

Diabetic Retinopathy: Documentation and Coding

Example: Progress note: Diabetes complicated by proliferative diabetic retinopathy
Diagnosis codes: 250.50, 362.02

The diagnosis of diabetic retinopathy requires a description of findings on retinal exam. It is important to distinguish between nonproliferative diabetic retinopathy (microaneurysms and intraretinal hemorrhages) and proliferative diabetic retinopathy (characterized by more extensive hemorrhages and neovascularization).

The progression of severity of disease is from mild to moderate to severe diabetic nonproliferative retinopathy and then to proliferative diabetic retinopathy. Background diabetic retinopathy is synonymous with nonproliferative diabetic retinopathy.

Diabetic macular edema may be present with any stage of diabetic retinopathy, so the correct diagnosis also includes whether the patient has nonproliferative or proliferative retinopathy.

Documentation and ICD-9 coding for diabetic retinopathy always begins with the appropriate 5-digit diabetes code (250.5x where x = 0, 1, 2, or 3) plus:

ICD-9 Physician Documentation

362.01 background diabetic retinopathy

362.02 proliferative diabetic retinopathy

362.03 nonproliferative diabetic retinopathy NOS (not otherwise specified)

362.04 mild nonproliferative diabetic retinopathy

362.05 moderate nonproliferative diabetic retinopathy

362.06 severe nonproliferative diabetic retinopathy

362.07 diabetic macular edema - [must be used with a code for diabetic retinopathy (362.01-362.06)]

Examples: The correct documentation and coding for diabetic retinopathy might be:

- **Progress note:** AODM with diabetic macular edema and nonproliferative diabetic retinopathy
- **Diagnosis codes:** 250.50, 362.07, 362.03
- **Progress note:** Uncontrolled adult diabetes with background diabetic retinopathy
- **Diagnosis codes:** 250.52, 362.01

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.