Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Optimal Diabetes Care and Optimal Vascular Care
Measure Changes for 2015 Dates of Service

These measure and field specifications are for patients with **2015 Dates of Service** (1/1/2015 to 12/31/2015) with data submission occurring in Jan/Feb **2016**.

These do not apply to the next cycle of data submission Jan/Feb 2015 for patients with dates of service in 2014 (1/1/2014 to 12/31/2014).

The primary purpose of these specifications is to inform medical groups of the changes related to the cholesterol components for both the Optimal Diabetes and Vascular Care Measures. While this is not the final data collection guide and is abbreviated to focus on changes to the measure, it is not anticipated that the measure construction or data field specifications will change.

Also note that the aspirin anti-platelet fields have been modified to align with the methodology adopted for the statin component. Fields were added to clarify actual use of aspirin or antiplatelet medication (numerator credit) and the type of contraindication will be indicated as part of the submission.

The Optimal Diabetes Care measure specifications were used to illustrate these changes; anticipate identical changes to the Optimal Vascular Care measure.

Modifications to the specifications and existing field definitions are indicated by underlined red font. New fields are shaded in blue.

New and Modified Fields

Please refer to field definitions starting on page 4.

New Fields for Cholesterol Component

Column	Field Name
AD	Statin Medication
AE	Statin Medication Date
AF	Statin Medication Exception
AG	Statin Medication Exception Date

Fields for Aspirin or Anti-platelet Medication Component

Column	Field Name	Changes
AH	Aspirin or Anti-platelet Medication	Add Yes/No field
AI	Aspirin or Anti-platelet Date	Field name
AJ	Aspirin or Anti-platelet Medication Exception	Add field; submit specific exemption
AK	Aspirin or Anti-platelet Medication Exception Date	Field name

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Description	Composite ("optimal" care) measure of the percentage of adult patients who have type 1 or type 2 diabetes with optimally managed modifiable risk factors.
Methodology	Population identification is accomplished via a query of a practice management system or electronic medical record (EMR) to identify the population of eligible patients (denominator). Data elements are either extracted from an EMR system or abstracted through medical record review. Full population data is required for clinics that had an EMR in place by 01/01/201x.
Rationale	According to the Minnesota Department of Health, diabetes is a high impact clinical condition in Minnesota. More than one in three adults and one in six youth in Minnesota have diabetes or are at high risk of developing it. Each year more than 20,000 Minnesotans are newly diagnosed with diabetes. Diabetes is the sixth leading cause of death in Minnesota and is a significant risk factor in developing cardiovascular disease and stroke, non-traumatic lower extremity amputations, blindness, and end-stage renal disease. Diabetes costs Minnesota almost $2.7 billion annually, including medical care, lost productivity and premature mortality. According to the American Diabetes Association, an estimated 25.8 million American children and adults have diabetes. Most people with diabetes have other risk factors, such as high blood pressure and cholesterol that increase the risk for heart disease and stroke. In fact, more than 65% of people with diabetes die from these complications.
Measurement Period	Measurement period will be a fixed 12-month period: 01/01/2015 to 12/31/2015.
Denominator	Patients who meet each of the following criteria are included in the population: • Patient was age 18 to 75 years at the start of the measurement period (date of birth was on or between 01/01/1940 to 01/01/1997). • Patient was seen by an eligible provider in an eligible specialty face-to-face visit at least two times during the last two measurement periods (01/01/2014 to 12/31/2015) with visits coded with a diabetes mellitus ICD-9 diagnosis code (in any position, not only primary). Use this date of service range when querying the practice management or EMR system to allow a count of the visits. • Patient was seen by an eligible provider in an eligible specialty face-to-face visit at least one time during the measurement period (01/01/2015 to 12/31/2015) for any reason. This may or may not include a face-to-face diabetes visit with a diabetes mellitus ICD-9 code. • Diagnosis of Diabetes mellitus; ICD-9 diagnosis codes include: 250.00 to 250.93. Eligible specialties: Family Medicine, General Practice, Internal Medicine, Geriatric Medicine, Endocrinology

