



Complete Summary

TITLE

Comprehensive diabetes care: percentage of members with diabetes mellitus (type 1 and 2) who had an eye exam (retinal) performed.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

Brief Abstract

DESCRIPTION

This measure assesses the percentage of members 18-75 years with diabetes (Type 1 and 2) who were continuously enrolled during the measurement year and who had an eye exam (retinal) performed.

This measure is a component of a composite measure; it can also be used on its own.

RATIONALE

Effective use of eye exams is an important means to minimize further health risks from diabetes. This measure is consistent with the Diabetes Quality Improvement Project (DQIP) set of measures.

PRIMARY CLINICAL COMPONENT

Diabetes mellitus; retinopathy

DENOMINATOR DESCRIPTION

Members with diabetes (Type 1 and Type 2) age 18 through 75 years as of December 31 of the measurement year who were continuously enrolled during the measurement year (see the related "Denominator Inclusions/Exclusions" field in the Complete Summary)

NUMERATOR DESCRIPTION

An eye screening for diabetic retinal disease. This includes those diabetics who have had a retinal or dilated eye exam in the measurement year by an eye care professional (optometrist or ophthalmologist), as documented through either

administrative data or medical record review. The managed care organization (MCO) is allowed to count toward the numerator a negative retinal eye exam (an examination by an eye-care professional with no evidence of retinopathy) performed in the year prior to the measurement year if the member meets both of the following criteria:

- The member was not prescribed or dispensed insulin during the measurement year
- The member's most recent HbA1c level (performed during the measurement year) is less than 8.0%.

See the related "Numerator Inclusions/Exclusions" field in the Complete Summary.

Evidence Supporting the Measure

PRIMARY MEASURE DOMAIN

Process

SECONDARY MEASURE DOMAIN

Not applicable

EVIDENCE SUPPORTING THE MEASURE

A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence

A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences

A systematic review of the clinical literature

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Use of this measure to improve performance

EVIDENCE SUPPORTING NEED FOR THE MEASURE

National Committee for Quality Assurance (NCQA). The state of health care quality 2003: industry trends and analysis. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 61 p.

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Accreditation

Decision-making by businesses about health-plan purchasing

Decision-making by consumers about health plan/provider choice

Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Managed Care Plans

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Measure is not provider specific

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Single Health Care Delivery Organizations

TARGET POPULATION AGE

Age 18 through 75 years

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

About 16 million persons in the U.S. are estimated to have diabetes mellitus, but only half have been diagnosed. Individuals diagnosed as diabetic are grouped into two main diagnostic categories based on the etiologic nature of their underlying disease. Over 90% are Type 2 diabetics (previously termed non-insulin dependent), with the remainder being Type 1, or insulin-dependent diabetics.

EVIDENCE FOR INCIDENCE/PREVALENCE

Harris MI. Summary. In: National Diabetes Data Group. Diabetes in America [NIH Pub. No. 95-1468]. 2nd ed. Bethesda (MD): National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 1995. p. 1-13.

National Diabetes Information Clearinghouse. Diabetes statistics [NIH Pub. No. 94-3822]. Bethesda (MD): National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); 1994.

Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Diabetes Care 1997 Jul;20(7):1183-97. [PubMed](#)

ASSOCIATION WITH VULNERABLE POPULATIONS

Elderly

EVIDENCE FOR ASSOCIATION WITH VULNERABLE POPULATIONS

Harris MI. Summary. In: National Diabetes Data Group. Diabetes in America [NIH Pub. No. 95-1468]. 2nd ed. Bethesda (MD): National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 1995. p. 1-13.

BURDEN OF ILLNESS

As a result, diabetes mellitus is the seventh leading cause of death in the U.S., contributing to 160,000 deaths annually and nearly 20% of all deaths in persons over age 25. Complications of diabetes include metabolic abnormalities, micro and macrovascular disorders, blindness, neuropathy and renal insufficiency. Diabetic morbidity produces significantly increased health utilization and disability among those afflicted.

EVIDENCE FOR BURDEN OF ILLNESS

American Diabetes Association. Diabetes 1996 vital statistics. Alexandria (VA): American Diabetes Association; 1995.

Harris MI. Summary. In: National Diabetes Data Group. Diabetes in America [NIH Pub. No. 95-1468]. 2nd ed. Bethesda (MD): National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 1995. p. 1-13.

UTILIZATION

In 1990, diabetics made 53 million visits to physician offices, another 30 million visits to outpatient clinics and other ambulatory care settings, nearly 2 million visits to emergency departments, and had 11 million telephone contacts.

EVIDENCE FOR UTILIZATION

American Diabetes Association. Diabetes 1996 vital statistics. Alexandria (VA): American Diabetes Association; 1995.

COSTS

Direct and indirect costs of diabetes have a significant impact on society, especially when lost productivity due to diabetes-related morbidity and mortality is included. The Medical Technology and Practice Patterns Institute estimated the 1992 cost of diabetes in the United States to be \$91.8 billion. This figure includes \$45.2 billion for direct health care costs and \$46.4 billion for indirect costs.

