Communication with the Physician Managing Ongoing Diabetes Care

*This measure is to be reported for all patients aged 18 years and older with diabetic retinopathy—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 with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the macular or fundus exam at least once 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

If the dilated macular or fundus exam was performed (as described above), you will then need to report:

- Whether or not you communicated[1] the findings of the dilated macular or fundus exam to the physician managing the patient's diabetes care

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

There may be times when it is not appropriate to communicate the findings of the dilated macular or fundus exam, 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]Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

[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 19, 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) / /	☐ Male ☐ Female Gender
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 also have the other requirements for this measure?			
	Yes	**No**	**Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)**
Did patient have dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy?	☐	☐	If **No,** report only 2021F–8P and STOP. If **Yes,** report 2021F and proceed to Step 3.
Step 3 Does patient meet or have an acceptable reason for not meeting the measure?			
Dilated Macular of Fundus Exam Findings	**Yes**	**No**	**Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)**
Communicated[1]	☐	☐	5010F
Not communicated for one of the following reasons: • Medical[2]	☐	☐	5010F–1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐	5010F–2P
Document reason here and in medical chart. _____ _____			If **No** is checked for **all** of the above, report 5010F–8P (Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified.)

[1]Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

[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 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:

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

Quality codes for this measure (at least 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–8P:*** Dilated macular or fundus exam not performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy, reason not otherwise specified
- ***CPT II 5010F:*** Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
- ***CPT II 5010F–1P:*** Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.
- ***CPT II 5010F–2P:*** Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.
- ***CPT II 5010F–8P:*** Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified.