Comprehensive diabetes care: retinal eye exam

This measure examines the percentage of adults ages 18-75 with diabetes (Type 1 and Type 2) who had a retinal eye exam to screen for diabetic retinal disease. The frequency of the exam is determined by the results.

Qualifying eye exams

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) performed annually unless the result is negative for retinal disease. If negative, the exam would be done every other year.

Documentation

Requires one of the following:

- A note or letter from ophthalmologist, optometrist, primary care physician or other health care professional stating that the ophthalmoscopic exam was completed by an eye care professional, which includes the date and result of the exam.

- A chart or retinal photograph indicating the date that it was performed and evidence of the test being read by an eye care professional or a qualified reading center operating under the direction of a medical director who is a retinal specialist.

- A negative retinal or dilated exam by eye care professional in the year prior to the current year stating “retinopathy not present” or “normal findings” on dilated or retinal eye exam.

Did you know?

- Diabetic retinopathy is the leading cause of blindness in American adults.

- Controlling blood sugar, blood pressure and lipids reduces the risk of developing diabetic retinal disease.

- Early diagnosis and treatment of diabetic retinal disease can prevent blindness.

- Up to 50 percent of patients do not receive proper screening for eye disease or receive it too late for treatment to be effective.

* HEDIS, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.
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Frequently asked questions

Q. What should I do if my patient doesn’t have vision insurance?
A. Diabetic eye exams are covered under the patient’s medical insurance and may be subject to copays and deductibles.

Q. What if my patient had a negative dilated retinal eye exam last calendar year, do they need another this year?
A. No. As long as there is documentation of a negative exam, the date of the exam and documentation that the exam was done by an eye care professional, then they do not need an exam this calendar year. For example, if your patient had a negative exam in 2016 and the exam is properly documented, then they will not need one again until 2018

Q. How do I code for retinal eye exams?
A. **PCP’S, PCP-LIKE PHYSICIANS (NON-EYE CARE PROFESSIONALS)** – PCP’s and PCP-like physicians cannot submit claims for eye exams, however:

When you receive a eye exam report for your diabetic patients (from an eye care professional), review the report and place it in the patients medical record, **AND** submit a $0 claim for the following CPT® II codes as appropriate:

- **CPT II code 2022F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
- **CPT II code 2024F:** 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
- **CPT II code 2026F:** Eye imaging validated to match diagnosis from 7 standard field stereoscopic photo results documented and reviewed
- **CPT II code 3072F:** Low risk for retinopathy (no evidence of retinopathy in the prior year)

These CPT II codes can be billed alone or with other services.

**FOR EYE CARE PROFESSIONALS ONLY** – In addition to billing the appropriate eye exam service, when your diabetic patient has a negative eye exam, make sure you submit your eye exam claim with either of the following ICD-10-CM codes:

- **E10.9** – Type 1 diabetes mellitus without complications
- **E11.9** – Type 2 diabetes mellitus without complications

You may also submit CPT II code 3072F = Low risk for retinopathy (no evidence of retinopathy in the prior year)

If your diabetic patient has a positive exam, make sure you submit your eye exam claim with the appropriate ICD-10-CM diagnosis

<table>
<thead>
<tr>
<th>ICD-10 Codes for Diabetes</th>
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<tbody>
<tr>
<td><strong>DIAGNOSIS</strong></td>
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<tr>
<td>No Retinopathy</td>
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<tr>
<td>PDR and ME</td>
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<tr>
<td>PDR and no ME</td>
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<td>Mild NPDR and ME</td>
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<td>Severe NPDR and ME</td>
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<td>Severe NPDR and no ME</td>
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ME – Mascular Edema; PDR – Proliferative Diabetic Retinopathy; neovascularization and/or vitreous/preterinal hemorrhage; NPDR – Nonproliferative Diabetic Retinopathy; Mild NPDR – Microaneurysms only; Moderate NPDR – more than mild NPDR but less than severe; Severe NPDR – no PDR and two or more of the following: severe intraretinal hemorrhages and microaneurysms in each of four quadrant, definite venous bleeding in two or more quadrants, and moderate intraretinal microvascular abnormalities in one or more quadrants.

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