

**\*Measure #12: Primary Open Angle Glaucoma: Optic Nerve Evaluation**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation 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 primary open-angle glaucoma (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for primary open-angle glaucoma.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients who have an optic nerve head evaluation during one or more office visits within 12 months

**Numerator Coding:**

**Optic Nerve Head Evaluation Performed**

**CPT II 2027F:** Optic nerve head evaluation performed

**OR**

**Optic Nerve Head Evaluation not Performed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **2027F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing an optic nerve head evaluation

**OR**

**Optic Nerve Head Evaluation not Performed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2027F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Optic nerve head evaluation was not performed, reason not otherwise specified

**DENOMINATOR:**

All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of primary open-angle glaucoma and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

**ICD-9 diagnosis codes:** 365.01, 365.10, 365.11, 365.12, 365.15

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists (Lee, 2006). Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

**CLINICAL RECOMMENDATION STATEMENTS:**

The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005).

**\*Measure #13: Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended**

**DESCRIPTION:**

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had AREDS prescribed/recommended 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 age-related macular degeneration (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for age-related macular degeneration.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients with who had AREDS prescribed/recommended within 12 months

**Definition:** Medical record must include documentation of the term "AREDS" if it is recommended. If it is prescribed, it must specify the AREDS formulation.

**Numerator Coding:**

**AREDS Prescribed/Recommended**

**CPT II 4007F:** Age-Related Eye Disease Study (AREDS) formulation prescribed or recommended

**OR**

**AREDS not Prescribed/Recommended for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **4007F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing or recommending the AREDS formulation (e.g. mild AMD, patient does not meet criteria for antioxidant vitamin or mineral supplements as outlined in the AREDS study, patient smokes)

**OR**

**AREDS not Prescribed/Recommended, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4007F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Age-Related Eye Disease Study (AREDS) formulation was not prescribed or recommended, reason not otherwise specified

**DENOMINATOR:**

All patients aged 50 years and older with a diagnosis of age-related macular degeneration

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of age-related macular degeneration and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

**ICD-9 diagnosis codes:** 362.50-362.52

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye (Age-Related Eye Disease Study Research Group, 2001). From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with *mild* AMD alters the natural history of mild AMD.

**CLINICAL RECOMMENDATION STATEMENTS:**

According to the American Academy of Ophthalmology, patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports (Level A:I Recommendation) (AAO, 2005).

**\*Measure #14: Age-Related Macular Degeneration: Dilated Macular Examination**

**DESCRIPTION:**

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity 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 age-related macular degeneration (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for age-related macular degeneration.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

**Numerator Coding:**

**Dilated Macular Examination Performed**

**CPT II 2019F:** Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

**OR**

**Dilated Macular Examination not Performed for Medical or Patient Reasons**

Append a modifier (**1P** or **2P**) to CPT Category II code **2019F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing a dilated macular examination
- **2P:** Documentation of patient reason(s) for not performing a dilated macular examination

**OR**

**Dilated Macular Examination not Performed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2019F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated macular exam was not performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity, reason not otherwise specified

**DENOMINATOR:**

All patients aged 50 years and older with a diagnosis of age-related macular degeneration

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of age-related macular degeneration and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

**ICD-9 diagnosis codes:** 362.50-362.52

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Further, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced “wet” form of AMD occurs. While no data exists on the frequency or absence of regular examinations of the macula when patients are under the care of an ophthalmologist for AMD, parallel data for key structural assessments for glaucoma and cataract and diabetic retinopathy suggest that significant gaps are likely.

**CLINICAL RECOMMENDATION STATEMENTS:**

According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation (Level A: III Recommendation) (AAO, 2005).

**\*Measure #15: Cataracts: Assessment of Visual Functional Status**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status 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 cataracts (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for cataracts.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients who were assessed for visual functional status during one or more office visits within 12 months

**Definition:** Documentation in medical record of visual functional status must include: documentation that patient is operating well with vision or not operating well with vision based on discussion with the patient **OR** documentation of use of a standardized scale or completion of an assessment questionnaire (e.g., VF-14, ADVS [Activities of Daily Vision Scale], VFQ [Visual Function Questionnaire]).

**Numerator Coding:**

**Visual Functional Status Assessed**

**CPT II 1055F:** Visual functional status assessed

**OR**

**Visual Functional Status not Assessed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **1055F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not assessing patient's visual functional status

**OR**

**Visual Functional Status not Assessed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **1055F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Visual functional status was not assessed, reason not otherwise specified

**DENOMINATOR:**

All patients aged 18 years and older with a diagnosis of cataracts

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of cataracts and a CPT procedure code for ophthalmologic services are required for denominator inclusion.

**ICD-9 diagnosis codes:** 366.00-366.04, 366.09, 366.10-366.17, 366.19, 366.20, 366.22, 366.34, 366.41-366.43, 366.45, 366.46

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

The primary reason for cataract surgery is to improve the patient's visual functional status and quality of life, since there is no scientific threshold for measures such as visual acuity when cataract surgery is or is not indicated on a population basis. Data indicate that actual measured performance on important activities varies linearly with visual acuity and contrast sensitivity, two visual parameters directly affected by cataracts (West, 2002). The impact of such decrements varies from person to person. As such, it is vital to assess functioning related to vision prior to cataract surgery. Outcomes of cataract surgery, such as patient satisfaction, have been found to vary directly with the degree of pre-operative impairment (Schein, 1995; Tielsch, 1995).

**CLINICAL RECOMMENDATION STATEMENTS:**

According to the American Academy of Ophthalmology, the initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health (Level A:III Recommendation) (AAO, 2005).

**\*Measure #16: Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who had cataract surgery who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within 6 months prior to the procedure

**INSTRUCTIONS:**

This measure is to be reported each time a cataract surgery (in either one or both eyes) with intraocular lens (IOL) placement is performed during the reporting period. It is anticipated that clinicians who provide the primary management of patients undergoing cataract surgery will submit this measure.

**This measure can be reported using CPT Category II codes:**

ICD-9 procedure codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 procedure codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation documented as performed within 6 months prior to the procedure.

**Numerator Coding:**

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method Performed and Documented**

**CPT II 3073F:** Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented (must be performed within six months prior to surgery).

**OR**

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Performed and Documented for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **3073F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing the pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation

**OR**

**Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Performed and Documented, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **3073F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P**: Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation was not documented (must be performed within six months prior to surgery), reason not otherwise specified

**DENOMINATOR:**

All patients aged 18 years and older who had cataract surgery

**Denominator Coding:**

An ICD-9 or CPT procedure code is required to identify patients who underwent cataract surgery (in either one or both eyes) with IOL placement for denominator inclusion.

**ICD-9 procedure codes:** 13.70, 13.71

**OR**

**CPT procedure codes:** 66982-66984

**RATIONALE:**

An important outcome of cataract surgery is improved visual function and attainment of the patient's desired refractive outcome. Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. These data are not always documented in the patient record (McGlynn, 2003). Further, there are various methods to measure axial length and corneal power, and different lens calculation formula that can be used. The rationale for documenting these measurements and IOL power calculation formula used is to help increase the likelihood of achieving an appropriate postoperative refractive target, and to be able to review potential causes of any postoperative refractive surprises (postoperative refraction does not equal the plan/targeted refraction).

**CLINICAL RECOMMENDATION STATEMENTS:**

Achieving the targeted postoperative refraction requires measuring axial length accurately, determining corneal power, and using the most appropriate IOL power formula. (AAO).

**\*Measure #17: Cataracts: Pre-Surgical Dilated Fundus Evaluation**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who had cataract surgery who had a dilated fundus evaluation performed within six months prior to the procedure

**INSTRUCTIONS:**

This measure is to be reported each time a cataract surgery (in either one or both eyes) with or without intraocular lens (IOL) placement is performed during the reporting period. It is anticipated that clinicians who provide the primary management of patients undergoing cataract surgery will submit this measure.

**This measure can be reported using CPT Category II codes:**

ICD-9 procedure codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 procedure codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients who had a dilated fundus evaluation performed within six months prior to the procedure

**Numerator Coding:**

**Pre-surgical Dilated Fundus Evaluation Performed**

**CPT II 2020F:** Dilated fundus evaluation performed within six months prior to cataract surgery

**OR**

**Pre-surgical Dilated Fundus Evaluation not Performed for Patient Reasons**

Append a modifier (**2P**) to CPT Category II code **2020F** to report documented circumstances that appropriately exclude patients from the denominator.

- **2P:** Documentation of patient reason(s) for not performing a dilated fundus evaluation

**OR**

**Pre-surgical Dilated Fundus Evaluation not Performed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2020F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated fundus evaluation was not performed within six months prior to cataract surgery, reason not otherwise specified

**DENOMINATOR:**

All patients aged 18 years and older who had cataract surgery

**Denominator Coding:**

An ICD-9 procedure code or CPT procedure code to identify patients who underwent cataract surgery (in either one or both eyes) with or without IOL placement is required for denominator inclusion.

**ICD-9 procedure codes:** 13.11, 13.19, 13.2, 13.3, 13.41, 13.42, 13.43, 13.51, 13.59, 13.64, 13.65, 13.66, 13.69, 13.70-13.72

**OR**

**CPT procedure codes:** 66840, 66850, 66852, 66920, 66930, 66940, 66982-66984

**RATIONALE:**

All patients undergoing cataract surgery should have a comprehensive eye examination prior to the scheduled procedure, with particular attention to the presence of other ocular conditions that may impact the advisability and expected outcomes of surgery. The presence of a dilated fundus examination is often lacking in pre-operative assessments (Lee, 1996). In addition, the outcomes of cataract surgery are significantly impacted by the presence or absence of comorbid ocular conditions (Schein, 1995; Tielsch, 1995; Mangione, 1995).

**CLINICAL RECOMMENDATION STATEMENTS:**

The initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health (Level A:III Recommendation) (AAO, 2001).

**\*Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**

**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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

**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

**Definition:** Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

**Numerator Coding:**

**Macular or Fundus Exam Performed**

**CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

**OR**

**Macular or Fundus Exam not Performed for Medical or Patient Reasons**

Append a modifier (**1P** or **2P**) to CPT Category II code **2021F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- **2P:** Documentation of patient reason(s) for not performing a dilated macular or fundus examination

**OR**

**Macular or Fundus Exam not Performed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2021F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated macular or fundus exam was not performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy, reason not otherwise specified

**DENOMINATOR:**

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

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of diabetic retinopathy and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

**ICD-9 diagnosis codes:** 362.01-362.06

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study - DRS, Early Treatment Diabetic Retinopathy Study - ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

**CLINICAL RECOMMENDATION STATEMENTS:**

Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage (Level A:III Recommendation) (AAO, 2003).

**\*Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes 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 ongoing care of the patient with diabetes 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 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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.

**This measure can be reported using CPT Category II codes:**

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

**NUMERATOR:**

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

**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 the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

**Numerator Coding:**

**Dilated Macular or Fundus Exam Findings Communicated**

**CPT II 5010F:** Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

**AND**

**CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.

**OR**

**Dilated Macular or Fundus Exam Findings not Communicated for Medical or Patient Reasons**

Append a modifier (**1P** or **2P**) to CPT Category II code **5010F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
- **2P:** Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes

**AND**

**CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.

**OR**

**If patient does not meet denominator inclusion because:**

**Patient did not have dilated macular or fundus exam performed:**

Append a reporting modifier (**8P**) to CPT Category II code **2021F** to report circumstances when the action described does not meet denominator inclusion and the reason is not otherwise specified.

- **8P:** Dilated macular or fundus exam not performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy, reason not otherwise specified

**OR**

**Dilated Macular or Fundus Exam Findings not Communicated, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **5010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

**AND**

**CPT II 2021F:** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.

**DENOMINATOR:**

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

**Denominator Coding:**

An ICD-9 diagnosis code to identify patients with a diagnosis of diabetic retinopathy and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

**ICD-9 diagnosis codes:** 362.01-362.06

**AND**

**CPT procedure codes:** 99201-99205, 99212-99215, 99241-99245, 92002, 92004, 92012, 92014

**RATIONALE:**

The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease (Diabetes Control and Complications Trial - DCCT, UK Prospective Diabetes Study - UKPDS).

**CLINICAL RECOMMENDATION STATEMENTS:**

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician (Level A: III Recommendation) (AAO, 2003).