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

	Eligible providers: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN)
Allowable Exclusions	The following are allowable exclusions: • Patient was a permanent nursing home resident during the measurement period. • Patient was in hospice or receiving palliative care at any time during the measurement period. • Patient died prior to the end of the measurement period. • Patient was pregnant during measurement period (ICD-9 diagnosis codes include: 648.00 to 648.04; See Table 3). • Documentation that diagnosis was coded in error.
Numerator	The number of diabetes patients who met ALL of the following targets: • The most recent HbA1c in the measurement period has a value less than 8.0. • The most recent Blood Pressure in the measurement period has a systolic value of less than 140 and a diastolic value of less than 90 (both values must be less than). • The patient is on a statin medication unless contraindication or valid exception is documented. • Patient is currently a non-tobacco user. • If the patient has a co-morbidity of Ischemic Vascular Disease, the patient is on daily aspirin OR an accepted contraindication or valid exception is documented (any date). Diagnosis of Ischemic Vascular Disease; ICD-9 diagnosis codes include: 410.00 to 410.92, 411.0 to 411.89, 412, 413.0 to 413.9, 414.00 to 414.07, 414.2, 414.3, 414.8, 414.9, 429.2, 433.00 to 433.91, 434.00 to 434.91, 440.1, 440.20 to 440.29, 440.30 to 440.32, 440.4, 440.8, 440.9, 444.01 to 444.9, 445.01 to 445.89.

Data Elements and Field Specifications – Example using Optimal Diabetes Care

Col	Field Name	Notes
Measure Specific Fields- Optimal Diabetes Care Measure		
T	Patient Has IVD?	Enter a code to indicate if the patient has a comorbidity diagnosis of ischemic vascular disease (IVD) that can be confirmed upon validation audit. See Table 2 on pages 7-9 in Measure Specifications for list of IVD ICD-9 diagnosis codes. 1 = Yes 0 = No This field determines if the aspirin component is applicable. The MNCM auditor will look for a diagnosis of IVD in the measurement period and the year prior. The following sources may be used to identify the diagnosis: • Patient's problem list;

Col	Field Name	Notes
		• Documentation in patient's record (progress notes, etc.); OR • ICD-9 codes (EMR or practice management system).
U	Patient Has Depression?	Enter a code to indicate if the patient has a diagnosis of depression that can be confirmed upon validation audit (e.g., ICD-9 codes 296.2x, 296.3x, 300.4, and/or 311). See list of ICD-9 diagnosis codes in Table 4 on pages 10 for a list of Major Depression or Dysthymia ICD-9 diagnosis codes. 1 = Yes 0 = No Leave BLANK if Unknown/Not submitting data. The following sources may be used to identify the diagnosis: • Patient's problem list; • Documentation in patient's record (progress notes, etc.); OR • ICD-9 codes (EMR or practice management system). NOTE: The 311 code is not used for the purpose of identifying patients for MNCM's Depression Care Measures denominator; however, please include the 311 code for identifying a depression co-morbidity diagnosis for this measure.
V	Type 1 or Type 2 Diabetes?	Enter a code to indicate the patient's diabetes diagnosis type (Type 1 or Type 2 diabetes). 1 = Type 1 2 = Type 2 3 = Not specified or documented Blank values will create ERRORs upon submission.
W	HbA1c Date	Enter the date of the most recent HbA1c test on or prior to 12/31/2015. Leave BLANK if an HbA1c was never performed. • Do NOT enter test date that occurred in 2016. Dates in 2016 will create ERRORs upon submission. • Test from an outside referring provider or specialist is acceptable (not required) but only if documented in the primary clinic's record and is more recent than the primary clinic's test. • Point-of-care HbA1c labs: If the HbA1c is "too high to calculate," enter the HbA1c date field and leave the HbA1c value field blank.
X	HbA1c Value Target = Less than 8.0	Enter the value of the most recent HbA1c test on or prior to 12/31/2015. Leave BLANK if an HbA1c was never performed.
Y	LDL Date	Enter the date of the most recent LDL test on or prior to 12/31/2015. Leave BLANK if an LDL was never performed. • Test from an outside referring provider or specialist is acceptable (not required) but only if documented in the primary clinic's record and is more recent than the primary clinic's test. • Elevated Triglyceride: If LDL is "too high to calculate," enter the LDL date field and leave the LDL value field blank. • LDL values within the last five years will be used to calculate potential exceptions to being on a statin medication. The data portal will determine if an appropriate exception exists based on the following evidence based guidelines: o Patients with diabetes and ischemic vascular disease ages 21 to 75 should be on a statin unless LDL < 40 o Patients with diabetes and LDL > 190 ages 21 to 39 should be on a statin; LDL < 190 = numerator pass o Patients with diabetes ages 40 to 75 should be on a statin unless LDL < 70
Z	LDL Value	Enter the value of the most recent LDL test on or prior to 12/31/2015.

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Col	Field Name	Notes
		Leave BLANK if an LDL was never performed.
AA	BP Date	Enter the date of the most recent Blood Pressure (BP) test on or prior to 12/31/2015. Leave BLANK if a BP was never performed. • For multiple BPs on the same date, it is acceptable (not required) to use the lowest systolic value and lowest diastolic value from any of the readings on that date. The systolic and diastolic results do not need to be from the same reading. • Do NOT enter BP date that occurred in 2016. Dates in 2016 will create ERRORs upon submission. • BP from any outside referring provider or specialist is acceptable (not required) but only if documented in the primary clinic's record and is more recent than the primary clinic's reading. • Nurse-only BP checks in the clinic may be used. • Do NOT enter BP reported by or taken by the patient. • For medical groups in an integrated delivery system with a common medical record, do NOT submit BP taken in the following settings: Inpatient, Emergency Department, Urgent Care or other settings designated for surgical or diagnostic procedures. • If you are able to determine that the most recent BP was for a visit associated with acute pain, you may elect to exclude this BP reading and select the next most recent BP. • Patient-reported pain and elevated BP: If your clinic uses a patient-reported pain assessment tool and you are able to identify visits in which the patient reports an elevated pain score, you may elect to exclude this BP reading and select the next most recent BP. For a patient-reported pain score, the level of pain must be moderate to severe/intolerable (i.e., 4 or higher on a 0 to 10 pain scale).
AB	BP Systolic Target = Less than 140	Enter the "systolic" value according to the rules above for selecting the correct BP date. The systolic BP is the upper number. For example, the systolic value for a BP 124/72 is "124." Leave BLANK if a BP test was never performed.
AC	BP Diastolic Target = Less than 90	Enter the "diastolic" value according to the rules above for selecting the correct BP date. The diastolic BP is the lower number. For example, the diastolic value for a BP 124/72 is "72." Leave BLANK if a BP test was never performed.
AD	Statin Medication Target: Diabetic patients prescribed a statin unless valid exceptions documented.	Enter the value indicating if the patient is prescribed a statin medication or a statin medication is active on the patient's medication list any time during the measurement year. Please refer to Appendix X-1 for a list of statin medications. 1 = Yes, patient was prescribed a statin medication 2 = No, patient was not prescribed a statin medication ▪ Prescribed is defined as any of the following: statin prescription indicated in medical record, statin medication is ordered or statin medication is active on the medication list any time during the measurement year. ▪ It is not necessary to be on the statin medication the entire duration of the measurement period, any portion of the period is acceptable. ▪ For patients not on a statin, the data portal will determine if an appropriate exception exists based on the most recent LDL within the last five years. The following age parameters and LDL values are applicable: o Patients with diabetes and ischemic vascular disease ages 21 to 75 should be on a statin unless LDL < 40 o Patients with diabetes and LDL > 190 ages 21 to 39 should be on a statin; LDL < 190 = numerator pass o Patients with diabetes ages 40 to 75 should be on a statin unless LDL < 70

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Col	Field Name	Notes
AE	Statin Medication Date	Enter the most recent date of a statin prescription, order or review of active medications list during the measurement period. If no statin prescribed, ordered, or reviewed as an active medication during the measurement period, leave blank
AF	Statin Medication Exception	If the patient was not prescribed a statin medication during the measurement year (Field AD Statin Medication = 2); please indicate if any of the following contraindications or exceptions apply by entering one of the values below. Values 1 through 5 have associated diagnosis codes that may be used to identify the condition; either by patient's problem list, encounter diagnoses codes or other EMR generated fields indicating the condition exists. Code lists for guidance are located in Appendix X-2. Values 6 through 10 do not have any associated diagnosis codes; EMR fields or progress notes may be used as a source for these exceptions. 1 = pregnancy during the measurement period 2 = active liver disease (liver failure, cirrhosis, hepatitis) 3 = rhabdomyolysis 4 = end stage renal disease on dialysis 5 = heart failure 6 = other provider documented reason: breastfeeding during the measurement period 7 = other provider documented reason: woman of childbearing age not actively taking birth control 8 = other provider documented reason: allergy to statin 9 = other provider documented reason: drug interaction (valid drug-drug interactions include HIV protease inhibitors, nefazone, cyclosporine, gemfibrozil, and danazol) 10 = other provider documented reason: intolerance (with supporting documentation of trying a statin at least once within the last 5 years) If one of the above categories is not documented in the record; leave BLANK If the reason the patient is not on a statin is due to low LDL (see parameters in field Statin Medication); it is acceptable to leave this field blank. The data portal will use the actual LDL submitted to calculate the exception. Note: For those groups with EMR systems that historically have stored allergy and intolerance in the same discrete field, it is acceptable to default to value = 10 other provider documented reason: intolerance On validation audit, MNCM will confirm either the intolerance (more common) or allergy (rare), but will not be considered an error if an allergy is coded as value 10. Groups are encouraged to consider future separation of allergies and intolerance into separate discrete fields as these have different implications for clinical practice.
AG	Statin Medication Exception Date	If the patient has a documented statin medication exception (values 1 through 10 in Column AF) enter the date of the statin medication exception. If only the month and year is known (e.g., Liver failure- June 2012), enter a valid date to indicate the time, (e.g., 6/01/2012). Look back at least three years (dates of service in 2015, 2014 or 2013) for contraindication date. Looking back four years or more is optional. Leave BLANK if on a statin or if there is no known exception, this field is only needed for patients not taking a statin medication with a documented reason for exception to statin medication.

