# Diabetes

## OVERVIEW

Diabetes is one of the most frequently under-documented and inaccurately coded conditions, especially when it involves coding for diabetes with chronic complications. It's essential that medical records provide details on all diabetes-related conditions to the highest level of specificity known to the provider. Even if a medical coder can recognize the inference of a condition, only what the provider has documented can be coded.

## DOCUMENTATION

Document the following items when evaluating patients with diabetes:

- Type:
  - Type 1 (E10.-)
  - Type 2 (E11.-)
    - If you don't document a type, Type 2 is the default code
  - Due to underlying condition (E08.-)
  - Drug or chemical induced (E09.-)
  - Other specified (E13.-)
  - Gestational diabetes and pre-existing Type 1 and Type 2 diabetes mellitus in pregnancy, childbirth, and the puerperium (O24.-)
- Cause:
  - Clearly document the cause of the diabetes if it's caused by drug, chemical, or an underlying condition.
- Complications:
  - The diabetes complication codes in ICD-10 are combination codes that include the type of diabetes, the body system affected, and the complications affecting that body system.
  - A provider's documentation must clearly indicate a causal relationship.
  - Indicate the conditions complicating diabetes to the highest specificity.
    - Example: Type 2 diabetes mellitus with kidney complications, CKD 4
  - Use the correct ICD-10 combination code to link the manifestation directly to the diabetes with terms such as: due to diabetes, associated with, diabetic, in diabetes, or diabetes with.
  - Address both the diabetes and manifestation with a plan of care in the same encounter note
  - Indicate hyperglycemia or hypoglycemia when the diabetes is uncontrolled.
    - There isn't a code for "uncontrolled" in ICD-10.

## CODING

- First choose the code from the appropriate diabetic type category, with or without complications.
- If a drug, chemical, or an underlying condition is the cause of the diabetes, select a code for the cause first, followed by a code from a diabetic type category.
- Some complications require an additional code to describe the specificity of the complicating condition.
    - Example: Include a code indicating the stage of CKD if there's a kidney complication or an ulcer causing a skin complication.
- If a patient has multiple complications, select a code from the diabetes section for each complication.
    - Example: A patient has type 2 diabetes with neuropathy, nephropathy, and right heel ulcer (with necrosis of muscle) complications. You'd use the following codes:
        - E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
        - E11.21 Type 2 diabetes mellitus with diabetic nephropathy
        - E11.621 Type 2 diabetes mellitus with foot ulcer
        - L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
- For all types, except Type 1, use an additional code to identify control, such as:
    - Insulin (Z79.4)
    - Oral antidiabetic drugs (Z79.84)
    - If the patient is treated with both oral medication and insulin, only code the insulin

**When NOT to code diabetes mellitus**

If diabetes hasn't been confirmed, avoid coding diabetes. You can choose one of the following when sending your patient for diabetic testing without a confirmed diagnosis:

Abnormal glucose R73.0-

- Impaired fasting glucose R73.01
- Impaired glucose tolerance (oral) R73.02
- Prediabetes R73.3
- Other abnormal glucose R73.09
- Hyperglycemia, unspecified R73.9

## OTHER HEPLFUL TIPS AND RESOURCES

It's important for all of the patient's providers to understand the relationship of the conditions found in the progress notes. Documenting the cause and effect of a condition in the medical record provides a complete picture of what occurred during the patient's office visit.

It is the provider's responsibility to document when diabetes is not the underlying cause of conditions that are frequently a complication of diabetes. If a patient has two or more conditions that commonly occur together, it doesn't necessarily mean they're related.

Accurate ICD-10 code assignment is crucial to funding the appropriate level of care for the patient and may qualify them for certain chronic condition management programs.

- When seeing patients for comorbidities and coexisting conditions of diabetes, remember to also code diabetes at least once annually, even if it's well managed.
- Remember to document and code all conditions to the highest specificity at least once annually.

For more information about coding of diabetes or any other chronic and complex condition, contact your Quality and Risk Adjustment Provider Clinical Consultant.