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

*This measure is to be reported for all patients aged 18 years and older with diabetic retinopathy (in either one or both eyes) — 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 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

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[1]

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

There may be times when it is not appropriate to perform a dilated macular or fundus exam which included documentation of the level of severity of retinopathy and the presence or absence of macular edema, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason) OR
- Patient reasons (eg, patient declined, economic, social, religious, other patient reason)

In these cases, you will need to indicate which reason applies, and 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]Medical 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.