HEDIS® Helpful Hints:
CPT II Coding for Gap Closure
Eye Exam for Patients with Diabetes (EED)

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Did you know?
Capturing retinal eye exams has become a lot easier, and reportable! By using CPT Category II (CPT II) codes when billing claims, we can streamline reporting, and potentially avoid the need to share your records for HEDIS Measure improvement. For more information on how to do this, keep reading!

What are CPT II Codes?[1]: CPT II codes are supplemental tracking codes that can be used for performance measurement. The use of the tracking codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other healthcare professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are billed with a $0 billable charge amount.

EED Measure Description[2]: The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

	Codes	Compliant Result	Definition
Diabetic Retinal Exam Negative in Prior Year	**3072F***	✓	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Eye Exam with Evidence of Retinopathy in Current Year	**2022F**	✓	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2024F	✓	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2026F	✓	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
Eye Exam without Evidence of Retinopathy in Current Year	**2023F**	✓	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2025F	✓	7 standard field stereoscopic retinal photos w/ interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2033F	✓	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy

When results are received from an ophthalmologist or optometrist, submit the results on a claim with the appropriate CPT II code. Exams completed by remote reading of retinal photographs meet this requirement if the reading is done by an ophthalmologist or optometrist.

For detailed information about this measure

Resources / Disclaimers:
*CPT Category II code 3072F can only be used if the claim/encounter is dated during the measurement year. The CPT II code indicates the member had "no evidence of retinopathy in the prior year". Additionally, because the code definition itself indicates the results were negative, and automated result is not required.
[1] CPT® overview and code approval | American Medical Association (ama-assn.org)
[2] HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans

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