*Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

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 mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy 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 and/or G-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 and/or G-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 AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

> Definition: Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., 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.
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> *NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Dilated Macular or Fundus Exam Findings Communicated

(One CPT II code & one G-code [5010F & G8397] are required on the claim form to submit this category)

CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Patient or System Reasons

(One CPT II code & one G-code [5010F-xP & G8397] are required on the claim form to submit this category)

Append a modifier (2P or 3P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.

- 5010F *with* 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
- 5010F *with* 3P: Documentation of system 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

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:

(One G-code [G8398] is required on the claim form to submit this category)

G8398: Dilated macular or fundus exam not performed

OR

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Specified

(One CPT II code & one G-code [5010F-8P & G8397] are required on the claim form to submit this category)

Append a reporting modifier (8P) to CPT Category II code 5010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 5010F *with* 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

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:
The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial - DCCT, UK Prospective Diabetes Study - UKPDS)

CLINICAL RECOMMENDATION STATEMENTS:
While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)