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Col	Field Name	Notes
AH	Aspirin or Anti-platelet Medication Target = Patient with a diagnosis of IVD comorbidity has documented daily ASA or anti-platelet use anytime during the measurement period or valid contraindication or exception. If there is no diagnosis of IVD, the patient automatically passes the aspirin component.	Enter the value indicating if the patient is prescribed a daily aspirin product or antiplatelet medication or an aspirin product or anti-platelet medication is active on the patient's medication list any time during the measurement year. Please refer to Appendix X-3 for methods to identify appropriate aspirin products or antiplatelet medications. 1 = Yes, patient was prescribed a daily aspirin product or antiplatelet medication 2 = No, patient was not prescribed a daily aspirin product or antiplatelet medication ▪ As aspirin products are most frequently obtained over-the-counter, so "prescribed" for aspirin products is defined as any of the following: daily aspirin product is indicated in medical record, aspirin product is ordered or active on the medication list any time during the measurement year. ▪ For antiplatelet medications, prescribed is defined as any of the following: antiplatelet prescription indicated in medical record, antiplatelet is ordered or antiplatelet is active on the medication list any time during the measurement year. ▪ It is not necessary to be on the aspirin product or anti-platelet medication the entire duration of the measurement period, any portion of the period is acceptable ▪ A discrete field in the EMR indicating patient is taking daily aspirin is acceptable. ▪ Do NOT count ASA/narcotic combo medication for the "daily aspirin use" component of the measure. ▪ Do NOT assume that a pre-op standing order like, "Do not take ASA seven days prior to the procedure," means that a patient is taking ASA every day; there must be other documentation in the record that the patient is taking daily ASA. ▪ If the ASA has been discontinued prior to a surgical procedure, do NOT count this as a contraindication; rather document this patient as taking ASA during the measurement period. Note: Some patients taking lower dose anti-coagulant medication are able to take and tolerate aspirin products or anti-platelet medication. If this is true, enter information for the aspirin/ anti-platelet medication use and do not enter an exception.
AI	Aspirin or Anti-platelet Date	Enter the most recent date of documented (prescribed/ordered/indicated) aspirin product or anti-platelet medication (prescribed/ordered) during the measurement period. If no aspirin prescribed or ordered during the measurement period, leave blank • Do NOT enter a 2016 date. Dates in 2016 will create ERRORs upon submission.
AJ	Aspirin or Anti-platelet Medication Exception	If the patient was not (prescribed/ordered/ indicated) aspirin product or anti-platelet medication (prescribed/ ordered) during the measurement period (Field AH Aspirin or Anti-platelet Medication = 2); please indicate if any of the following contraindications or exceptions apply by entering one of the values below. Values 2 and 3 have associated diagnosis codes that may be used to identify the condition; either by patient's problem list or encounter diagnoses codes. Please refer to Appendix X-4 for diagnosis codes that may be used to identify gastrointestinal or intracranial bleed; however the history of these events may be contained in places other than historical encounter diagnosis codes. 1 = prescribed/ ordered anti-coagulant medication 2 = history of gastrointestinal bleed 3 = history of intracranial bleed 4 = other provider documented reason: allergy to aspirin or anti-platelets 5 = other provider documented reason: use of non-steroidal anti-inflammatory agents 6 = other provider documented reason: documented risk for drug interaction 7 = other provider documented reason: uncontrolled hypertension (>180 systolic, >110 diastolic)

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Col	Field Name	Notes
		8 = other provider documented reason: gastroesophogeal reflux disease (GERD) If one of the above categories is not documented in the record; leave BLANK Note: Some patients taking lower dose anti-coagulant medication are able to take and tolerate aspirin products or anti-platelet medication. If this is true, enter information for the aspirin/ anti-platelet medication use and do not enter an exception.
AK	Aspirin or Anti-platelet Medication Exception Date	If the patient has a documented aspirin product or anti-platelet medication exception (values 1 through 8 in Column AJ) enter the date of the aspirin product or anti-platelet medication exception. If only the month and year is known (e.g., GI Bleed- June 2012), enter a valid date to indicate the time, (e.g., 6/01/2009). Look back at least three years (dates of service in 2015, 2014 or 2013) for contraindication date. Looking back four years or more is optional. Leave BLANK if patient is prescribed/ ordered an aspirin product or anti-platelet medication or if there is no known exception, this field is only needed for patients not taking an aspirin product or anti-platelet medication with a documented reason for exception to aspirin products or anti-platelet medication. • If the patient is on an anticoagulant, enter the most recent prescription/ order date.
AF	Tobacco Status Documentation Date Target = Within current measurement period or prior measurement period (01/01/2014 to 12/31/2015)	Enter the most recent date the patient's tobacco status was documented. This date can be in 2015 or prior as long as it is the most recent documented status. The MNCM auditor must be able to validate the date and status, and validate that the date and status are the most recent. • Leave BLANK and enter 2 (No Documentation) for the Tobacco Status (Column AG) if the patient was not asked or there is no associated date with the patient's tobacco status. • Do NOT enter any 2016 tobacco status date. Dates in 2016 will create ERRORs upon submission. Quality Check: Verify each cell has date prior to 2016 entered if data is entered.
AG	Tobacco Status Target = Tobacco Free Status	Enter the tobacco status. Tobacco includes any amount of cigarettes, cigars, pipes, or "chew." Do NOT count e-cigarettes as tobacco products. 1 = Tobacco Free (patient does not use tobacco) 2 = No Documentation 3 = Current Tobacco User Blank values will create ERRORs upon submission. Quality Check: Verify each cell has an accepted code if data is entered.

