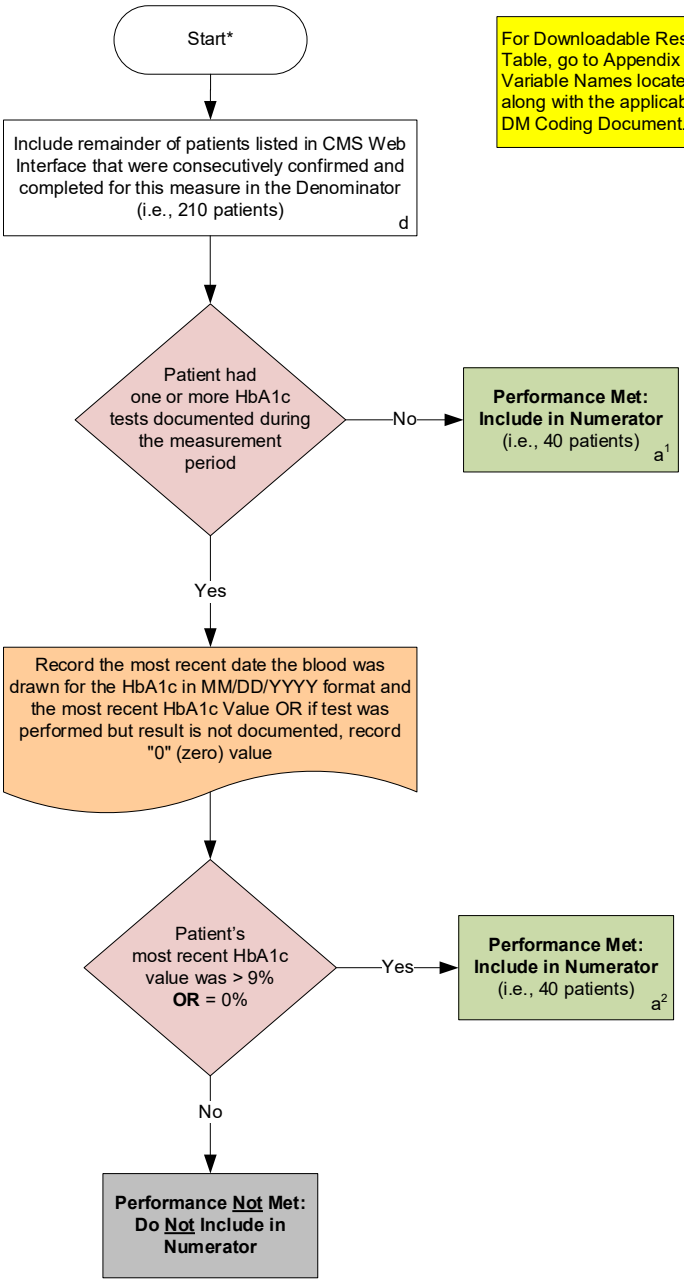
Measure Confirmation Flow for DM-2

Specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved measure Reason" should be evaluated for each measure where the patient appears.



*See the posted measure submission document for specific coding and instructions to submit this measure.
**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the DM-2 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
***"Other CMS Approved Reason" may only be selected if the CMS Web Interface updated the resolution of the skip request to be "Approved".

Measure Flow for DM-2



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a^1=40 patients+a^2=40 patients) = 80 patients = **38.10%**

Denominator (d=210 patients) = 210 patients

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE
FOR THIS MEASURE, A LOWER RATE INDICATES BETTER PERFORMANCE/CONTROL

*See the posted measure submission document for specific coding and instructions to submit this measure.

Patient Confirmation Flow

For 2023, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.

1. Start Patient Confirmation Flow.
2. Check to determine if Medical Record can be found.
    a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, Medical Record found, continue processing.
3. Check to determine if Patient Qualified for the sample.
    a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2023) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for DM-2.

Measure Confirmation Flow for DM-2

For 2023, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.

1. Start Measure Confirmation Flow for DM-2. Complete for consecutively ranked patients aged 18 to 75 years. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the DM-2 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient has an active diagnosis of diabetes during the measurement period OR an active diagnosis of diabetes the year prior to the measurement period

    a. If no, the patient does not have an active diagnosis of diabetes during the measurement period OR an active diagnosis of diabetes the year prior to the measurement period, mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing

    b. If yes, the patient does have an active diagnosis of diabetes during the measurement period OR an active diagnosis of diabetes the year prior to the measurement period, continue processing.

3. Check to determine if the patient qualifies for the measure (Denominator Exclusion).

    a. If no, the patient does not qualify for the measure select: Denominator Exclusion for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing.

    b. If yes, the patient does qualify for the measure, continue processing.

4. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason)

    a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. "Other CMS Approved Reason" may only be selected if the CMS Web Interface updated the resolution of the skip request to be "Approved". Stop processing.

    b. If yes, the patient does qualify for the measure, continue to DM-2 measure flow.

Measure Flow for DM-2

For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the DM Coding Document.

