Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

*This measure is to be reported for all patients aged 18 years and older with diabetic retinopathy (in either one or both eyes) — a minimum of **once** per reporting period.*

Measure 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

What will you need to report for each patient with diabetic retinopathy for this measure?

If you select this measure for reporting, you will report:

- Whether or not you performed a dilated macular or fundus exam which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema[1]

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to perform a dilated macular or fundus exam which included documentation of the level of severity of retinopathy and the presence or absence of macular edema, due to:

- Medical reasons[2] OR
- Patient reasons (eg, patient declined, economic, social, religious, other patient reason)

In these cases, you will need to indicate which reason applies, specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).

[1]Medical record must include: Documentation of the level of severity of retinopathy (eg, background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

[2]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.

PQRI 2007 Measure 18, Effective Date 07/01/2007

Diabetic Retinopathy

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PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	**No**	**Code Required on Claim Form**
Patient is aged 18 years and older.	☐	☐	Verify date of birth on claim form.
Patient has a diagnosis of diabetic retinopathy.	☐	☐	Refer to coding specifications document for list of applicable codes.
There is a CPT E/M Service Code for this visit.	☐	☐	
If **No** is checked for any of the above, STOP. Do not report a CPT category II code.			
Step 2 Does patient meet or have an acceptable reason for not meeting the measure?			
Dilated Macular or Fundus Exam (including documentation of the level of severity of retinopathy AND the presence or absence of macular edema)[1]	**Yes**	**No**	**Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)**
Performed	☐	☐	2021F
Not performed for one of the following reasons:			
• Medical[2]	☐	☐	2021F–1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐	2021F–2P
Document reason here and in medical chart. _____ _____			If **No** is checked for **all** of the above, report 2021F–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.)

[1]Medical record must include: Documentation of the level of severity of retinopathy (eg, background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

[2]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.

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Coding Specifications

Codes required to document patient has diabetic retinopathy and a visit or procedure for ophthalmologic services occurred:

An ICD-9 diagnosis code for diabetic retinopathy and a CPT E/M service code are required to identify patients to be included in this measure.

Diabetic retinopathy ICD-9 diagnosis codes

- 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 (diabetic retinopathy)

AND

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient)

Quality codes for this measure (one of the following for every eligible patient):

CPT II Code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- ***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
- ***CPT II 2021F–1P[1]:*** Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- ***CPT II 2021F–2P:*** Documentation of patient reason(s) for not performing a dilated macular or fundus examination
- ***CPT II 2021F–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

[1]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.