**QCDR Measure:**

IRIS-9: Diabetic Retinopathy: Dilated Eye Exam

**National Quality Strategy Domain:**

Effective Clinical Care

**Measure Type:**

Process

**Description:**

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

**Instructions:**

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

**Denominator:**

All patients aged 18 years and older with a diagnosis of diabetic retinopathy.

Denominator Criteria

**Patients aged ≥ 18 years**

AND

**Diagnosis of diabetic retinopathy**

ICD-9 [for use 1/1/2015 – 9/30/2015]

- Diabetic retinopathy (ICD-9: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06)

ICD-10 [for use 10/1/2015 – 12/31/2015]

- Diabetic retinopathy (ICD-10: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359)

AND

**Patient encounter during the reporting period**
(CPT: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337)

**Numerator:**

Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

Definitions:
Documentation – The medical record must include: documentation of the level of severity of retinopathy (eg, background diabetic retinopathy, proliferative diabetic retinopathy, non-proliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
Macular Edema – Acceptable synonyms for macular edema include: intraretinal thickening, serous detachment of the retina, or pigment epithelial detachment.
Severity of Retinopathy – mild nonproliferative, preproliferative, very severe nonproliferative.

Numerator Options:

| | |
|---|---|
| Performance Met: | Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy |
| Performance Exclusion: | Documentation of medical reason(s) for not performing a dilated macular or fundus examination<br><br>*OR*<br><br>Documentation of patient reason(s) for not performing a dilated macular or fundus examination |
| Performance Not Met: | Dilated macular or fundus exam was not performed, reason not otherwise specified |

**Improvement Notation:**

Higher score indicates better performance