Diabetic Eye Exams
Reference Guide for Documentation and Claim Coding
Measurement Year 2024

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What is the HEDIS* measure specific to diabetics and eye exams?

This measure assesses the percentage of patients ages 18-75 with a diagnosis of diabetes (type 1 and type 2) who had a retinal eye exam.

How is the diabetic eye exam identified and monitored?

Screening or monitoring for diabetic retinal disease is identified by one of the following:

- Retinal or dilated eye exam must be performed by an eye care professional (optometrist or ophthalmologist) in the measurement year (2024)
- A **negative** retinal or dilated eye exam (negative for retinopathy) must be performed by an eye care professional in the year prior to the measurement year (2023)
- Bilateral eye enucleation any time during the patient's history through December 31 of the measurement year (2024)

Procedural Notations

- If your patient has diabetes and does not have retinal disease, one of the CPTII codes below must be added to your claim, OR, one of the three ICD-10 codes listed below must be the Primary Diagnosis code for the claim.

It is a critical claim submission component that CPT, CPTII and ICD-10 codes be added to the claim to demonstrate the outcome of retinal exams related to the HEDIS measure.**

Code Type	Code	Definition	With/Without Retinopathy
CPT	92229	Automated eye examination	With/Without
CPT	92002/92004/92012/92014	Ophthalmological services	With/Without
CPT	92018/92019	Ophthalmological examination under general anesthesia	With/Without
CPT	92134	Ophthalmic diagnostic imaging	With/Without
CPT	92201/92202	Ophthalmoscopy with interpretation and report	With/Without
CPT	92227/92228	Imaging of retina for detection of disease	With/Without
CPT	92235	Ophthalmic angiography	With/Without
CPT	92230/92240/92250/92260	Ophthalmoscopy with medical diagnostic evaluation	With/Without
CPTII	2022F 2024F 2026F	Dilated retinal eye exam Seven standard field stereoscopic retinal photos Eye imaging validated to match diagnosis from seven standard field **with evidence of retinopathy**	With
CPTII	2023F 2025F 2033F	Dilated retinal eye Seven standard field stereoscopic retinal photos Eye imaging validated to match diagnosis from seven standard field **without evidence of retinopathy**	Without
CPTII	3072F	Low risk/negative for retinopathy in prior year (2023)	Without
ICD10	E10.9, E11.9, E13.9	Type 1/Type 2/Other specified diabetes mellitus without complications	Without

How to Document

At a minimum, documentation in the medical record must include one of the following:

- A note/letter prepared by an eye care professional indicating that an ophthalmoscopic exam was completed, the date of the procedure, and the results
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an optometrist/ophthalmologist reviewed the results. Results may be interpreted using artificial intelligence (AI) or at a qualified reading center
- Documentation of a negative retinal or dilated eye exam by an optometrist/ophthalmologist in the year prior to the measurement year, results indicating that retinopathy was not present
- Documentation anytime in the patient's history of evidence that the patient had a bilateral enucleation or acquired absence of both eyes

**HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance, or NCQA. Measure specifications are from the National Committee for Quality Assurance.*

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