GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

STAR MEASURE: EYE EXAM FOR PATIENTS WITH DIABETES (EED)

Measure Steward: National Committee for Quality Assurance (NCQA)

Gold Coast Health Plan Total Care Advantage's (HMO D-SNP) goal is to help its providers gain compliance with their annual Managed Care Accountability Set (MCAS) / Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet will provide the key components to the Star measure, *"Eye Exam for Patients with Diabetes (EED)."*

Measure Description: This measures the percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam during the measurement year.

Measure Specification: Identify persons with a diagnosis of diabetes. Either of the following meets criteria:

- Claim / encounter data. At least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period.
- Pharmacy data. At least one diagnosis of diabetes **and** at least one diabetes medication dispensing event of insulin or a hypoglycemic/anti-hyperglycemic medication (Diabetes Medications List) during measurement period.

Data Collection Method: Administrative[1]

EED Clinical Code Set

- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.

Methods used to identify members diagnosed with diabetes

Method 1: Members with at least two diagnoses of diabetes on different dates of service during the measurement year (MY) or year prior to measurement year (PMY).	Click here for the list of diabetes diagnosis codes.
Method 2: Members with at least one diagnosis of diabetes and at least one diabetes medication dispensing event of insulin or hypoglycemic medication during the MY or PMY.	Click above for the list of diabetes diagnosis codes. Click here for the list of diabetes medications.

Codes used to identify a diabetic eye exam (retinal eye exam, fundus photography).

Description	Year of Screening	ICD-10-CM	CPT	CPT II	HCPCS	LOINC
Retinal eye exam by eye care professional	MY		92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245		S0620, S0621, S3000	
Retinal eye exam by eye care professional with diagnosis of diabetes ***without*** complications	PMY	E10.9, E11.9, E13.9				
Retinal eye exam billed by any provider	MY			2022F, 2024F, 2026F, 2023F, 2025F, 2033F, 3072F		

Description	Year of Screening	ICD-10-CM	CPT	CPT II	HCPCS	LOINC
Retinal imaging interpretation billed by any practitioner	MY		92227, 92228			
Autonomous eye exam billed by any provider	MY		92229			105914-6 with result
Eye exam with no evidence of retinopathy billed by any provider	PMY			2023F, 2025F, 2033F,		

Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined.

Description	Year of Screening	ICD-10-PCS	LOINC
Left eye with retinopathy	MY		LOINC 71490-7 with any of the following: LA18643-9, LA18644-7, LA18645-4, LA18646-2, LA18648-8
Left eye without retinopathy	PMY		LOINC code 71490-7 with LA18643-9
Left eye enucleation anytime during the member's history	Lifetime	08T1XZZ	
Right eye with retinopathy	MY		LOINC 71491-5 with any of the following: LA18643-9, LA18644-7, LA18645-4, LA18646-2, LA18648-8
Right eye without retinopathy during prior MY	PMY		LOINC code 71491-5 with LA18643-9
Right eye enucleation anytime during the member's history	Lifetime	08T0XZZ	

Exclusion Criteria – Members with any of the following conditions are excluded from the EED measure:

- Members who do not have a diagnosis of diabetes during the measurement year or the year prior.
- Members with bilateral absence of eyes or eye enucleation.
- Members who have received hospice services any time during the measurement year.
- Members age 66 and older with advanced illness and frailty.
- Members who passed away during the measurement year.
- Members who received palliative care during the measurement year.
- Medicare members age 66 and older as of Dec. 31 of the measurement year who are either enrolled in an institutional Special Needs Plan (I-SNP) or living long term in an institution (LTI).
- Note: Blindness is not an exclusion for a diabetic eye exam.

Medical Record Must Include:

- To document a history of a dilated eye exam without the official report, you must include the date of service, the name or specialty of the assessing eye care professional (optometrist or ophthalmologist), and the exam findings or results (stating whether retinopathy was present).
  - For example: "Last diabetic eye exam with John Smith, OD, was June 2024 with no retinopathy."
- 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. Including only the date of the progress note will not count.
- For fundus photography to count toward the EED measure, strict documentation requirements must be met:
  - The results of the fundus photography must be interpreted by a qualified eye care professional, such as an optometrist or an ophthalmologist.
  - Documentation must indicate an optometrist or ophthalmologist read / reviewed the results.
  - The patient's medical record must include the date of the service, results of the retinal photography, and the name and credentials of the interpreting eye care professional.
  - The photographs themselves must be retained in the patient's record.
  - For remote imaging (teleretinal screening): Images captured by a non-eye professional and sent to a specialist for interpretation and the specialist's report must be retained in the medical record.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
- Make outreach calls and/or send letters to advise members of the need for a visit.
- Ensure that outreach methods include educational information.
- Ensure members with positive retinopathy are receiving a retinal or dilated eye exam from an eye care professional annually, and every two years for patients without evidence of retinopathy.
- Document date of service, eye exam results, and eye care professional's name with credentials in the patient's medical history to meet measure criteria.
- Total Care Advantage offers free health education services, materials, classes, and online resources to help members achieve a healthy lifestyle. Providers can contact the Health Education Department or refer patients / guardians / caregivers to the following information:
  - Providers, call: 1-805-437-5961
  - Members, call: 1-888-301-1228 / TTY 711
  - GCHP website, Health Education Resources (provided in English and Spanish): Click here
- Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health. Total Care Advantage Care Management referrals can be made by submitting the referral form available on the Gold Coast Health Plan (GCHP) website or by contacting the Care Management team by phone or email.
  - Care Management Contact: 1-805-437-5656
  - Care Management Email: CareManagement@goldchp.org
  - English Referral Form: Click Here
  - Spanish Referral Form: Click Here
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.