*Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure. The system 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.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P-system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients 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

> Definition: Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent
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> Numerator Coding:
> Macular or Fundus Exam Performed
> 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

OR

Macular or Fundus Exam not Performed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P, or 3P) to CPT Category II code 2021F to report documented circumstances that appropriately exclude patients from the denominator.

- 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination
- 3P: Documentation of system reason(s) for not performing a dilated macular or fundus examination

OR

Macular or Fundus Exam not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2021F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Dilated macular or fundus exam was not performed reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy

Denominator Coding:
An ICD-9 diagnosis code for diabetic retinopathy and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
AND
CPT codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study - DRS, Early Treatment Diabetic Retinopathy Study - ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

CLINICAL RECOMMENDATION STATEMENTS:
Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage. (Level A:III Recommendation) (AAO, 2003)