Eye Exam for Patients with Diabetes (EED)

The Eye Exam for Patients with Diabetes measure evaluates patients 18-75 years of age with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an ophthalmologist or optometrist in the measurement period.

Product lines	Quality programs impacted	Collection and reporting method
• Commercial • Medicaid • Medicare	• CMS Star Ratings • NCQA Health Plan Ratings • State Performance Measure • Quality Rating System	• Administrative • Claim data

Numerator compliance	Screening or monitoring for diabetic retinal disease by an eye care professional. This includes people with diabetes who had one of the following: • A retinal or dilated eye exam in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement year.		
Denominator eligibility criteria	**A member is considered eligible for the EED measure if they have evidence of a diabetes diagnosis in one of the following ways:** • **Claims/Encounter Data**: At least **two separate diagnoses of diabetes** on different dates of service, either during the measurement year or the year prior • **Pharmacy Data**: At least **one diagnosis of diabetes** and at least **one prescription fill** for a diabetes medication (such as insulin or a hypoglycemic/antihyperglycemic medication), during the measurement year or the year prior		
Time period	Jan. 1, 2026 – Dec. 31, 2026		
Billing codes	**Description**	**Code type**	**Codes**
	Retinal eye exams	CPT	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92137, 92201, 92202, 92230, 92235, 92250, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245
		HCPCS	S0620, S0621, S3000
		SNOMED	18188000, 21593001, 252779009, 252780007, 252781006, 252782004, 252783009, 252784003, 252788000, 252789008, 252790004, 252846004, 274795007, 274798009, 308110009, 30842004, 314972008, 36844005, 391999003, 392005004,

			410441007, 410450009, 410451008, 410452001, 410453006, 410455004, 416369006, 417587001, 420213007, 425816006, 427478009, 53524009, 56072006, 56204000, 6615001, 700070005, 722161008
	Any code in the retinal eye exam value set with a diagnosis of diabetes without complications	ICD10	E10.9, E11.9, E13.9
		SNOMED	111552007, 1217044000, 1217068008, 1290118005, 1481000119100, 190412005, 290002008, 31321000119102, 313436004, 443694000, 444073006, 44407400, 444110003, 445353002, 870528001, 164971000119101, 721111000124107, 721121000124104, 721201000124104
	Eye exam with evidence of retinopathy	CPT II	2022F, 2024F, 2026F
	Eye exam without evidence of retinopathy	CPT II	2023F, 2025F, 2033F
	Retinal imaging	CPT	92227, 92228
		SNOMED	3047001, 20067007, 314971001
	Diabetic retinal screening negative in prior year (Billed by any provider)	CPT II	3072F
	Autonomous eye exam	CPT	92229
		LOINC	105914-6 **with** a result
	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:		
	Left Eye	Right Eye	
	Retinal exam finding: Any level of retinopathy (LOINC code 71490-7 **with** Diabetic Retinopathy Severity Level Value Set) during the measurement year	Retinal exam finding: Any level of retinopathy (LOINC code 71491-5 **with** Diabetic Retinopathy Severity Level Value Set) during the measurement year	
	Description	**Code type**	**Codes**

	Diabetic retinopathy severity level	LOINC	LA18643-9, LA18644-7, LA18645-4, LA18646-2, LA18648-8
	Retinal exam finding: No retinopathy (LOINC code 71490-7 with LOINC code LA18643-9) in the year prior to the measurement year	Retinal exam finding: No retinopathy (LOINC code 71491-5 **with** LOINC code LA18643-9) in the year prior to the measurement year	
	Enucleation: ICD-10-PCS code 08T1XZZ any time during the member's history through December 31 of the measurement year.	Enucleation: ICD-10-PCS code 08T0XZZ any time during the member's history through December 31 of the measurement year.	
Frequency/occurrence	Every year		
Required exclusions	• Bilateral absence of eyes any time during the member's history through December 31 of the measurement year • Bilateral eye enucleation any time during the patient's history – Unilateral eye enucleation with a bilateral modifier (CPT Modifier code 50) – Two unilateral eye enucleations with service dates 14 days or more apart – Left unilateral eye enucleation and right unilateral eye enucleation on the same or different dates of service – A unilateral eye enucleation and a left unilateral eye enucleation with service dates 14 days or more apart – A unilateral eye enucleation and a right unilateral eye enucleation with service dates 14 days or more apart • Members who use hospice services • Members receiving palliative care • Medicare members 66 years of age and older as of December 31 of the measurement year who are enrolled in an institutional SNP (I-SNP) or living long-term in an institution • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness / dispensed dementia medication		
Required exclusion billing codes	**Description**	**Code type**	**Codes**
	Bilateral absence of eyes	SNOMED	15665641000119103

	Unilateral eye enucleation or **Unilateral eye enucleation with bilateral modifier**	CPT	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
		SNOMED	59590004, 172132001, 205336009, 397800002. 397994004, 398031005, 1303651001, 1303652008
		Modifier	50
	Left unilateral eye enucleation	ICD-10-PCS	08T1XZZ
	Right unilateral eye enucleation	ICD-10-PCS	08T0XZZ
Test, service or procedure to close care opportunity	• Dilated or retinal eye exam • Fundus photography • Negative retinal or dilated eye exam from prior year • Bilateral eye enucleation or acquired absence of both eyes anytime during their history		
Medical record documentation	Medical records dates: 01/01/2026 - 12/31/2026 Submit medical record documentation for open gaps of care to Priority Health HEDIS department • Electronically uploading medical records – contact HEDIS@PriorityHealth.com to get a file set up or for more information • Email: HEDIS@PriorityHealth.com • Fax: 616.975.8897 • Mail: HEDIS at 1231 E Beltline, NE Mail Stop 1280, Grand Rapids, MI, 49525		
Common deficiencies	No referral to an ophthalmologist or optometrist		
Claim submission deficiencies	Not submitting CPT II codes on claims submissions		

Tips and best practices

→ **Check your PIP reports to identify patients with open care opportunities**
→ Always list the date of service, test, result and eye care professional's name and credentials together if you're documenting the history of a dilated eye exam in a patient's chart and you don't have the eye exam report from the eye care professional. The care provider must be an optometrist or ophthalmologist
→ A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an ophthalmologist or optometrist reviewed the results will be compliant. The fundus photography must include the result, date and signature of the reading eye care professional for compliance
→ Create a process to follow-up with patients within 60 days of referral if eye exam isn't completed
→ Use EHR/EMR alerts for patients due for a retinal eye exam
→ The use of CPT II codes helps identify clinical outcomes such as diabetic retinal screening with an eye care professional. It can also reduce the need for chart review
→ Timely submission of claim data

Dilated retinal eye exams with results can be accepted as supplemental data

Important notes

- Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that patients with evidence of any type of retinopathy have an eye exam annually, while patients who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year