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Appendix X-1
List of Statin Medications

Generic Name	Brand / Trade Name
Atorvastatin	Lipitor
Fluvastatin	Lescol XL or Lescol
Lovastatin (Mevinolin)	Mevacor or Altoprev
Pitavastatin	Livalo
Pravastatin Sodium	Pravachol
Rosuvastatin Calcium	Crestor
Simvastatin	Zocor
Amlodipine Besylate/Atorvastatin Calcium	Caduet
Ezetimibe/Simvastatin	Vytorin
Niacin/Lovastatin	Advicor
Niacin/Simvastatin	Simcor
Sitagliptin/Simvastatin	Juvisync
Sitagliptin Phosphate/Simvastatin	Juntadueto

Appendix X-2
ICD-9 Diagnosis Codes that <u>may</u> be used to Identify Exceptions 1 through 5

Suggested Maternal ICD-9 Diagnosis Codes that Indicate Delivery

I-9 Code	I-9 Descriptions
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparity
V23.41	Pregnancy with history of pre-term labor
V23.42	Pregnancy with history of ectopic pregnancy
V23.49	Pregnancy with other poor obstetrical history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida
V23.85	Pregnancy resulting from assisted reproductive technology
V23.86	Pregnancy with history of in utero procedure during previous pregnancy
V23.87	Pregnancy with inconclusive fetal viability
V23.89	Other high risk pregnancy

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Note: Table of all ICD-9 diagnosis codes 641.01 to 679.02 indicating delivery will be provided in (~ 13 pages of code)

Suggested ICD-9 Diagnosis Codes that Indicate Active Liver Disease (liver failure, cirrhosis, hepatitis)

I-9 Code	I-9 Description
570	Acute and subacute necrosis of liver
571.0	Alcoholic fatty liver
571.1	Acute alcoholic hepatitis
571.2	Alcoholic cirrhosis liver
571.3	Alcoholic liver damage, unspecified
571.40	Chronic hepatitis, unspecified
571.41	Chronic persistent hepatitis
571.42	Autoimmune hepatitis
571.49	Other (chronic hepatitis- active, aggressive or recurrent)
571.5	Cirrhosis of liver without mention of alcohol
571.6	Biliary cirrhosis
571.8	Other chronic non-alcoholic liver disease
571.9	Unspecified chronic liver disease without mention of alcohol
572.2	Hepatic encephaolopathy
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.1	Hepatitis in viral diseases classified elsewhere
573.2	Hepatitis in other infectious diseases classified elsewhere
070.0	Viral hepatitis A with hepatic coma
070.1	Viral hepatitis A without mention hepatic coma
070.20	Viral hepatitis B with hepatic coma, acute without delta
070.21	Viral hepatitis B with hepatic coma, acute with delta
070.22	Viral hepatitis B with hepatic coma, chronic without delta
070.23	Viral hepatitis B with hepatic coma, chronic with delta
070.30	Viral hepatitis B without hepatic coma, acute without delta
070.31	Viral hepatitis B without hepatic coma, acute with delta
070.32	Viral hepatitis B without hepatic coma, chronic without delta
070.33	Viral hepatitis B without hepatic coma, chronic with delta
070.41	Acute hepatitis C with hepatic coma
070.42	Hepatitis delta without mention of active hepatitis B with hepatic coma
070.43	Hepatitis E with hepatic coma
070.44	Chronic hepatitis C with hepatic coma
070.49	Other specified viral hepatitis with hepatic coma
070.51	Acute hepatitis C without hepatic coma
070.52	Hepatitis delta without mention of active hepatitis B without hepatic coma

