



Comprehensive Diabetes Care – Eye Exam (CDC–Eye)

HEDIS measure overview

Monitoring diabetic retinopathy is not just important to your patients' eye health. Comprehensive Diabetes Care – Eye, or CDC–Eye, is one of the Centers for Medicare & Medicaid Services (CMS) Star performance measures used to evaluate the care and services provided by physicians and other healthcare providers. CDC–Eye measures the percentage of diabetic patients who had a comprehensive eye exam during the measurement year.

Please note that the information offered in this flyer is based on Healthcare Effective Data Information Set (HEDIS®) technical specifications. It is not meant to replace your clinical judgment.

Who is included in the CDC–Eye measure?

Patients 18–75 years old with diabetes (type 1 or type 2) who met any of the following criteria during the measurement year or the year prior to the measurement year:

- Patients who were dispensed diabetic medication, including insulin and oral antiglycemics
- Patients with two outpatient visits with a diagnosis of diabetes
- Patients with at least one hospitalization with a diagnosis of diabetes

Measure performance is determined by the number of eligible patients who had an eye exam to check for damage from diabetes during the measurement year.

Exclusions

- Patients in hospice or using hospice services
- Patients 66–75 years old who live long-term in an institutional setting and/or with frailty and advanced illness

Performing well on the CDC–Eye measure

One of the following services performed for eligible members will satisfy the measure requirement:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation any time during the patient's history through Dec. 31 of the measurement year

Physicians should ensure that diabetic patients receive an eye exam (retinal or dilated) performed by an eye care professional (optometrist or ophthalmologist) in the measurement year or that the patient tested negative for retinopathy during a retinal or dilated eye exam by an eye care professional in the year prior to the measurement year. If a patient tests negative for retinopathy, practices should utilize one of the codes provided to report these results. This will satisfy the measure requirement for two years.



Best practices for primary care physicians and eye care professionals

- Discuss with patients the importance of an annual comprehensive eye exam.
- Refer patients to eye care professionals and schedule appointments for patients, if necessary.
- Ensure patients have completed an annual comprehensive eye exam.
- If utilizing fundus photography technology in a primary care office setting, ensure the retinal image has been reviewed and interpreted by an eye specialist.
- Send a copy of the exam to the primary care physician (PCP) to store in the patient's medical record.
- Review and use the appropriate CPT II code to indicate review of the eye exam result.
- Ensure that a proper billing code is used to indicate an eye exam has been performed.
- Submit a proper diagnosis code identifying the patient as having diabetes, if appropriate.
- Use a proper diagnosis code to report results if the patient tested negative for retinopathy.

Patient out-of-pocket cost information

- Diabetic eye exams are covered for all plans and, for most common CPT codes, have \$0 in-network cost share for Humana-covered patients with diabetes at all outpatient levels of service.
 - For plans with a deductible or for vision services performed by an out-of-network provider, this service will apply to the plan deductible. Humana-covered patients who have this service prior to meeting their plan deductible may have out-of-pocket costs.
- Coverage applies to one eye exam during the calendar year starting at the plan effective date under Medicare-covered vision services at both specialist and PCP levels of service.

Coding for eye exams

The following tables contain the codes used to document eye exams that support the CDC–Eye measure.

Codes from eye care professionals

(National Provider Identification [NPI] required in addition to code[s] to close a care opportunity)

Most common CPT	92002, 92004, 92012, 92014, 92134, 92225, 92226, 92227, 92228, 92230, 92250, 92260
Other CPT	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92018, 92019, 92201, 92202, 92235, 92240, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
ICD-10-PCS codes for eye enucleation	08T1XZZ, 08T0XZZ
HCPCS	S0620, S0621, S3000
ICD-10-CM to report negative results	E10.9, E11.9, E13.9
CPT codes for eye enucleation	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Note: CPT code 99212 billed by an eye care professional does not meet the specification requirement of a retinal or dilated eye exam. CPT: Current Procedural Terminology; HCPCS: Healthcare Common Procedure Coding System ICD-10-CM: International Classification of Diseases-Clinical Modification ICD-10-PCS: International Classification of Diseases-Procedure Coding System	

Codes from any provider

(National Provider Identifier [NPI] is required in addition to code[s] to close care opportunity)

Description	Without evidence of retinopathy†	With evidence of retinopathy‡
• Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist, documented and reviewed • 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed • Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed • Low risk for retinopathy (no evidence of retinopathy in the prior year)	• 2023F • 2025F • 2033F • 3072F	• 2022F • 2024F • 2026F • N/A

† When negative retinopathy results are reported for a patient, they will be compliant for the measurement year in which the testing occurred through the end of the following measurement year. 2023F, 2025F and 2033F are new CPT II codes that can be used for dates of service beginning Jan. 1, 2020.

‡ When these codes are used for dates of service prior to Jan. 1, 2020, please report negative retinopathy results using diagnostic codes E10.9, E11.9 and E13.9.

Note: Physicians should retain a copy of the eye exam in the patient's medical record.

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