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Making the Diagnosis: Diabetic Nephropathy

One of the most common errors physicians make in documentation and coding is that they forget to actually make a clear diagnosis. A common example is diabetic nephropathy.

Almost all physicians check for microalbuminuria in patients with long-standing diabetes. But when the microalbuminuria level is persistently abnormal, they often forget to document the diagnosis of diabetic nephropathy and instead simply write “diabetes with microalbuminuria”. The resulting diagnosis is coded as uncomplicated diabetes and an abnormal lab test:

Doctor documents: “diabetes with microalbuminuria”
Correct ICD-9 codes: 250.00 – uncomplicated diabetes
791.0 – proteinuria

Doctor documents: “diabetic nephropathy”
Correct ICD-9 codes: 250.40 – diabetic nephropathy
583.81 – nephritis or nephropathy in diseases classified elsewhere

In addition, **every patient who has or is suspected of having chronic kidney disease (CKD) should have the stage of CKD determined and documented**. This can be easily done by estimating the glomerular filtration rate (GFR) based on the patient’s serum Creatinine, age, gender, height, weight, and race. Some laboratories automatically do the calculation whenever you order a serum Creatinine while most others will do it if requested.

What is the correct way to diagnose, document, and then code diabetic nephropathy?
1) Start with a patient who has diabetes
2) Order lab tests for microalbuminuria, serum Creatinine, and estimated GFR
3) Based on the results; determine if the patient has chronic kidney disease and the stage of the CKD: e.g. GFR = 30-59 mL/min/1.73m2 is consistent with Stage 3 CKD
4) Rule out causes of renal disease other than diabetes: e.g. medication-induced
5) Document accurately and completely and submit the correct codes with your claim

Examples: The correct documentation and coding for a patient with diabetic nephropathy seen at least once each year might be:

- **Progress note:** diabetes complicated by stage 3 CKD
- **Diagnosis codes:** 250.40, 585.3

- **Progress note:** end stage renal disease due to uncontrolled diabetes
- **Diagnosis codes:** 250.42, 585.6

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

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