070.53	Hepatitis E without hepatic coma
070.54	Chronic hepatitis C without hepatic coma
070.59	Other specified viral hepatitis without hepatic coma
070.6	Unspecified viral hepatitis with hepatic coma
070.70	Unspecified viral hepatitis C without hepatic coma
070.71	Unspecified viral hepatitis C with hepatic coma
070.9	Unspecified viral hepatitis without mention of hepatic coma

Suggested ICD-9 Diagnosis Code- Rhabdomyolysis

I-9 Code	I-9 Description
728.88	Rhabdomyolysis

Suggested ICD-9 Diagnosis Codes that Indicate and End Stage Renal Disease (ESRD) on Dialysis

I-9 Code	I-9 Description
V56.0	Extracorporeal dialysis
V56.8	Other dialysis (peritoneal)
V45.11	Renal dialysis status
585.6	End stage renal disease (requiring dialysis)

Suggested ICD-9 Diagnosis Codes that Indicate Heart Failure

I-9 Code	I-9 Description
428.0	Congestive heart failure, unspecified
428.1	Left heart failure
428.20	Systolic heart failure, unspecified
428.21	Systolic heart failure, acute
428.22	Systolic heart failure, chronic
428.23	Systolic heart failure, acute on chronic
428.30	Diastolic heart failure, unspecified
428.31	Diastolic heart failure, acute
428.32	Diastolic heart failure, chronic
428.33	Diastolic heart failure, acute on chronic
428.40	Combined systolic and diastolic heart failure, unspecified
428.41	Combined systolic and diastolic heart failure, acute
428.42	Combined systolic and diastolic heart failure, chronic
428.43	Combined systolic and diastolic heart failure, acute on chronic
428.9	Heart failure, unspecified

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Appendix X-3
Aspirin, Anti-Platelet, and Anticoagulant Medications

Aspirin and Aspirin Containing Products:

The intent of the daily aspirin component of this measure is to reduce cardiovascular risk for diabetic patients who have IVD. Unless contraindicated, taking daily aspirin or an anti-platelet medication can prevent the formation of clots by reducing platelet adhesion and reduce the risk of heart attack, stroke or other vascular events.

Products containing solely aspirin, any dosage, can be counted as meeting the daily aspirin use. The following are a few combination products that are also acceptable for the intent of daily aspirin use:

- aspirin AND stomach acid reducer (buffered)
- aspirin AND nitrate (chest pain)
- aspirin AND statin

However, not all products containing an aspirin derivative can be assumed to meet the intent of daily aspirin use. Most of these combination products would not be taken on a daily basis and should not be considered "daily aspirin use." Many of the combination products are intended to be used on an as needed basis for control of pain or cold/ flu symptoms. Combination products containing aspirin AND any of the following are NOT acceptable as meeting the intent of daily aspirin:

- acetaminophen
- caffeine
- narcotics
- muscle relaxants
- decongestants
- antihistamines

Anti-Platelet Medications

Anti-platelet medications (listed in the table below) may also be used to meet the intent of "daily aspirin use". Like aspirin products, these medications can prevent the formation of clots by reducing platelet adhesion.

Table 5: Oral Anti-Platelet Medications

aspirin and dipyridamole; Aggrenox®	dipyridamole; Persantine®	ticagrelor; Brilinta®
cilostazol; Pletal®	prasugrel; Effient®	
clopidogrel; Plavix®	ticlopidine; Ticlid®	

Anti-Coagulant Medications

Anti-coagulant medications, "blood- thinners", can frequently be a contraindication to taking daily aspirin or anti-platelet medication. This however is not an absolute contraindication as some patients on lower doses of warfarin and also safely take daily aspirin. If the patient is indeed taking daily aspirin in addition to an anti-coagulant, it is acceptable to submit as taking daily aspirin and not indicate a contraindication.