EVIDENCE FOR COSTS

American Diabetes Association. Diabetes 1996 vital statistics. Alexandria (VA): American Diabetes Association; 1995.

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

Members with diabetes (Type 1 and Type 2) age 18 through 75 years as of December 31 of the measurement year, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year

DENOMINATOR SAMPLING FRAME

Enrollees or beneficiaries

DENOMINATOR (INDEX) EVENT

Clinical Condition
Encounter
Therapeutic Intervention

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions

Members with diabetes (Type 1 and Type 2) age 18 through 75 years as of December 31 of the measurement year who were continuously enrolled during the measurement year.

Two methods are provided to identify diabetic members--pharmacy data and claims/encounter data. Managed care organizations (MCOs) must use both methods to identify the eligible population. However, a member only needs to be identified in one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Those who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis. Refer to the original measure documentation and NCQA's Web site at www.ncqa.org to identify prescriptions.

Claims/encounter data. Those who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. MCOs may count services that occur over both years. Refer to the original measure documentation for International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, Universal Billing 1992 (UB-92) Revenue codes and Current Procedure Terminology (CPT) codes to identify ambulatory or non-acute inpatient and acute inpatient or emergency department (ED) encounters.

Exclusions

MCOs should exclude any members with a diagnosis of polycystic ovaries that do not have two face-to-face encounters with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year.

MCOs should exclude any members with gestational diabetes or steroid-induced diabetes during the measurement year.

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions

An eye screening for diabetic retinal disease. This includes those diabetics who have had a retinal exam in the measurement year by an eye care professional (optometrist or ophthalmologist), as documented through either administrative data or medical record review. Managed care organizations (MCOs) are also allowed to count toward the numerator a retinal exam performed in the year prior to the measurement year if the member meets at least two of the following three criteria:

- the member was not prescribed or dispensed insulin during the measurement year
- the member's most recent HbA1c level (performed during the measurement year) is less than 8.0 percent

- the member had an examination by an eye care professional with no evidence of retinopathy during the year prior to the measurement year (negative diagnosis must be verified in the medical record).

For all members eligible for the two-year eye exam time frame, MCOs may count toward the numerator a retinal exam in the measurement year or the year prior to the measurement year, as documented through either administrative data or medical record review using the criteria identified below.

Administrative. A claim/encounter with one of the Current Procedure Terminology (CPT) or International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes listed in the original measure documentation.

Medical record. Documentation in the medical record of a retinal exam performed in the measurement year or a retinal exam performed in the year prior to the measurement year if the member meets at least two of the three criteria presented above.

Documentation in the medical record must include, at a minimum:

- a note or letter from an ophthalmologist, optometrist, or other health care professional summarizing the date on which the procedure was performed and the results of a retinal evaluation performed by an eye care professional or
- a chart or photograph of retinal abnormalities. If fundus photography was used in the exam, there must be documentation in the medical record indicating the date on which the procedure was performed and evidence that the results were reviewed by an eye care professional. Alternatively, the results may be read by a qualified reading center, as long as it operates under the direction of a medical director who is a retinal specialist.

In the HEDIS audit, the MCO must be able to identify the quality assurance protocols the reading center used to monitor and validate its practices with regard to process with regard to the process by which the photographs are read, or

- a note, which may be prepared by a primary care provider, indicating the date on which the procedure was performed, and that an ophthalmoscopic exam was completed by an eye care professional, with results of the exam.

Exclusions
Unspecified

DENOMINATOR TIME WINDOW

Time window precedes index event

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Administrative data
Medical record
Pharmacy data

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Analysis by subgroup (stratification on patient factors)

DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS

This measure requires that separate rates be reported for commercial, Medicare, and Medicaid plans.

STANDARD OF COMPARISON

External comparison at a point in time
External comparison of time trends
Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

Comprehensive diabetes care (eye exam [retinal] performed).

MEASURE COLLECTION

[HEDIS® 2004: Health Plan Employer Data and Information Set](#)

COMPOSITE MEASURE NAME

[Comprehensive diabetes care](#)

DEVELOPER

National Committee for Quality Assurance - Private Nonprofit Organization

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

1999 Jan

REVISION DATE

2002 Jan

MEASURE STATUS

This is the current release of the measure.

SOURCE(S)

National Committee for Quality Assurance (NCQA). HEDIS 2004. Health plan employer data & information set. Vol. 2, Technical specifications. Washington (DC): National Committee for Quality Assurance (NCQA); 2003. 374 p.

MEASURE AVAILABILITY

The individual measure, "Comprehensive Diabetes Care (Eye Exam [Retinal] Performed)," is published in "HEDIS 2004. Health Plan Employer Data & Information Set. Vol. 2, Technical Specifications."

For more information, contact the National Committee for Quality Assurance (NCQA) at 2000 L Street, N.W., Suite 500, Washington, DC 20036; Telephone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC STATUS

This NQMC summary was completed by ECRI on July 18, 2003. The information was verified by the measure developer on August 29, 2003.

COPYRIGHT STATEMENT

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For detailed specifications regarding the National Committee on Quality Assurance (NCQA) measures, refer to HEDIS Volume 2: Technical Specifications, available from the NCQA Web site at www.ncqa.org.

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