HEDIS® Tip Sheet

Effectiveness of Care Measure

CalViva HEALTH

health net

Eye Exam for Patients With Diabetes

Health Net*, on behalf of CalViva Health, wants to help your practice increase HEDIS® rates. This tip sheet outlines key details of the eye exam for patients with diabetes (EED) measure, its codes and guidance for documentation.

Measure

The percentage of members ages 18-75 with diabetes (types 1 and 2) who had a retinal eye exam during the measurement year, as defined by the following criteria:

- Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:
  - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
  - Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Exclusions

Members who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time during the measurement year.
- Died any time during the measurement year.
- Received palliative care any time during the measurement year.
- Medicare members ages 66 and older as of December 31 of the measurement year who are either enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution.
- Members ages 66 and older (for all product lines) with frailty and advanced illness.

Best practices

Helpful documentation tips

- 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 therefore do not require an exam.
- An eye exam result documented as "unknown" does not meet criteria.
- If one eye is not accessible, leading to an indeterminate result, this is not considered a result/finding.
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.

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Best practices

- Documentation in the patient's medical record must include certification that a dilated or retinal exam was performed. Ensure the patient's date of service, test date or result and the provider's credentials are documented in the progress notes.
- The provider must be an optometrist or ophthalmologist to meet compliancy.
- Documentation can be in the form of a note or letter prepared by an ophthalmologist, optometrist, primary care physician, or other health care provider indicating that an ophthalmoscopy exam was completed by an eye care professional (optometrist or ophthalmologist), the date of when the procedure was performed and the results.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
- Documentation does not have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates “diabetes without complications” does not meet criteria.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) or qualified reading center reviewed the results, or that results were read by a system that provides artificial intelligence (AI) interpretation.
- Obtain eye exam report(s). If the report(s) are not available, document eye care provider's name and credentials in the patient's chart.

How to improve HEDIS scores

- Educate patients on the risks associated with diabetic eye disease.
- Encourage patients to schedule their annual preventive retinal exams with an eye care professional.
- Prepare a standing referral to an eye care professional, assist the patient in making an eye appointment and track the referral until you get the eye care provider's report.

Helpful coding tips

- Use CPT Category II codes when billing for retinal eye exam.
- Confirm that CPT Category II codes listed on the superbill or within the electronic health record (EHR) are valid.
- Consider adding a $0.01/one cent charge when using CPT Category II codes to ensure they are not rejected on the encounter or claim.

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Code sets

Description	CPT II/CPT-CAT II/HCPCS codes
Automated eye exam	CPT: 92229
Eye exam with evidence of retinopathy	CPT-CAT II: 2022F, 2024F, 2026F
Eye exam without evidence of retinopathy	CPT-CAT II: 2023F, 2025F, 2033F
Diabetic retinal screening negative in prior year[2]	CPT-CAT II: 3072F
Unilateral eye enucleation	CPT: 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Unilateral eye enucleation - left	CD-10-PCS: 08T1XZZ
Unilateral eye enucleation - right	CD-10-PCS: 08T0XZZ
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, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245 HCPCS: S0620, S0621, S3000
Bilateral modifier	CPT: 50

[1]Healthcare Effectiveness Data and Information Set (HEDIS). National Committee for Quality Assurance (NCQA). HEDIS MY 2024 Technical Specifications for Health Plans, Volume 2, Washington, D.C., 2022.

[2]Must be a negative result to be compliant, and the reported date should be the date provider reviewed the patient's eye exam from the prior year.

24-358 (4/24)