

Diabetic Retinopathy Evaluation Form Explanation

In an effort to promote communication and documentation of diabetic retinal exams, members of the Michigan Association of Health Plans Quality Improvement Directors and Medical Directors committees collaborated to develop the Diabetic Retinopathy Evaluation form as a communication tool for use by PCPs and eye care specialists. This collaborative approach provides a uniform reporting form.

Background

Health plans across Michigan have found that documentation of diabetic retinal examinations provided to diabetic members is a problem for primary care physicians (PCPs) as well as the health plans themselves.

Reasons for the Diabetic Retinopathy Evaluation form include:

- Eye care specialists (Ophthalmologists and Optometrists) conducting exams on health plan members do not always know who the member's PCP is or how to contact them. PCPs, therefore, have neither the documentation that retinal or dilated eye exams are occurring nor the exam results for their diabetic patients.
- The health plan will not have a claim documenting the exam if the member does not have a vision benefit with the plan. Without a claim, health plans do not know if the exam has occurred without reviewing medical records.
- If the PCP has not received a report of the exam, neither the PCP nor the health plan knows whether an exam has occurred that meets the retinal or dilated exam HEDIS criteria established by the National Committee for Quality Assurance.

Importance

Current medical evidence supports the value of diabetics receiving regular dilated eye exams to screen for diabetic retinal disease as part of comprehensive diabetes care.

Health plans measure and report the rates for retinal or dilated eye screening as one of the HEDIS measures. NCQA includes this rate in annual calculation of the plan's accreditation score.

Health plan compliance with the Diabetic Eye Exam HEDIS measure requires the exam occur each year. Examination within the year prior to the measurement year is accepted only if the prior year exam was negative, the member is not on insulin during the measurement year, and has documentation of an HbA1c level <8.0%.

HealthPlus of Michigan process for promoting use of the Diabetic Retinopathy Evaluation form

Representatives of the Medical Services and Provider Services departments have agreed to encourage use of the Diabetic Retinopathy Evaluation form by:

- Distribution of the form to participating PCP practices and eye care specialists. It is available in both electronic and hard copy formats.
- Assuring that participating eye care specialists have access to current PCP contact information, available on the HealthPlus web site [www.healthplus.com]. This information is needed for eye care specialists to route completed forms to diabetic members' PCPs.
- Encouraging PCPs to place completed forms they receive from eye care specialists in their diabetic patients' medical records for reference when assessing.

HealthPlus of Michigan Contact

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DIABETIC RETINOPATHY EVALUATION

Patient Information

Name: _____ DOB: _____

Date of Exam: _____ VSP Plan ID: _____

Health Plan: _____

Primary Care Physician Information

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

FINDINGS

No diabetic retinopathy is found in either eye. **OR**

RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:

Background changes noted in:

Right (*Circle Grade*) Mild Moderate Severe

Clinically significant diabetic macular edema? Yes No

Left (*Circle Grade*) Mild Moderate Severe

Clinically significant diabetic macular edema? Yes No

Proliferative changes noted in:

Right (*Circle Grade*) Active Regressed/Stable

Left (*Circle Grade*) Active Regressed/Stable

FOLLOW UP

Routine follow-up exam is recommended in one year. **OR**

Follow-up of abnormalities in my office is recommended in _____ (timeframe).

Referral to Dr. _____ is recommended in _____ (timeframe).

Cataracts or Glaucoma detected **OR** laser treatment is needed. Letter to follow.

Thank you for referring this patient for diabetic retinal evaluation.

Sincerely,

_____ (Signature)

_____ (Practitioner's Printed Last Name)

Please fax or mail this document to the patient's Primary Care Physician identified above.

Billing Instructions: (to be provided by VSP)