AMERICAN ACADEMY™
OF OPHTHALMOLOGY

Measure 19: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

NOTE: *There are changes to this measure in 2016. The deleted information has a strikethrough. The new information is underlined.*

Reporting Options: Claims, Registry, EHR, Diabetic Retinopathy Measures Group

Quality Domain: Communication and Care Coordination ~~Effective Clinical Care~~

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Instructions: This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy 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.

Definition:

Communication: May include documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care or a copy of a letter in the medical record to the clinician managing

Findings: Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema, the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Category II and HCPCS Codes:

Note: There are four options for reporting this measure. Each requires a Category II code and one HCPCS G code.

5010F Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care; and G8397 Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy;

or

5010F 1P Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on-going care of the patient with diabetes

and

G8397 Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy

or

5010F 2P Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on-going care of the patient with diabetes

and

G8397 Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy ,

or

G8398 Dilated macular or fundus exam not performed

or

5010F 8P Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

and

G8397 Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy

CPT Codes:

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

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Diagnosis Codes:

Diagnosis for diabetic retinopathy: 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