

Screening and Documentation Tool

DIABETES, CKD AND PAD

THE CHALLENGE: CONDITION RECOGNITION 'GAP'

<p>DIABETES:</p> <p>Approximately one third of cases are not diagnosed, despite a high-prevalence in older individuals (over age 60) of 23%.¹</p>	<p>CHRONIC KIDNEY DISEASE:</p> <p>There is strong evidence of under-diagnosis. In the absence of GFR calculation, up to 74% may be missed.² Even in more severe stages of CKD, many are unaware of their disease (as high as 40% in stage IV).³</p>	<p>PERIPHERAL ARTERY DISEASE:</p> <p>Most major cardiovascular events occur in those without a prior diagnosis of vascular disease (over 50% with PAD will not have previous vascular symptoms, 40% have atypical symptoms).⁴ It is estimated that only 25% of afflicted individuals receive care.⁵</p>
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FOR PATIENTS OVER AGE 65, USE OF A CLINICAL TESTING FLOW SHEET (SEE THE BACK OF THIS SHEET) WILL FACILITATE CAPTURE DATES AND RESULTS OF THE FOLLOWING:

Blood pressure, weight and BMI (every visit)

- "Adults with treated or untreated BP > 135/80 mm Hg should be screened for diabetes." (USPSTF Recommendation)

Ankle-brachial index

- to screen for asymptomatic PAD in those with cardiovascular risk.⁶

Dilated eye exam

- annually for patients with diabetes; Type 1 begin within 5 years of initial diagnosis; Type 2 soon after the diagnosis

Foot exam

- annual comprehensive exam: sensory: include standardized monofilament testing combined with vibratory/position sense (tuning fork, pinprick, reflexes) (ADA recommendations)

Blood glucose (fasting, random or OGTT)⁷

Criteria for diabetes:

- fasting (8 hours): ≥ 126 mg/dl
- random (casual) but with 'classic' symptoms: ≥ 200 mg/dl
- glucose tolerance test: ≥ 200 mg/dl 2hr after 75 gm glucose load

Hemoglobin A1C

- (in 2009 may become diagnostic)⁷
- every 3 months: if modifying therapy;
- twice a year: if regimen stable (ADA recommendation)

Urine for microalbuminuria AND calculated eGFR (annually for patients with diabetes)*

- repeat in 3 months if positive (urine albumin to Cr ratio of 30–299 ug/mg)
- eGFR added to microalbuminuria identifies more cases of nephropathy²

Lipid profile (annually)

- cholesterol, HDL, LDL and triglycerides
- achieving target < 100mg/dl can reduce CV risk by up to 50% in diabetic patients

Additional support materials and resources are available from Ingenix. Please call your Ingenix Market Outreach Consultant today for more information.

ICD-9 CODING GUIDE

Diabetes, no mention of complications	250.00	Chronic Kidney Disease (prior to assigning CKD codes, all abnormal findings monitored & confirmed after at least 3 months)		Peripheral Artery Disease, unspecified Intermittent claudication NOS	443.9
Diabetes with complications; use additional code(s) to identify all documented diabetic manifestations		Stage I: GFR ≥ 90 mL/min with albuminuria or kidney damage	585.1	Atherosclerosis / Arteriosclerosis of native arteries of the extremities with:	
renal manifestations	250.4x	Stage II: GFR 60–89 mL/min with albuminuria or kidney damage	585.2	intermittent claudication	440.21
ophthalmic manifestations	250.5x	Stage III: GFR 30–59 mL/min	585.3	rest pain	440.22
neurological manifestations	250.6x	Stage IV: GFR 15–29 mL/min	585.4	ulceration (specify location and code also 707.10-707.9)	440.23
peripheral circulatory disorders	250.7x	Stage V: GFR less than 15 mL/min	585.5	gangrene	440.24
with other specified manifestations diabetic hypoglycemia NOS hypoglycemic shock NOS	250.8x	ESRD: Stage V on chronic dialysis or transplant	585.6	unspecified	440.20
x=0 Type 2 or unspecified type, not stated as uncontrolled		<i>Note: Use additional code to identify kidney transplant status (V42.0) or renal dialysis status (V45.11), if applicable</i>		Atherosclerosis of bypass graft of the extremities, unspecified graft	440.30
x=1 Type 1, not stated as uncontrolled					
x=2 Type 2 or unspecified type, uncontrolled					
x=3 Type 1, uncontrolled					

2009 ICD-9-CM Professional for Physicians – Volumes 1 & 2
Codes valid 10/01/2008 to 9/30/2009

¹ Cowie C.C., Rust K.F., Byrd-Holt D.D., Eberhardt M.S., Flegal K.M., Engelgau M.M., et al., "Prevalence of diabetes and impaired fasting glucose in adults in the U.S. population." *National Health and Nutrition Examination Survey* 29(2006): 1263-8.
² Ryan T.P et al., "Chronic Kidney Disease Prevalence and Rate of Diagnosis." *American Journal of Medicine* 120(2007): 981-986.
³ Plantinga, L.C. et al., "Patient Awareness of Chronic Kidney Disease Trends and Predictors." *Arch Internal Medicine* 168(2008): 2268-2275.
⁴ Hirsch A.T., Criqui M.H., Treat-Jacobson D., et al., "Peripheral arterial disease detection, awareness, and treatment in primary care." *JAMA* 286(2001): 1317-24.
⁵ Heart Association Statistics Committee and Stroke Statistics Subcommittee, "Heart Disease and Stroke Statistics." *The American Circulation* 117(2008): e25-e146.
⁶ ACC, AHA, "Guidelines for the Management of Patients With Peripheral Arterial Disease." *Journal of American College of Cardiology* 47(2006): e1-e192.
⁷ American Diabetes Association, "Standards of Medical Care in Diabetes." *Diabetes Care* 32(2009): 32-87.

PATIENT NAME _____

Medical Record # _____

SERVICE OR TEST	✓ done in 2009	date _____	date _____	date _____	date _____
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EXAMINATION

BLOOD PRESSURE					
WEIGHT					
BMI					
ANKLE-BRACHIAL INDEX					
DILATED EYE EXAM					
FOOT EXAM					
VISUAL EXAM					
10G MONOFILAMENT					
VIBRATION/REFLEXES					

LABORATORY TESTING

BLOOD GLUCOSE					
FASTING					
RANDOM					
A1C					
URINE FOR ALBUMIN					
URINE ALBUMIN TO CR					
CALCULATED GFR					
LIPID PROFILE					
TOTAL CHOLESTEROL					
TRIGLYCERIDES					
HDL CHOLESTEROL					
LDL CHOLESTEROL					

RESOURCES & MATERIALS:

National Diabetes Education Program –
<http://ndep.nih.gov/index.htm>

National Kidney Foundation – GFR calculator –
http://www.kidney.org/professionals/kdoqi/gfr_calculator.cfm

NDEP Foot Care –
<http://ndep.nih.gov/resources/feet/annual-foot-exam.htm>

Peripheral Artery Disease Coalition –
<http://www.padcoalition.org/resources/guidelines.php>

The information presented herein is for informational purposes only. It is not intended, nor is it to be used, to define a standard of care or otherwise substitute for informed medical evaluation, diagnosis and treatment which can only be performed by a qualified medical professional.