1. Start processing 2023 DM-2 (NQF 0059) Flow for the patients that qualified for the sample in the Patient Confirmation Flow and the Measure Confirmation Flow for DM-2. **Note:** Include remainder of patients listed in the CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (eligible denominator, i.e. 210 patients).

2. Check to determine if the patient had one or more HbA1c tests performed during the measurement period.

    a. If no, patient did not have one or more HbA1c tests performed during the measurement period, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a¹' category (numerator, i.e. 40 patients). Stop processing.

    b. If yes, the patient had one or more HbA1c tests performed during the measurement period, record the most recent date the blood was drawn for the HbA1c in MM/DD/YYYY format and the most recent HbA1c value OR if test was performed but result is not documented, record "0" (zero) value. Continue processing.

3. Check to determine if the patient's most recent HbA1c value was greater than nine percent or equal to zero percent.

    a. If no, patient's most recent HbA1c value was not greater than nine percent or equal to zero percent, performance is not met and the patient should not be included in the numerator. Stop processing.

    b. If yes, patient's most recent HbA1c value was greater than nine percent or equal to zero percent, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a²' category (numerator, i.e. 40 patients). Stop processing.

Sample Calculation:

Performance Rate equals Performance Met (a^1 equals 40 patients plus a^2 equals 40 patients) divided by Denominator (d equals 210 patients). All equals 80 patients divided by 210 patients. All equals 38.10 percent.

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE
FOR THIS MEASURE, A LOWER RATE INDICATES BETTER PERFORMANCE/CONTROL

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2023 CMS Web Interface DM Coding Document.

***DM-2: Diabetes: Hemoglobin A1c Poor Control (>9%)**

Measure Component/ Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator/Denominator Codes	Diabetes Diagnosis	DM_DX_CODE	I9 I10 SNM
Denominator Exclusion/Denominator Exclusion Codes/Denominator Exclusion Drug Codes	Exclusion/66 years and older residing longer than 90 consecutive days	HOUSING_STATUS_CODE AND NURSING_HOME_CODE	LN AND SNM AND residing longer than 90 consecutive days
	Exclusion/66 years and older with at least one claim/encounter for frailty AND dispensed dementia medication	FRAILTY_DEVICE_CODE OR MEDICAL_EQUIPMENT_CODE AND FRAILTY_DEVICE_CODE OR FRAILTY_DIAGNOSIS_CODE OR FRAILTY_ENCOUNTER_CODE OR FRAILTY_SYMPTOM_CODE AND DEMENTIA_DRUG_CODE	SNM OR LN AND SNM OR I10 SNM OR C4 HCPCS OR I10 SNM AND RxNorm (Drug EX=Y)

Measure Component/ Excel Tab	Data Element	Variable Name	Coding System(s)
	Exclusion/66 years and older with at least one claim/encounter for frailty AND EITHER **one** acute inpatient encounter with advanced illness OR **two** outpatient, observation, ED or nonacute inpatient encounters on different dates with advanced illness	FRAILTY_DEVICE_CODE OR MEDICAL_EQUIPMENT_CODE AND FRAILTY_DEVICE_CODE OR FRAILTY_DIAGNOSIS_CODE OR FRAILTY_ENCOUNTER_CODE OR FRAILTY_SYMPTOM_CODE AND EITHER ACUTE_INPATIENT_CODE WITH ADVANCED_ILLNESS_CODE OR OUTPATIENT_CODE OR EMERGENCY_DEPT_CODE OR NONACUTE_INPATIENT_CODE WITH ADVANCED_ILLNESS_CODE	SNM OR LN AND SNM OR I10 SNM OR C4 HCPCS OR I10 SNM AND EITHER C4 SNM WITH I10 SNM OR C4 HCPCS SNM OR C4 SNM OR C4 SNM WITH I10 SNM
Numerator/Numerator Codes	Hemoglobin A1c	A1C_CODE	LN WITH most recent A1c date and value

**For EHR mapping, the coding within the DM-2 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

Diabetes is the seventh leading cause of death in the United States. In 2017, diabetes affected approximately 34 million Americans (10.5 percent of the U.S. population) and killed approximately 84,000 people (Centers for Disease Control and Prevention [CDC] , 2020a). Diabetes is a long-lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly (CDC, 2020b). People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney damage, amputation of feet or legs, and premature death (CDC, 2021).

In 2017, diabetes cost the U.S. an estimated $327 billion: $237 billion in direct medical costs and $90 billion in reduced productivity. This is a 34 percent increase from the estimated $245 billion spent on diabetes in 2012 (American Diabetes Association [ADA], 2018).

Controlling A1c blood levels helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) (ADA, 2021).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2021):

- An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) without significant hypocalcemia is appropriate. (Level of evidence: A)

- On the basis of provider judgement and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable and even beneficial, if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Level of evidence: C)

- Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients with limited life expectancy, where the harms of treatment are greater than the benefits. (Level of evidence: B)

Appendix IV: Use Notices, Copyrights, and Disclaimers

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