

PRESENTED BY HIGHMARK RISK ADJUSTMENT ACCURACY MANAGEMENT

Diabetic Retinopathy



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Agenda

1. Overview of the condition
 2. Coding & documentation considerations
 3. Documentation example
 4. Additional resources
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Diabetic Retinopathy

Diabetic retinopathy (DR), the most common form of retinopathy and a leading cause of adult vision loss and blindness in diabetics, damages the retina's blood vessels. This damage leads to fluid leakage into the macula, causing blurred vision, and the growth of abnormal, fragile blood vessels that can bleed and obstruct vision.



Although diabetic retinopathy has no cure, early detection allows for effective management and prevention of further vision loss. In the early stages, careful monitoring with dilated eye exams every 2-4 months is typical. While treatment cannot reverse existing damage in later stages, it can prevent further deterioration. These treatments include injections of anti-VEGF drugs or corticosteroids, laser therapy to reduce retinal swelling, and vitrectomy for severe cases with retinal bleeding or scarring. Importantly, controlling underlying conditions like diabetes, blood pressure, and cholesterol is crucial to managing the disease.

Coding Considerations

To correctly assign an ICD-10-CM code for **nonproliferative diabetic retinopathy (NPDR)**, the documentation must include the following details: the **type of diabetes**, the **severity of the retinopathy**, and the **presence or absence of macular edema** and the **affected eye(s)**.

E _ _ . 3 _ _ _

Example: Type 2 diabetes with mild nonproliferative retinopathy and macular edema (right eye) **E11.3211**

Diabetes Type	Severity	Edema	Affected Eye(s)
08 Due to underlying condition	2 Mild	1 With Macular Edema	1 Right
09 Drug or chemical induced	3 Moderate	9 Without Macular Edema	2 Left
10 Type 1	4 Severe		3 Bilateral
11 Type 2			

Coding Considerations

To correctly assign an ICD-10-CM code for **proliferative diabetic retinopathy (PDR)**, the documentation must include the following details: the **type of diabetes**, the **stage of the retinopathy**, and the **affected eye(s)**.

E _ _ . 3 5 _ _

Example:

Type 2 diabetes with PDR with macular edema, bilateral

E 11 . 3 5 1 3

Refer to the current version of the ICD-10-CM Official Guidelines for Coding and Reporting, the ICD-10-CM Index to Diseases and Injuries, and the Tabular List of Diseases for a list of all ICD-10-CM codes and coding instructions.

Diabetes Type

- 08 Due to underlying condition
- 09 Drug or chemical induced
- 10 Type 1
- 11 Type 2

Staging

- 1 With macular edema
- 2 With traction retinal detachment involving the macula
- 3 With traction retinal detachment not involving the macula
- 4 With combined traction retinal detachment & rhegmatogenous retinal detachment
- 5 Stable
- 9 Without macular edema

