

Communication with the Physician Managing Ongoing Diabetes Care

*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 with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once 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

If the dilated macular or fundus exam was performed (as described above), you will then need to report:

- Whether or not you communicated¹ the findings of the dilated macular or fundus exam to the physician managing the patient's diabetic care

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

There may be times when it is not appropriate to communicate the findings of the dilated macular or fundus exam, due to:

- Patient reasons (eg, patient declined, economic, social, religious, other patient reason) OR
- System reasons²

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).

¹Communication 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.

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.

Diabetic Retinopathy

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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?			Code Required on Claim Form
	Yes	No	
Patient is aged 18 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
Patient has a line item diagnosis of diabetic retinopathy.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
There is a CPT 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 G-code or CPT category II code.			
Step 2 Does patient also have the other requirements for this measure?			Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)
	Yes	No	
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?	<input type="checkbox"/>	<input type="checkbox"/>	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?			Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Dilated Macular or Fundus Exam Findings	Yes	No	
Communicated ¹	<input type="checkbox"/>	<input type="checkbox"/>	5010F
Not communicated for one of the following reasons:			
• Patient (eg, patient declined, economic, social, religious, other patient reason)	<input type="checkbox"/>	<input type="checkbox"/>	5010F-2P
• System ²	<input type="checkbox"/>	<input type="checkbox"/>	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.)

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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.

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Coding Specifications

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

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

All measure-specific coding should be reported ON THE SAME CLAIM.

Diabetic retinopathy line item ICD-9 diagnosis codes:

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

AND

CPT service codes:

- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary)

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-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.
- **CPT II 5010F-3P¹:** Documentation of system 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.
- **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.

¹The 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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