**Comprehensive Diabetes Care (CDC) - Eye Exam**

**Definition**
Percentage of patients ages 18–75 with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year, negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year, or a bilateral eye enucleation anytime during the patient’s history through December 31 of the measurement year.

**Plans Affected**
- Commercial.
- Medicaid.
- Medicare Advantage.

**Quality Programs Affected**
- CMS Star Ratings.
- CPC+.
- HMAA P4Q.
- HMAA PT.
- NCQA Accreditation.

**Collection and Reporting Method**
- Hybrid claim/encounter data and medical record documentation.

**This is a quick reference tool to help you with coding and documentation of quality measures that close care gaps.**

**Codes**

<table>
<thead>
<tr>
<th>Diabetic eye exam</th>
<th>CPT/CPT II</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, 2022F, 2024F, 2026F, 3072F</td>
</tr>
</tbody>
</table>

| HCPCS       | S0620, S0621, S3000 |

**Exclusion(s)**

<table>
<thead>
<tr>
<th>Standard exclusions</th>
<th>Timeframe</th>
</tr>
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<tbody>
<tr>
<td>Patients in hospice.</td>
<td>Anytime during the measurement year.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Optional exclusions</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who have no diagnosis of diabetes in any setting and a diagnosis of gestational or steroid-induced diabetes.</td>
<td>Anytime between January 1 and December 31 of the measurement year and the year prior.</td>
</tr>
</tbody>
</table>

**Medical Record Documentation**

**Test, service, or procedure to close the care gap**
- Dilated or retinal eye exam.
- Fundus photography.
  - Patients without retinopathy should have an eye exam every two years.
  - Patients with retinopathy should have an eye exam every year.

**Medical record detail, any of the following:**
- Eye exam report.
- Diabetic flow sheets.
  - Consultation reports.
  - Progress notes.
**Tips and Best Practices to Help Close the Care Gap**

- Patients who don’t have a preferred optometrist or ophthalmologist can be referred to HMSA’s Customer Relations team at 948-6000 on Oahu or 1 (800) 660-4672 toll-free on the Neighbor Islands for help in locating an eye care professional.

- To reduce chart review and improve quality scores, PCPs can confirm completion of eye exam services through use of CPT II codes. PCPs should code an appropriate CPT II code at the appointment following receipt of the report from the specialist: 2022F, 2024F, 2026F, or if report is negative for retinopathy, the preferred code is 3072F.

- **Always list the date of service, test, and result together if you’re documenting the history of a dilated eye exam in a patient’s chart and don’t have the eye exam report from an eye care professional.** For example: “Last diabetic eye exam with Jane Doe, O.D., was June 201X with no retinopathy.”

- If the history and result of a dilated eye exam are in your progress notes, please ensure that a date of service, the test or result, and the care provider’s credentials are documented. The care provider must be an optometrist or ophthalmologist. Including only the date of the progress note won’t count.

- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn’t specific enough to meet the criteria. The medical record must indicate that a dilated or retinal exam was performed. If the words “dilated” or “retinal” are missing in the medical record, a notation of “dilated drops used” and findings for macula and vessels will meet the criteria for a dilated exam.

- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will be compliant. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- To be reimbursable, billing of fundus photography code 92250 must be submitted by an optometrist or ophthalmologist and meet disease state criteria.

For information about Medicare Star Ratings measures, please visit the Provider Resource Center at hmsa.com/portal/provider/zav_pel.aa.MED.100.htm.

Information in this guide is based on National Committee for Quality Assurance (NCQA) HEDIS technical specifications. For details, visit ncqa.org.

If you have any questions, call HMSA Provider Services at 948-6820 on Oahu or 1 (877) 304-4672 toll-free on the Neighbor Islands.