Condition management – diabetes

Eye Exam for Patients With Diabetes (EED)

Eye Exam for Patients With Diabetes (EED) Measure year 25 | Weight = 1

Measurement period
January–December

Eligible population
Patients 18–75 years of age with type 1 or type 2 diabetes

Service needed for compliance
- Screening or monitoring for diabetic retinal disease via a retinal or dilated eye exam during the current measurement year
- Retinal or dilated eye exam performed in prior year with negative results for diabetic retinopathy

Note: Document the date of most recent diabetic eye exam with results and name the eye care provider in the patient's medical record. If possible, also obtain and retain the most recent eye exam record in the patient's medical record.

Exclusions
- Bilateral eye enucleation anytime during the patient's history through the current measurement year.
  - Two unilateral eye enucleations 14 days apart or
  - A left and right unilateral eye enucleation on the same or different dates of service

Note: Blindness is not an exclusion for diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and do not require an exam.

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients died anytime during the measure year
- Patients who did not have a diagnosis of diabetes during the measure year or the year prior to the measure year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measure year or the year prior
- Patients 66 years of age and older as of Dec. 31 of the measurement year who live long-term in an institutional setting or are enrolled in an Institutional Special Needs Plan (I-SNP)
- Patients 66 years of age and older who have frailty and advanced illness

Measure best practices

- Review diabetes services needed at each office visit and refer patients to see an eye care professional for a comprehensive dilated or retinal eye exam during the current year.
- Ensure the practice has a process to conduct reviews of patients' records when diagnosed with diabetes and those who are new to the practice or Medicare, especially those who are also receiving care from specialists, and submit records that document evidence of completed tests in the measurement year through supplemental data.
- Ensure processes exist when referring patients to eye specialists to follow up with specialist or patient to obtain records and result of exam.
- Submit claims with appropriate Current Procedural Terminology (CPT®) Category II codes to indicate result of the exam when performing the exam in the office (via fundus photography) with results interpreted by an appropriate eye care professional, at a reading center with a retinal specialist serving as medical director or a system with artificial intelligence.
- Submit supplemental data when a claim is not submitted that includes the record and result of the exam including place of service, provider and result. (Patients whose exams have negative results showing no evidence of retinopathy will be compliant with this measure for the year in which the screening occurred and the following measurement year.)

Healthcare Effectiveness Data and Information Set (HEDIS®)

Code type	Code
Most common CPT codes for diabetic retinal screening	
CPT	92002, 92004, 92012, 92014, 92134, 92225, 92228, 92230, 92250, 92260
Other CPT codes for diabetic retinal screening	
CPT	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92018, 92019, 92201, 92202, 92229, 92235, 92240, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
CPT code for automated eye exam	
CPT	92229
Without evidence of retinopathy*	
CPT II	2023F, 2025F, 2033F, 3072F
With evidence of retinopathy	
CPT II	2022F, 2024F, 2026F
Healthcare Common Procedure Coding System (HCPCS)	S0620, S0621, S3000
ICD-10-CM to report diabetes mellitus without complications	
International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)	E10.9, E11.9, E13

* When negative retinopathy results are reported for a patient, he or she will be compliant for the measurement year in which the testing occurred through the end of the following measurement year.

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

The information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

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