Data Abstraction Definitions
Diabetes Mellitus (DM)

DATA ELEMENTS/ VARIABLE NAMES	INSTRUCTIONS (DEFINITIONS, VALID VALUES)	INCLUSIONS/SYNONYMS	EXCLUSIONS
Confirm Diagnosis of Diabetes Mellitus (DM) **[DMCONFIRMED]**	Instruction: Determine if the patient has a documented history of DM during the measurement period or year prior to the measurement period. **Yes (1):** Select this option if the patient has a documented history of DM in the office/clinic record. **No/No reason documented (0):** Select this option if the patient has no documented history of DM in the office/clinic record. **Not Included for Medical Reasons (3):** Select this option if the patient has polycystic ovaries, gestational diabetes or steroid induced diabetes. **If "No" or "Not Included for Medical Reasons", STOP ABSTRACTION** **Skip (2):** Select this option if you are unable to find the patient's medical record.	Adult onset diabetes mellitus, AODM, adult onset diabetes, AOD, diabetes mellitus, diabetes, Type II diabetes, IDDM, insulin dependent diabetes mellitus, NIDDM, non-insulin dependent diabetes mellitus, Type I diabetes	Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement period or year prior to the measurement period. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement period.

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HbA1c Management Testing/Poor Control **[DMHBA1CTEST]** **[DMHBA1CDATE]** **[DMHBA1CVALUE]** **[DMHBA1CTEST]**	Instruction: Determine if the patient had one or more HbA1c tests performed during the measurement period. **Yes (1):** Select this option if the patient had one or more A1c tests. • *Record the most recent date the blood was drawn for the A1c in MM/DD/YYYY format* • *Record the most recent A1c value* **No/No reason documented (0):** Select this option if the patient did not have one or more A1c tests. *Note: 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.* Use the following priority ranking: • Lab report draw date • Lab report date • Flow sheet documentation • Practitioner notes • Other documentation	Glycohemoglobin A1c, HbA1c, Hemoglobin A1c, HgbA1c, A1c	None

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Blood Pressure Management **[DMBPMEASURE]** **[DMBPDATE]** **[DMBPSYSTOLIC]** **[DMBPDIASTOLIC]** **[DMBPMEASURE]**	Instruction: Determine if the patient's most recent BP during the measurement period was recorded. **Yes (1):** Select this option if the patient's most recent BP was recorded. • *Record the date of the most recent BP in MM/DD/YYYY format* • *Enter the systolic BP recorded in mm Hg* • *Enter the diastolic BP recorded in mm Hg* **No /No reason documented (0):** Select this option if the patient's most recent BP measurement was not recorded. *Note: Identify the BP reading from that visit. If there is one BP reading from that visit, it becomes the representative BP. If there are multiple BPs from a single visit, physicians should use the lowest BP of the visit as the representative BP; however, sitting BP is preferred.* *The following steps should be followed below to determine representative BP:* • *Identify the most recent visit to the practitioner's office or clinic that occurred during the measurement period in which a BP reading was noted.* o *To be eligible, the representative BP must have been obtained during a visit to the practitioner's office or other nonemergency outpatient facility, such as a clinic or urgent care center. Outpatient visits for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) are not eligible.* o *BP measurements obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room are not eligible.*	None	None

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Lipid Management Testing/Control **[DMLDLCTEST]** **[DMLDLCDATE]** **[DMLDLCVALUE]** **[DMLDLCTEST]**	Instruction: Determine if the patient had one or more LDL-C tests during the measurement period. **Yes (1):** Select this option if the patient had one or more LDL-C tests. • *Record the most recent date the blood was drawn for LDL-C in MM/DD/YYYY format* • *Record the most recent LDL-C value [if laboratory unable to calculate LDL-C value due to high triglycerides, record 0 (zero)]* **No /No reason documented (0):** Select this option if the patient did not have one or more LDL-C tests. *Note: At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result.* *Use the following priority ranking:* • *Lab report draw date* • *Lab report date* • *Flow sheet documentation* • *Practitioner notes* • *Other documentation*	Cholesterol analysis, cholesterol panel, cholesterol profile, fasting lipids, LDL:HDL, LDL:HDL ratio, lipid analysis, lipid panel, lipid profile, lipids, lipoprotein analysis, low density lipoprotein (LDL), LDL-Cholesterol, LDL-C	None

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Urine Protein Screening **[DMNEPHROPATHY]**	Instruction: Determine if the patient had any test for urine microalbumin, or who had evidence of medical attention for nephropathy, or had a positive macroalbumin test or received ACE Inhibitor/ARB therapy during the measurement period. *Note*: *The default setting for this element is SKIP.* **Yes (1):** Select this option if the patient had any test for urine microalbumin, or had evidence of medical attention for nephropathy or had a positive macroalbumin test or received ACE Inhibitor/ARB therapy. **No/No reason documented (0):** Select this option if the patient did not have any test for urine microalbumin, or evidence of medical attention for nephropathy, or received ACE Inhibitor/ARB therapy. **Skip (2):** Select this option if you are not abstracting records for claims-based measures. *Note: At a minimum, documentation in the medical record must include a note indicating the date on which the urine microalbumin test was performed and the result. Notation of the following may count in the medical record for urine microalbumin test:* • *24-hour urine for microalbumin* • *Timed urine for microalbumin* • *Spot urine for microalbumin* • *Microalbumin/creatinine ratio* *Note: At a minimum, documentation in the medical record must include a note indicating the date on which the test was performed and a positive result for protein in the urine. The following may count in the medical record:* • *Positive urinalysis (timed, spot, microalbumin/creatinine ratio)* • *Positive urine dipstick* • *Positive tablet reagent*	**See drug list of ACE Inhibitor medications in Table 1 and ARBs in Table 2.**	"Trace" urine macroalbumin test results are not considered numerator compliant

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Urine Protein Screening cont.	*Note: Medical attention for nephropathy:* • *Visit to a nephrologist - documentation in the medical record must include, at a minimum, a note indicating medical attention during the measurement year for:* o *Diabetic nephropathy* o *A positive test result for urine microalbumin (i.e., urine protein or proteinuria)* o *End-stage renal disease (ESRD)* o *Chronic renal failure (CRF)* o *Renal insufficiency* o *Acute renal failure (ARF)* o *Dialysis, hemodialysis or peritoneal dialysis* *Note: Evidence of ACE Inhibitor/ARB therapy – Documentation must include, at a minimum, a note indicating that the patient received a prescription for ACE Inhibitors/ARBs on an ambulatory basis within the measurement period.*		

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Eye Examination **[DMEYEEXAM]**	Instruction: Determine if the patient had eye screening for diabetic retinal disease identified by: • a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement period **OR** • a *negative* retinal eye exam (no evidence of retinopathy) by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement period. *Note*: *The default setting for this element is SKIP*. **Yes (1):** Select this option if the patient had a dilated eye exam by an optometrist or ophthalmologist, or a negative retinal eye exam during the year prior to the measurement period. **No/No reason documented (0):** Select this option if the patient did not have a dilated eye exam by an optometrist or ophthalmologist, or a negative retinal eye exam during the year prior to the measurement period. **Skip (2):** Select this option if you are not abstracting records for claims-based measures. *Note: At a minimum, documentation in the medical record must include:* • *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 the exam, there must be documentation in the medical record indicating the date on which the procedure was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.* *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.*	None	None

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Foot Exam **[DMFOOTEXAM]**	Instruction: Determine if the patient had at least one of the following foot exam components performed during the measurement period. **Yes (1):** Select this option if the patient had at least one foot exam component performed during the measurement period. **No/No reason documented (0):** Select this option if a foot exam was not performed or there was no reason documented for not performing a foot exam. **Not performed for medical reasons (3):** Select this option if a complete foot exam was not performed due to history of bilateral foot/leg amputation.	A foot exam can include a visual inspection, a sensory exam with monofilament, or a pulse exam. Visual inspection May refer to foot lesions, ulcers, deformities, clubbing, cyanosis, edema, toe nail clipping, diabetic foot care (DFC) Sensory exam Testing with monofilament Pulse exam May refer to circulation in feet, temperature, pulses, dorsalis pedis, DP, pedal pulse, posterior tibial, PT, ankle/arm ratio	Documentation of lower extremities without mention of feet (e.g., “extremities, no edema”), range of motion (ROM) exams, patient self-report of foot condition, foot amputation, sensory exam with tuning fork