Communication with the Physician Managing Ongoing Diabetes Care

Coding Specifications

Codes required to document patient has diabetic retinopathy and a visit or procedure for ophthalmologic services occurred:

An ICD-9-CM diagnosis code for diabetic retinopathy and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Diabetic retinopathy ICD-9 diagnosis codes:

- 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 (diabetic retinopathy)

AND

CPT codes:

- 92002, 92004
- 92012, 92014
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality codes for this measure:

G-code and CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- ***G8397:*** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy
- ***G8398:*** Dilated macular or fundus exam not performed
- ***CPT II 5010F:*** Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
- ***CPT II 5010F–1P:*** Documentation of medical 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 (eg, not indicated, contraindicated, other medical reasons)
- ***CPT II 5010F–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 (eg, patient declined, economic, social, religious, other patient reasons)
- ***CPT II 5010F–8P:*** Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified