Eye Exam for Patients With Diabetes (EED)

New for 2025

Yes!
Supplemental data accepted

Added

- Bi-lateral eye enucleation is now a required exclusion
- The following scenarios were added to the gap closure criteria:
  - Retinal imaging by a qualified reading center
  - Indicated findings from a retinal exam for diabetic retinopathy performed in both eyes

Updated

- The Hybrid Data Collection Method was removed from this measure - measure will be reported as Administrative only

Definition

Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had any 1 of the following:

- Retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year

Plans(s) affected	Quality program(s) affected	Collection and reporting method
• Commercial • Exchange/Marketplace • Medicaid • Medicare	• CMS Star Ratings • CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/encounter data • Pharmacy data

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Eye Exam for Patients With Diabetes (EED) (cont.)

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice

Scenario 1: Eye exam with or without evidence of retinopathy billed by any provider type during the measurement year OR eye exam without evidence of retinopathy during prior year billed by any provider type

Diabetic eye exam without evidence of retinopathy	
CPT®/CPT II	2023F, 2025F, 2033F

Diabetic eye exam with evidence of retinopathy	
CPT®/CPT II	2022F, 2024F, 2026F

Scenario 2: Automated eye exam billed by any provider type during the measurement year

Automated eye exam (imaging of retina)	
CPT®/CPT II	92229

Scenario 3: Retinal imaging by a qualified reading center, billed by any provider type during the measurement year

Retinal imaging	
CPT®/CPT II	92227, 92228

Scenario 4: Diabetic retinal screening negative in year prior, billed by any provider type

Diabetic retinal screening negative in prior	
CPT®/CPT II	3072F

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Scenario 5: Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider

Left eye	Right eye
Any level of retinopathy (LOINC code 71490-7) **with** diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2) **during the measurement year**	Any level of retinopathy (LOINC code 71491-5) **with** diabetic retinopathy severity level (LOINC codes LA18644-7, LA18645-4, LA18643-9, LA18648-8, LA18646-2) **during the measurement year**
No retinopathy (LOINC code 71490-7 **with** LOINC code LA18643-9) in the **year prior to the measurement year**	No retinopathy (LOINC code 71491-5 **with** LOINC code LA18643-9) in the **year prior to the measurement year**

Scenario 6: Retinal eye exam billed by an eye care professional during the measurement year OR retinal eye exam billed by an eye care professional during the prior year with a diagnosis of diabetes without complications

Retinal eye exam	
CPT®/CPT II	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
HCPCS	S0620, S0621, S3000
SNOMED	252780007, 252781006, 252782004, 252783009, 252784003, 252788000, 252789008, 252790004, 252846004, 274795007, 274798009, 308110009, 30842004, 314971001, 314972008, 36844005, 390852004, 391999003, 392005004, 410441007, 410450009, 410451008, 410452001, 410453006, 410455004, 416369006, 417587001, 420213007, 425816006, 426880003, 427478009, 53524009, 56072006, 56204000, 6615001, 700070005, 722161008
Diabetes mellitus without complications	
ICD-10 Diagnosis	E10.9, E11.9, E13.9
SNOMED	721111000124107, 721121000124104, 721201000124104, 31321000119102, 1481000119100, 111552007, 1217068008, 1217044000, 190412005, 1290118005, 313435000, 313436004

Eye Exam for Patients With Diabetes (EED) (cont.)

Required exclusion(s)

Exclusion	Time frame
• Members in hospice or using hospice services • Members receiving palliative care • Members who died • Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either: – Enrolled in an Institutional Special Needs Plan (I-SNP) – Living long term in an institution*	Any time during the measurement year
• Members 66 years of age and older as of Dec. 31 of the measurement year with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to qualify as an exclusion: – **Frailty:** At least 2 diagnoses of frailty on different dates of service during the measurement year. Do not include claims where the frailty diagnosis was from an independent lab (POS 81). – **Advanced Illness:** Indicated by 1 of the following: o At least 2 diagnoses of advanced illness on different dates of service during the measurement year or year prior. Do not include claims where the advanced illness diagnosis was from an independent lab (POS 81). o Dispensed dementia medication Donepezil, Donepezil-memantine, galantamine, rivastigmine or memantine	• **Frailty** diagnoses must be in the measurement year and on different dates of service • **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year
• Bi-lateral eye enucleation	• Any time during the member's history through Dec. 31 of the measurement year

Eye Exam for Patients With Diabetes (EED) (cont.)

Important notes

	Test, service or procedure to close care opportunity	Medical record detail including, but not limited to
• Members without retinopathy should have an eye exam every 2 years • Members with retinopathy should have an eye exam every year	• Bilateral eye enucleation or acquired absence of both eyes • Dilated or retinal eye exam • Fundus photography	• Consultation reports • Diabetic flow sheets • Eye exam report • Progress notes

Eye Exam for Patients With Diabetes (EED) (cont.)

Tips and best practices to help close this care opportunity

- **Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- **If documenting the history of a dilated eye exam in a member's chart and do not have the eye exam report from the eye care professional, always list the date of service, test, result and that retinopathy was assessed by an eye care professional**
  - For example: "Last diabetic eye exam with John Smith, OD, was June 2024 with no retinopathy"
- Documentation of a diabetic eye exam by an optometrist or ophthalmologist isn't specific enough to meet the criteria. The medical record must indicate that a **dilated or retinal exam** was performed. If the words "dilated" or "retinal" are missing in the medical record, a notation of "dilated drops used" and findings for macula and vessels will meet the criteria for a dilated exam.
- If history of a dilated retinal eye exam and result is in your progress notes, please ensure that a date of service, the test or result, and the care provider's credentials are documented. The care provider must be an optometrist or ophthalmologist, and including only the date of the progress note will not count.
- A slit-lamp examination will not meet the criteria for the dilated eye exam measure. There must be additional documentation of dilation or evidence that the retina was examined for a slit-lamp exam to be considered compliant
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results will be compliant.
  - Alternatively, results may be read by:
    - A qualified reading center that operates under the direction of a medical director who is a retinal specialist
    - A system that provides artificial intelligence (AI) interpretation
- If a copy of the fundus photography is included in your medical record it must include results, date and signature of the reading eye care professional for compliance
- To be reimbursable, billing of fundus photography code 92250 must be submitted globally by an optometrist or ophthalmologist and meet disease state criteria
- Documentation of hypertensive retinopathy should be considered the same as diabetic retinopathy
- If your office submits CCDs to UnitedHealthcare via our clinical data exchange program, please ensure the CCD function within your EMR system is set up to send CPT II Codes in the extract

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- The use of CPT® Category II codes helps UnitedHealthcare identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for some chart review.
  - Adding CPT II modifier codes to a claim may result in the gap not closing
- Dilated retinal eye exams with results can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status.
  - As part of the UnitedHealthcare clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.

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