

Saying Goodbye to the Annual Diabetic Eye Exam

A study of why the annual diabetic eye exam is no longer required under HEDIS

James E. Grue, O.D. with Alistair L. Jackson, M.Ed.

The longstanding HEDIS regulation that established an annual diabetic eye exam by an optometrist or ophthalmologist is no longer in effect. It has been replaced by a new HEDIS regulation that allows any physician to order, and be reimbursed for, an annual fundus photo interpretation to detect diabetic retinopathy.

Why this has occurred is a study in understanding health care reform. It is a study that should show every optometrist that the delivery system we have grown accustomed to is gone and that we need to understand the new rules, Value-Driven Health Care rules, in order to remain competitive in the future. It demonstrates a new role that we as eye care providers must play and a new role that our leadership organizations must accept in order to guide our profession through the complex reform process in health care reimbursement.

Let's look at what led to the change in the HEDIS regulation regarding annual diabetic eye exams. Although every OD is well aware of the standard of care regarding the "annual dilated eye exam for every diabetic patient by an optometrist or ophthalmologist", few know that this standard was established by the adoption of that wording by HEDIS, one of the main organizations that evaluates quality of health care delivery. Certainly, as this standard became well established, similar wording has been adopted by most insurance companies and health care agencies. Therefore, it became the common practice.

The regulation was put in place originally as a result of what was considered a best practice at that time. Health care reform is challenging all health care best practices. Health care reform is based on measuring actual outcomes and re-visiting regulations and reimbursement on the basis of *demonstrated outcomes* not assumed outcomes. In the specific case of HCPCS code S0625, HEDIS has measured the outcomes from the original regulation, compared them to newer practices, and made the determination that a change in regulation was necessary to enforce what has been demonstrated to be a new best practice. Eye care, on the other hand, has *assumed* that a complete exam represents the best practice and has, therefore, done little to adopt any alternative or better practice, proven through measurement to provide the best care, in this example, to the diabetic patient.

Our first step, then, in understanding how this change occurred, largely undetected by eye care, is to realize that the underlying problem goes deeper than just the care of diabetic patients. It belies an inadequate level of communication between the regulatory agencies and eye care. (We will discuss this problem further in our next article as we consider another important new set of HEDIS changes: a team approach to the continuity and coordination of care for chronic patients.)

The communication “gap” pertaining to the diabetic eye exam regulation, which led to the current change, was a misunderstanding of the purpose of the original regulation. As annual eye exams for diabetics became common place, eye care providers and organizations made decisions based on the assumption that the annual eye exam was to detect and treat the associated *eye care* complications of diabetes. Although this is indeed important for the general health of the patient, the HEDIS regulation was aimed at a different aspect of care: that the *primary care provider* needed to know the results of the eye exam in order to make the best clinical decisions for the *overall care* of the patient.

Let us note carefully this example of a new best practice identified through measured and demonstrated outcomes, and a resultant change to the HEDIS regulation that represents and codifies the new best practice. This process and this type of change are core tenets of health care reform.

HEDIS has long been a leader in measuring health care outcomes. As a result, the organization has very accurate measurements of the percentage of diabetic patients who receive annual dilated eye exams and for whom a report is returned and received by the primary care physician. Their statistics show clearly that the original regulation requiring an eye exam consistently resulted in a return rate of 50 – 80%. Yet HEDIS has long expressed the need for that statistic to approach 100%.

Organized Optometry and Ophthalmology responded by putting in place programs that encouraged members to send letters back routinely to the primary care physician on all diabetic patients. This effort addressed one component of a complex problem but failed to address the matter of patients who were told to have their eye

exam but neglected to do so. In addition, reports written and sent often did not find their way into the patient’s chart, whether lost or misfiled. Consequently, even the best efforts were inadequate and the effect of these efforts on HEDIS scores minimal.

A group of large ophthalmology-based institutions, communicating closely with HEDIS to really understand the needs, developed a completely different model. They incorporated readily available computer communications technologies to create national image-reading centers for diabetic retinopathy. This allowed a fundus camera to be placed in the primary care setting, fundus photos to be completed on all diabetic patients, and the images to be securely transferred to a national reading center. The center interprets the images and electronically sends back a report to be automatically included in the patient chart. The measurements of this process resulted in a HEDIS score that indeed approached 100%.

Therefore, let us note carefully this example of a new best practice identified *through measured and demonstrated outcomes*, and a resultant change to the HEDIS regulation that represents and codifies the new best practice. This process and this type of change are core tenets of health care reform.

Some eye care providers, not understanding the principles of value-driven health care, may suggest this was an irresponsible act and may even argue against it as they continue to assume that a complete eye exam must mean better care than interpreting a fundus photo. If the purpose of the HEDIS regulation

was to ensure every diabetic patient gets the best available eye care, this could be true and perhaps could be statistically proven. The problem, however, is that HEDIS is aimed first at ensuring the primary care physician has the results of the eye exam for use in the clinical decision-making process for the *overall care* of the patient. Aside from what optometrists – health care providers who have generally not been at the table – think, unbiased measurement has demonstrated that the best means (best practice) to achieve that goal is to have an image taken, interpreted and reported back electronically to the primary care physician. The new HEDIS regulation clears the road to change reimbursement practices to encourage this type of best-practice activity.

Does this mean that eye care providers no longer have a role in this kind of care? Definitely not. However it does mean that we need to accept that “best practices” means

something different in value-driven health care than how we, as providers, intuitively think.¹ It also means that we as a profession and as individual providers need to rapidly adapt to technologies fundamental to value-driven health care.²

We must have models of care in place that result in measureable outcomes in order to have a place at the table in shaping health care reform.

Finally, changes like this one also mean our leadership organizations, and we as individual providers, need to understand the principles of value-driven health care for every decision we make. The changes in health care reimbursement resulting from VDHC principles will affect virtually every area of our practice. This regulation change also demonstrates that arguing the value of the status quo is ineffective in health care reform. We must have models of care in place that result in measureable outcomes in order to have a place at the table in shaping health care reform. A critical need is for optometry to develop clinical models that provide best care for our patients and best position our profession to be viable, competitive and relevant within the total spectrum of health care.