Diabetic Retinopathy

Communication with the Physician Managing Ongoing Diabetes Care

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 G-code or 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 G8398 and STOP. If **Yes,** report G8397 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: • Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐	5010F–2P
• System[2]	☐	☐	5010F–3P
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 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.

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