COMMUNITY FIRST HEALTH PLANS

PROVIDER TIP SHEET

HEDIS® for Patients with Diabetes (EED)

Regular checks for diabetic retinopathy is vital for your patients' eye health. The Eye Exam for Patients with Diabetes (EED) is a quality measure used by the Centers for Medicare & Medicaid Services (CMS) to assess the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam. Currently, only about 60% of people with diabetes have a yearly screening for diabetic retinopathy. Left unmanaged, diabetes can lead to serious health conditions, including vision loss and blindness. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.

Best Practices

A retinal or dilated eye exam must be performed by an eye care professional annually for patients with positive retinopathy and every two years for patients without evidence of retinopathy.

- Review diabetic services needed at each office visit.
- Refer patients to an optometrist or ophthalmologist for a dilated or retinal eye exam annually and explain why this is different than a routine eye exam.
  - » Routine eye exams for glasses, glaucoma, or cataracts do not count. It must be a dilated/retinal exam.
  - » Educate patients about the importance of routine screening and medication compliance.
- Diabetic eye exams are covered under the patient's medical insurance and may be subject to copays and deductibles.
- Required documentation: date of service, eye exam results, and eye care professional's name with credentials are required.
- Patient reported eye exams are acceptable with the above documentation.
- If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.
  - » Review the report and document abnormalities in the active problem list.
  - » Eye exam result documented as unknown does not meet criteria.
  - » Evidence of prosthetic eye(s) is acceptable for enucleation.

- Unilateral enucleation would still require an exam on the other eye.
- Optical coherence tomography is considered imaging and is eligible for use. The fundus/retinal photography must have the date, result, and eye care professional credentials documented.

Coding Tips

When results are received from an eye care professional or the patient reports an eye exam, submit the results on a $0.01 claim with the appropriate codes.

Value Set Name	Code	Definition	Code System
Eye Exam With Evidence of Retinopathy	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam With Evidence of Retinopathy	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam With Evidence of Retinopathy	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II
Eye Exam Without Evidence of Retinopathy	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II