Table 6: Anticoagulant Medications

apixaban; Eliquis®	rivaroxaban; Xarelto®
dabigatran etexilate; Pradaxa®	warfarin sodium; Coumadin®, Jantoven®
enoxopren sodium; Lovenox®, Xaparin®, Clexane®	

Optimal Diabetes Care 2016
(01/01/2015 to 12/31/2015 Date of Service)
DRAFT Measure and Field Specifications

Appendix X-4
Suggested ICD-9 Diagnosis Codes that Indicate Gastrointestinal or Intracranial Bleeding

I-9 Code	I-9 Description
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432	Nontraumatic extradural hemorrhage
432.1	Subdural hemorrhage
432.9	Unspecified intracranial hemorrhage
578	Hematemesis
578.1	Blood in stool
578.9	Hemorrhage of gastrointestinal tract, unspecified
852	Subarachnoid hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
852.01	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness
852.02	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with brief [less than one hour] loss of cons
852.03	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with moderate [1-24 hours] loss of consc
852.04	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss
852.05	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss
852.06	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified
852.09	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
852.1	Subarachnoid hemorrhage following injury with open intracranial wound, unspecified state of consciousness
852.11	Subarachnoid hemorrhage following injury with open intracranial wound, with no loss of consciousness
852.12	Subarachnoid hemorrhage following injury with open intracranial wound, with brief [less than one hour] loss of consciousness
852.13	Subarachnoid hemorrhage following injury with open intracranial wound, with moderate [1-24 hours] loss of consciousness
852.14	Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours) loss of conscious
852.15	Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of conscious
852.16	Subarachnoid hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
852.19	Subarachnoid hemorrhage following injury with open intracranial wound, with concussion, unspecified
852.2	Subdural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
852.21	Subdural hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness
852.22	Subdural hemorrhage following injury without mention of open intracranial wound, with brief [less than one hour] loss of consc
852.23	Subdural hemorrhage following injury without mention of open intracranial wound, with moderate [1-24 hours] loss of consc
852.24	Subdural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of
852.25	Subdural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of
852.26	Subdural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified
852.29	Subdural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
852.3	Subdural hemorrhage following injury with open intracranial wound, unspecified state of consciousness
852.31	Subdural hemorrhage following injury with open intracranial wound, with no loss of consciousness
852.32	Subdural hemorrhage following injury with open intracranial wound, with brief [less than one hour] loss of consciousness
852.33	Subdural hemorrhage following injury with open intracranial wound, with moderate [1-24 hours] loss of consciousness
852.34	Subdural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness

852.35	Subdural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness
852.36	Subdural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
852.39	Subdural hemorrhage following injury with open intracranial wound, with concussion, unspecified
852.4	Extradural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
852.41	Extradural hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness
852.42	Extradural hemorrhage following injury without mention of open intracranial wound, with brief [less than 1 hour] loss of consc
852.43	Extradural hemorrhage following injury without mention of open intracranial wound, with moderate [1-24 hours] loss of consc
852.44	Extradural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of
852.45	Extradural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of
852.46	Extradural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified
852.49	Extradural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
852.5	Extradural hemorrhage following injury with open intracranial wound, unspecified state of consciousness
852.51	Extradural hemorrhage following injury with open intracranial wound, unspecified state of consciousness
852.52	Extradural hemorrhage following injury with open intracranial wound, with no loss of consciousness
852.53	Extradural hemorrhage following injury with open intracranial wound, with brief [less than one hour] loss of consciousness
852.54	Extradural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness
852.55	Extradural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness
852.56	Extradural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
852.59	Extradural hemorrhage following injury with open intracranial wound, with concussion, unspecified
853	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, unspecified state
853.01	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with no loss of consc
853.02	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with brief [less than
853.03	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with moderate [1-24
853.04	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with prolonged [more
853.05	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with prolonged [more
853.06	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with loss of
853.09	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with concussion,
853.1	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, unspecified state of consciousness
853.11	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with no loss of consciousness
853.12	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with brief [less than one hour] loss of
853.13	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with moderate [1-24 hours] loss of
853.14	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours]
853.15	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours]
853.16	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with loss of consciousness of
853.19	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with concussion, unspecified