

## Diabetic Eye Exams Reference Guide for Documentation and Claim Coding

Measurement Year 2025

### 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 (2025)
- 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 (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	92230/92250	Ophthalmoscopy with medical diagnostic evaluation	With/Without
CPT	99203/99204/99205	New patient office visit requiring 30+ minutes	With/Without
CPT	99213/99214/99215	Established patient office visit	With/Without
CPT	99242/99243/99244/99245	Office consultation for a new or established patient	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 <b>with evidence of retinopathy</b>	With
CPTII	2023F 2025F 2033F	Dilated retinal eye Seven standard field stereoscopic retinal photos Eye imaging validated to match diagnosis from seven standard field <b>without evidence of retinopathy</b>	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 or letter prepared by an ophthalmologist, optometrist, PCP, or other healthcare professional that an optometrist or ophthalmologist completed an ophthalmoscopic exam, the date when the procedure was performed, and the results of the procedure
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - evidence that an optometrist/ophthalmologist reviewed the results
  - evidence results were read by a system that provides an artificial intelligence (AI) interpretation
  - evidence that the patient had bilateral eye enucleation of acquired absence of both eyes; look as far back as possible in the patient's history through December 31, 2024
- Documentation of a negative retinal or dilated eye exam by an optometrist/ophthalmologist in 2024, where results indicate that retinopathy was not present

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