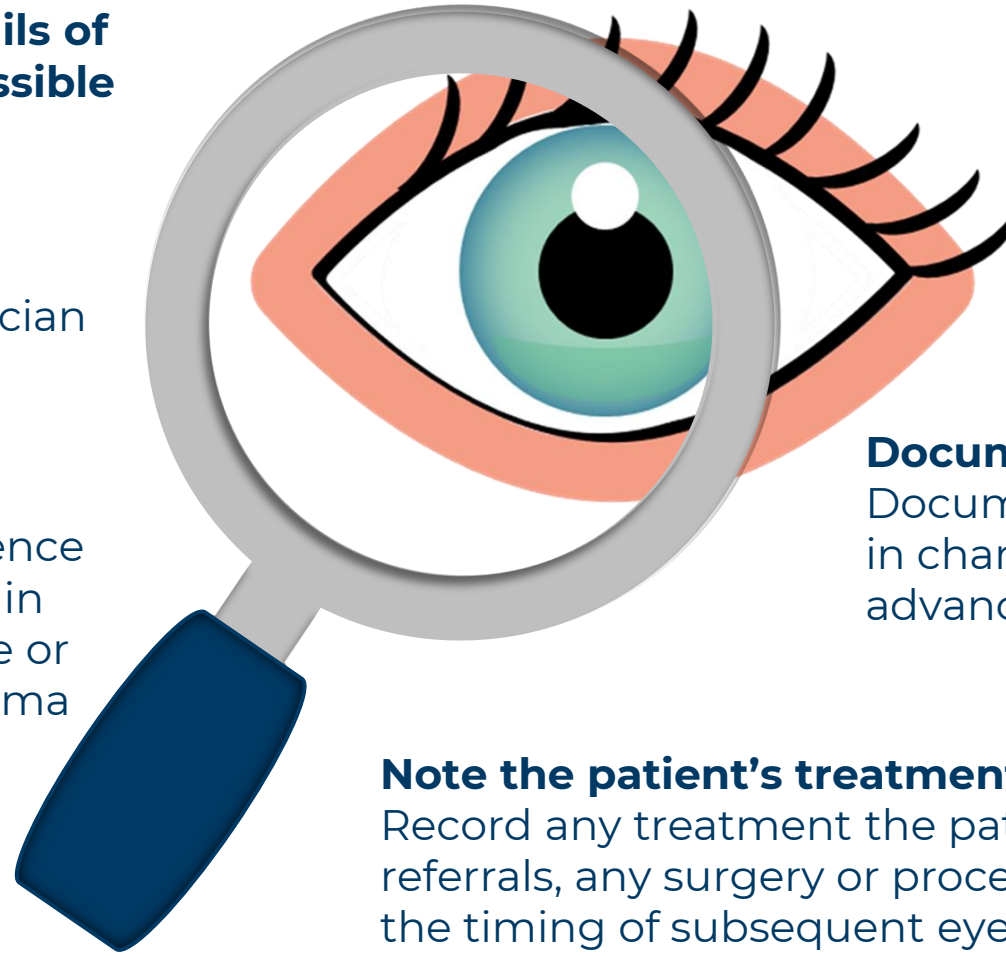
Affected Eye(s)

- 1 Right
- 2 Left
- 3 Bilateral

Documentation Considerations

Include the following details of the eye exam report, if possible

1. Date of the last eye exam
2. Type of eye exam
3. Name of performing clinician or location
4. Results
 - Documentation should explicitly state the presence and type of retinopathy in addition to the presence or absence of macular edema



Link both conditions

Specify the type of diabetes and the causal relationship between the diabetes and the retinopathy.

Document a detailed assessment

Document the status and any changes in characteristics to track disease advancement or improvement.

Note the patient's treatment

Record any treatment the patient is actively receiving, specialist referrals, any surgery or procedures, and the outcomes. Also, note the timing of subsequent eye exams and tests, if applicable.

Diabetic Retinopathy Example



Subjective:

63-year-old male with known diabetes. Here for AWW.

Labs:

A1c 6.2

Dilated Fundus Exam:

OD & OS: Proliferative diabetic retinopathy. Macular edema present.

Assessment & Plan:

Type 2 diabetes with proliferative diabetic retinopathy with macular edema, bilateral (E11.3513)

A1c shows **diabetes is well controlled on Lantus. Recent 7/1/25 eye exam with Dr. Jones confirmed bilateral proliferative diabetic retinopathy with macular edema and is receiving Lucentis injections once monthly.**

The clinician reviewed and incorporated the results from the ophthalmology visit. The retinopathy has been documented to the highest specificity and linked with diabetes. Additionally, the clinician has noted treatment for each condition.

Additional Resources

Documentation Best Practice Checklist



Annually assess all chronic conditions and document a plan for each one



Link medications to help establish ongoing treatment especially if the medication is used to treat multiple conditions.



Use the term “History of” before a condition if it no longer exists or has resolved



Validate patient reported findings



Code and document all coexisting conditions that require or affect patient care, treatment or management



Avoid using uncertain terms when a diagnosis has been confirmed for a patient



Choose the highest level of specificity when selecting an ICD-10 code



Keep problem list up to date by removing acute and one-time conditions

Highmark Provider Resource Center

KNOWLEDGE COLLEGE

15-minute on-demand courses on risk adjustment coding and documentation to help clinicians comply with CMS standards and ICD-10-CM guidelines

1. Log into Availity.
2. Navigate to the Provider Resource Center.
3. Locate “Resources and Education” in the menu bar and navigate to “Clinical Quality & Education”.
4. Select “Coding Education/HCC University”.

RISK ADJUSTMENT OVERVIEW

Review the foundations of what risk adjustment is, hierarchical condition categories, common errors, best practices and impacts to patient care



CODING & DOCUMENTATION CARDS

Reference cards to assist with documentation and coding according to CMS documentation standards and ICD-10-CM coding requirements



Have questions about risk adjustment?

**Want to share feedback or suggest topics
for future presentations?**

Email:

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