Simply Healthcare Plans, Inc. | Medicaid
Simply Healthcare Plans, Inc. | Medicare Advantage
Clear Health Alliance | Medicaid

HEDIS® Comprehensive Diabetes Care (CDC) — Eye Exam Guide

Who qualifies for the CDC Eye Exam measure?

Members 18 to 75 years of age as of December 31 of the measurement year (2020) with diabetes (type 1 and type 2)

Who provides medical and surgical vision services to Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) members?

iCare Health Solutions, LLC (iCare)* is the statewide subcontractor providing medical and surgical vision services to Simply and CHA members.

If you have questions regarding vision services and providers, call iCare Provider Services at **855-373-7627**.

An eye exam is:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Required eye exam documentation

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed, and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
  - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
  - Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (for example, documentation of normal findings).
- Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Additional information

The documentation needs to have the results of the eye exam, not just that the retinal exam was performed. There can be a large variety of notations of what can count as a result, but a notation that comprehensive ophthalmic exam was performed would be insufficient.

* iCare Health Solutions, LLC is an independent company providing medical and surgical vision services on behalf of Simply Healthcare Plans, Inc. and Clear Health Alliance.