

Diabetic Retinopathy

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

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
Patient has a diagnosis of diabetic retinopathy.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes.
There is a CPT E/M Service Code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	
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			Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
	Yes	No	
Performed	<input type="checkbox"/>	<input type="checkbox"/>	2021F
Not performed for one of the following reasons:			
• Medical (eg, not indicated, contraindicated, other medical reason)	<input type="checkbox"/>	<input type="checkbox"/>	2021F-1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	<input type="checkbox"/>	<input type="checkbox"/>	2021F-2P
• System ²	<input type="checkbox"/>	<input type="checkbox"/>	2021F-3P
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.)

¹Medical 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

²The 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.