HEDIS Measure: Comprehensive Diabetes Care – Retinal Eye Exam (DRE)

We are committed to working with you to improve the quality of care and health outcomes for our members, your patients. HEDIS® (Healthcare Effectiveness Data and Information Set) is one tool we use to measure many aspects of performance. This tip sheet details documentation and codes that can be submitted by primary care physicians (PCP) to close diabetic retinal exam gaps (DRE).

Acceptable Medical Record Documentation from a PCP

Primary care physicians can provide valuable information to close DRE gaps in care by screening or monitoring for diabetic retinal disease when there is documentation in the medical record of one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date the procedure was done and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results.

  Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year, where the results indicate retinopathy was not present.

DRE Codes — When Documentation Shows Exam by Eye Care Provider

PCPs can submit the ICD-10 diagnosis codes ***and*** the appropriate CPT Category II codes to meet DRE HEDIS technical specifications when documentation shows the exam was performed by a vision provider:

CPT Category II codes to identify diabetic retinal screening by an eye care provider:

2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

2024F – Seven standard field stereoscopic photos with interpretation by an ophthalmologist documented and reviewed

2026F – Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

OR Category II codes HCPCS and CPT to identify negative diabetic retinal screening for retinopathy:

3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)

- **HCPCS**: S0620, S0621, S3000
- **CPT II:** 3072F

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HEDIS Measure: Comprehensive Diabetes Care — DRE (continued)

PCP Performs DRE

When a PCP has the equipment to perform the diabetic retinal screening and has arrangements to have it read by a qualified vision provider.

- PCPs who perform a diabetic retinal exam and send the test to a vision provider to obtain the results of the exam can only be reimbursed at a global level. Florida Blue does not allow for unbundling, which is reimbursing the technical component and the reading/interpretation separately. Payment to the provider who reads the test performed by the PCP remains a business arrangement between those providers.

DRE Codes — When Exam by PCP and Read by Eye Care Provider

If submitted by a PCP, the following CPT codes **must be accompanied by a CPT II code to meet the HEDIS technical specifications indicating the services were performed by a qualified vision provider:**

CPT codes: 67028-67113, 67121-67221, 67227-67228, 92002-92014, 92018, 92019, 92134, 92225-92240, 92250-92260

CPT Category II codes to identify diabetic retinal screening with an eye care provider (descriptions for these codes are listed on page one):

2022F, 2024F, 2026F or 3072F (negative for retinopathy)

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