DIABETES MELLITUS

→ Specify the type of diabetes and any current complication/manifestation affecting a body system
→ Use linking language to clearly demonstrate cause-and-effect relationships
→ More than one complication/manifestation can be coded during an encounter
→ Document support for both the diabetes and the associated complication/manifestation

Clinical Concepts

American Diabetes Association criteria for the diagnosis of diabetes mellitus (DM):

- A1C ≥6.5%
- FPG ≥126 mg/dL
- Two-hour plasma glucose values of ≥200 mg/dL

In the absence of unequivocal hyperglycemia, diagnosis requires:

- 2 abnormal test results from the same sample
  or
- 2 separate test samples

Documentation Matters

History – document the date of onset, the presence or absence of current symptoms related to DM, and results of prior diagnostic testing.

Exam – a diabetes-focused examination may include a limited ocular, vascular and neurologic exam, as well as a foot assessment. Other systems should be examined as indicated by the patient's clinical situation. Document any evidence of end-organ damage.

Assessment – document the type of DM, as well as any associated conditions or contributing factors. Include the current status (e.g. controlled, worsening, improved, etc.).

Plan – document the treatment or management plan for DM and any relevant diabetic complications. Link associated prescription medications, diet and exercise instructions, orders for lab or diagnostic testing, and specialist referrals. Include a timeline for reevaluation or follow-up.

Coding Guidance

When documenting diabetes, specify:

- **Type**
  - 1 or 2
  - Secondary DM (must specify etiology)
    - Due to underlying condition
    - Drug-induced
    - Due to genetic defect (includes LADA)
    - Post-pancreatectomy
- **Complications/Manifestations**
  - Hyperglycemia or hypoglycemia
  - Nephropathy or CKD
  - Retinopathy
  - Neuropathy
  - Peripheral angiopathy
  - Foot ulcers
- **Long-term use of antidiabetic medications**
  - Insulin
  - Oral hypoglycemic drugs
  - Non-insulin injectables

Document and code only one type of diabetes per encounter.

"Uncontrolled" diabetes must be specified as either with hyperglycemia or hypoglycemia for proper code assignment to occur.

Do not code DM without complications when a combination code describing a current complication or manifestation is used.

Document and code as many diabetic complications or manifestations as needed to identify all associated conditions that are present and impacting medical decision making during the encounter.

Providers should clearly document cause-and-effect relationships using linking terms, such as "diabetic", "due to," "secondary to," "associated with," or "related to", even when conditions are presumed to be related to diabetes based on ICD-10-CM coding guidelines. Failure to specify or link complications may result in a query for clarification.

References

Up to Date: Initial Evaluation of DM in Adults
ICD-10-CM Official Guidelines for Coding & Reporting

Diabetes Diagnoses

ICD-10-CM	Code Description	HCC Model
E08*	DM due to underlying condition • Code first the underlying condition, such as pancreatitis, neoplasms, etc.	CMS/HHS
E09*	Drug or chemical induced DM • Code first poisoning or adverse effect of drug/toxin (T36-T65*)	HHS
E10*	Type 1 DM	CMS/HHS
E11*	Type 2 DM	CMS/HHS
E13*	Other specified DM • Includes Type 1.5/LADA, double DM, and DM due to genetic defects or pancreatectomy	CMS/HHS

Note: Codes listed below are for T2DM; 4th - 7th characters are the same for all types of DM.

ICD-10-CM	Body System	Complication / Manifestation	
E11.21	Kidney	DM with nephropathy	
E11.22		DM with chronic kidney disease • Code also CKD stage (N18*)	
E11.29		DM with other diabetic kidney complication • Must specify, link, and code the "other" complication	
E11.319	Ophthalmic	DM with unspecified retinopathy without macular edema	
E11.32*		DM with mild nonproliferative retinopathy	*7th character required: 1 – right eye 2 – left eye 3 – bilateral 4 – unspecified
E11.33*		DM with moderate nonproliferative retinopathy	
E11.34*		DM with severe nonproliferative retinopathy	
E11.35*		DM with proliferative retinopathy	
E11.36		DM with cataract	
E11.39		DM with other diabetic ophthalmic complication • Must specify, link, and code the "other" complication	
E11.40	Neurologic	DM with unspecified neuropathy	
E11.41		DM with mononeuropathy	
E11.42		DM with polyneuropathy	
E11.43		DM with autonomic neuropathy	
E11.44		DM with amyotrophy	
E11.49		DM with other diabetic neurological complication • Must specify, link, and code the "other" complication	
E11.51	Circulatory	DM with peripheral angiopathy without gangrene	
E11.59		DM with other diabetic circulatory complication • Must specify, link, and code the "other" complication	
E11.610	Musculoskeletal	DM with Charcot's joints	
E11.620	Skin	DM with diabetic dermatitis	
E11.621		DM with foot ulcer • Code also site and severity of ulcer (L97.4*, L97.5*)	
E11.622		DM with other skin ulcer • Code also site and severity of ulcer (L97.1-L97.9*, L98.41-L98.49*)	
E11.630	Oral	DM with periodontal disease	
E11.649	Glycemic	DM with hypoglycemia without coma	
E11.65		DM with hyperglycemia	
E11.69	Other	DM with other specified complication • Must specify, link, and code the "other" complication	
E11.9		DM without complications	
E11.A		DM without complications in remission (*Type 2 only*)	

Additional Diagnoses to Consider

ICD-10-CM	Code Description	HCC Model
D84.81	Immunodeficiency due to conditions classified elsewhere	HHS
E16.A*	Hypoglycemia level	-
E66*	Overweight and obesity	-
E78*	Hyperlipidemia	-
H40*	Glaucoma	-
I10 – I16*	Hypertension	-
I43	Cardiomyopathy in diseases classified elsewhere	CMS/HHS
I70.2*	Atherosclerosis of native arteries of extremities • Use as additional code to further specify type and site of diabetic peripheral angiopathy	-
K31.84	Gastroparesis	-
L97.4*	Non-pressure chronic ulcer of heel and midfoot	CMS/HHS
L97.5*	Non-pressure chronic ulcer of toe	CMS/HHS
M86*	Osteomyelitis	CMS/HHS
N52.1	Erectile dysfunction due to diseases classified elsewhere	-
O24*	Diabetes mellitus in pregnancy, childbirth, and the puerperium • Use additional code from E08-E13 to identify manifestations	HHS
R80*	Proteinuria	-
Z46.81	Encounter for fitting and adjustment of insulin pump	-
Z55.6	Problems related to health literacy	-
Z59.41	Food insecurity	-
Z59.71	Insufficient health insurance coverage	-
Z59.82	Transportation insecurity	-
Z59.86	Financial insecurity	-
Z71.3	Dietary counseling and surveillance	-
Z79.4	Long term (current) use of insulin	CMS/HHS
Z79.84	Long term (current) use of oral hypoglycemic drugs	-
Z79.85	Long term (current) use of non-insulin antidiabetic drugs	-
Z89.4*	Acquired absence of toe(s), foot, and ankle	CMS/HHS
Z89.5*	Acquired absence of leg below knee (BKA)	CMS/HHS
Z89.6*	Acquired absence of leg above knee (AKA)	CMS/HHS
Z90.410	Acquired total absence of pancreas	-
Z94.83	Pancreas transplant status	CMS/HHS
Z96.41	Presence of insulin pump (internal/external)	-

*Additional characters needed to complete code