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Eye Exam for Patients with Diabetes (EED)

Measure Overview

The percentage of members 18–75 years of age with diabetes (types 1 and 2) with a DOS that includes screening or monitoring both eyes for diabetic retinal disease (retinopathy) in the measurement year (MY) or year prior by an eye care provider (optometrist or ophthalmologist).

- A negative retinal or dilated eye exam (negative for retinopathy) by an optometrist or ophthalmologist in the measurement year or year prior.
- A positive retinal or dilated eye exam by an optometrist of ophthalmologist in the MY.

Lines of Business

Marketplace / Medicare / Medicaid

Special Considerations for Eye Exams

Retinopathy	Documentation does not specifically have to state "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear the member had a dilated or retinal exam by an eye care professional (optometrist or ophthalmologist) and retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.
Hypertensive Retinopathy	Hypertensive retinopathy should be considered the same as diabetic retinopathy when reporting the eye exam indicator for this measure. Therefore, an eye exam diagnosed as positive or negative for hypertensive retinopathy is counted as positive or negative for diabetic retinopathy.
Blindness	Blindness is NOT an exclusion for a 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 require no exam.
Unknown Result	An eye exam with a documented result of "unknown" does NOT meet criteria.
One Eye Inaccessible	If one eye is not accessible, leading to an indeterminate result, this would NOT be considered a result or finding.

Hybrid Measure Note

The EED measure is hybrid. Any care not received from claims during the measurement year will result in medical record requests during the HEDIS® medical record review project.

Tips and Best Practices for Documentation

The following notations are examples of **acceptable** documentation for EED:

Documentation from the following providers: ophthalmologist, optometrist, or by a qualified reading center that operates under the direction of a medical director who is a retinal specialist would be compliant for retinal exams performed.

Documentation from a PCP chart indicating a retinal exam was performed by an eye care professional with a date and the result would be compliant for exams completed in the MY.

Documented administration of dilating agents along with findings of a fundus eye exam.

Exams indicating positive or negative diabetic retinopathy in the MY would be numerator compliant as long as it was resulted by an appropriate eye care specialist.

Exams indicating negative diabetic retinopathy in the PY would be numerator compliant if it was resulted by an appropriate eye care specialist.

A note or letter prepared by an ophthalmologist or optometrist indicating the date an ophthalmoscope exam was completed along with the results. This can be a standalone letter/note or it can be documented in the PCPs chart.

A chart or photograph of the retina indicating the fundus photograph was performed and evidence an eye care professional completed the review with the date and 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.

Evidence the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the MY.

Evidence the member had retinal photos read by a system that provides an artificial intelligence (AI) interpretation.

An exam performed by an eye care provider with results of "no ocular evidence of diabetes" or "diabetes without ocular complications." This would be considered negative findings.

If an eye exam report contains a slit lamp exam and evidence of dilation or evidence the retina was examined, and only MD/DO credentials are found, it can be assumed to be done by an optometrist or ophthalmologist.

Documentation that the member is blind in one eye, or one eye is enucleated with documentation of a retinal or dilated exam of the functional eye by an eye care professional.

An OCT (Optical Coherence Tomography) alone is sufficient if performed by an appropriate eye care provider and results for retinopathy are documented.

Documentation of early macular edema, non-proliferative changes, pre-proliferative changes, or proliferative changes infer the exam is positive for diabetic retinopathy. This would meet compliancy for the MY only.

Documentation of Hypertensive retinopathy (Positive retinopathy) would meet compliancy for the MY only.

The following notations are examples of documentation that is **not acceptable** for EED:

For PY eye exam results, documentation of early macular edema, non-proliferative changes, pre-proliferative changes, or proliferative changes infers exam is positive for diabetic retinopathy and would not be numerator compliant.

Pure intraocular pressure exams (glaucoma screenings)

Fundus exams performed by specialists other than an ophthalmologist, optometrist, or eye care professional

Exams indicating positive diabetic retinopathy in the PY would not be numerator compliant.

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Documentation of other retinal diseases without evidence of an eye exam excluding diabetic retinopathy, would not be numerator compliant (i.e., documentation indicating retinal vein occlusion).

Prescription eye exams and refractive errors only exams would not meet criteria for a retinal exam.

Documentation from a PCP stating eye exam is current but does not contain documentation of the date of service, results, type, or named eye care professional exam.

Eye exam documentation with no credentials or identification supporting the provider was an optometrist or ophthalmologist.

Eye exam documentation with no results / findings. (Note: it is acceptable to infer a result based on findings)

Visual acuity exams or exams that do not examine the posterior segment of the eye.

Notation of "eye exam" or "Diabetic eye exam" alone since this does not indicate a retinal OR dilated exam.

Notation of "diabetes without complications" alone (no mention of no ocular / eye complications).

Retinal imaging / retinal photos with results for only one eye because the photos for the other eye were of poor quality (must have results for both eyes).

If there is no documentation of blindness or enucleation in one eye, then documentation of only one eye examined does not meet criteria.

Eye exams or fundus examination performed by a PCP.

Description	Codes*
Palliative Care	**HCPCS:** G9054, M1017
Outpatient Codes (must include a diagnosis of diabetes)	**CPT:** 99202–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Non-Acute Inpatient (must include a diagnosis of diabetes)	**CPT:** 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337
Telephone Visits (must include a diagnosis of diabetes)	**CPT:** 98966–98968, 99441–99443
Interactive Outpatient Encounter	**CPT:** 98970–98972, 99421–99423, 99444, 99457 **HCPCS:** G0071, G2010, G2012
Unilateral Eye Enucleation With a Bilateral Modifier	**CPT:** 65091, 65093, 65101, 65103, 65105, 65110,65112, 65114 **CPT Modifier:** 50
Diabetic Retinal Screening Negative in Prior Year	**CPT-CAT-II:** 3072F**
Eye Exam With Retinopathy	**CPT-CAT-II:** 2022F, 2024F, 2026F HCPCS: S0620, S0621, S3000
Eye Exam Without Retinopathy	**CPT-CAT-II:** 2023F, 2025F, 2033F

*Codes subject to change.

**3072F corresponds to the result performed in prior year to the measurement period and not present year. For tests performed this year, please report 2022F–2033F.