Diabetes: Eye Exam (CSM131)

The following is for educational purposed only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at https://ecqi.healthit.gov/ecqm/ec/2023/cms131v11

Quick Guide

Measure Details

Description *

Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period by an eye care professional during the measurement period or in the 12 months prior to the measurement period

Initial Population

Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period

Denominator

Equals Initial Population

Numerator

Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:

- Diabetic with a diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period
- Diabetic with no diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period

Denominator Exclusion

- Exclude patients who are in hospice care for any part of the measurement period
- Exclude patients receiving palliative care during for any part of the measurement period.
- Exclude patients 66 and older by the end of the measurement period who are living long term in an institution for more than 90 consecutive days during a nursing home any time on or before the end of the measurement period
- Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
 - Advanced illness with two outpatient encounters during the measurement period or the year prior OR
 - Advanced illness with one inpatient encounter during the measurement period or the year prior OR Taking dementia medications during the measurement period or the year prior

Numerator Exclusion

NA

Quick Guide

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Overview

What is Documented	When is it Documented	Where in QMER
Qualifying Encounter	During Measurement Period (2023)	Coded SOAP Note
Diagnosis of Diabetes	During Measurement Period (2023)	DxCPT Module
Retinal or Dilated Eye Exam	See numerator description	History Module

Exclusions/Exceptions	Where in QEMR
Patients who are in hospice care for any part of the measurement period	History Module
Patients receiving palliative care for any part of the measurement period	History Module
Patients 66 years and old living long term in a nursing home on or before the measurement period	History Module
 Patients 66 years and older with an indication of frailty during the measurement period and Advanced illness with two outpatient encounters during the measurement period or the year prior – OR Advanced illness with one inpatient encounter during the measurement period or the year prior – OR 	
 Taking dementia medications during the measurement period or the year prior 	

202	22 to 2023 Changes
NA	

Set Up

All codification shown is an example for incrementation, for a full list of accepted codes please visit <u>Value Set Authority</u> <u>Center</u>.

Qualifying Encounter

No set up is required.

Building History Items Eye Exam, Hospice Care and Palliative Care

Build the history items below:

- 1. Log into **QEMR** > Navigate to **Edit** > **History**
- 2. Highlight desired History Category list on left side bar
- 3. Click New hot button
- 4. Complete the Update History Screen as seen below
- 5. Click Save & Close hot button

Save&Cls Close			Save&Cls Close	
History Category :	Health Maintenance 🗸		* History Categor	y: Health Maintenance Screening V
Item Description :	Diabetic Eye Exam		* Item Descriptio	n : Hospice Care
Comments :	Evaluation of Retina		Comment	:5 : [
History Type :	Procedure v		History Typ	e : Procedure V
SNOMED :	427478009-Evaluation of retina]	SNOME	D: 305336008-Admission to hospice
ICD9/10:			ICD9/1	0 : 📃 🔍 🗙
CPT :			CP	T:
LOINC Code :			LOINC Cod	e :
Refusal\Reason Code :			Refusal\Reason Cod	e :

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ave&Cls Close		
* History Category :	Health Maintenance Screening v	
* Item Description :	Palliative Care	
Comments :		
History Type :	Procedure v	
SNOMED :	103735009-Palliative care	🔍 ×
ICD9/10:		Q. ×
CPT:		Q ×
LOINC Code :		Q ×
Refusal\Reason Code :		

Workflow

Qualifying Encounter

Following standard office workflow, document patient visit(s) via SOAP notes and code with CPT and diagnosis codes using either DxCPT, SmartDx or Smart CPT modules.

Diabetes Diagnosis

For this measure a diagnosis of Diabetes must be documented via **Dx and CPT** Follow standard in-office coding workflow for coding exams.

Documenting Eye Exam or Exclusion

To document, follow steps below:

- 1. Navigate to History Module > Health Maintenance category
 - a. Double-click applicable history item
 - b. Enter Occur Date



Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be documented using appropriate date based upon Measure Description.

Exam Coding

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If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit <u>Value</u> <u>Set Authority Center</u>.

CMS Guidance *

The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation.