**DIABETES MELLITUS**

**Provider documentation**

**Diabetes** is a chronic, lifelong metabolic disorder affecting uptake and storage of carbohydrate, protein and fat. Sustained high blood glucose leads to the diagnosis. Diabetes should be addressed in every encounter with the diabetic patient, as it will always affect outcomes and care.

**Documentation tips**

- Document the type of diabetes as:
  - Type 1 (autoimmune; no insulin production)
  - Type 2 (insulin resistance or low production; most common form)
  - Secondary, due to underlying condition
    - Document underlying condition (for example, CF, cancer, pancreatitis, Cushing’s)
  - Secondary, due to drugs/chemicals
    - Document drug or chemical causing the adverse effect (for example, corticosteroids, streptozotocin, alloxan, rodenticide Vacor)
  - Other specified form of diabetes
    - (document as monogenic, genetic defect, postpancreatectomy, etc.)
- **DO NOT document diabetes using these outdated terms:**
  - IDDM, NIDDM (from the 1970s, replaced with Type 1 and Type 2)
  - Juvenile onset, adult onset (Type 1 can occur in adults; type 2 can occur in children)
  - Brittle diabetes (not enough information to report)
- **Identify when comorbidity is not due to diabetes.** Coders will link the diabetes to other conditions, as this is guidance from CMS. If the patient’s CKD has another cause, be sure to document it, using clear language, like CKD stage 3 due to hypertension.”
- **Provide qualitative information regarding diabetic control.** E.g., “diabetes is in good control despite pneumonia. Blood glucose today is 105.” Patient’s A1C is 7.6, and his goal is 6.5.”
- **Identify treatment method:** Document whether patient is controlled by diet and exercise, antidiabetic meds, or insulin.
- **Address all complications of diabetes,** with qualitative language that documents the extent or severity of the complication, for example, “diabetic neuropathy has progressed to LOPS.”
- **State the obvious.** Do not document “BG of 495.” Instead, document, “patient’s blood glucose indicates hyperglycemia at 495.” Coders cannot connect the dots or code from lab values.
- **Document as status resulting from diabetes.** Ensure that the patient’s vision loss, amputation, or dialysis status is on the chart.
- **Remember to address status of annual exams.** Has the patient had a retinal eye exam? Foot exam? Are elevated A1Cs being addressed with changes to diet/medication? Has tobacco use and blood pressure been assessed?
- **Be aware the ICD does not allow for coding** type 2 diabetes with diabetic ketoacidosis (DKA), or type 1 diabetes with hyperosmolarity. Ensure you are documenting the appropriate acute condition, as type 2 diabetics rarely have DKA.
- **Document all referrals** for dietetic counseling, foot care, or other therapies:

<table>
<thead>
<tr>
<th><strong>Pregnancy and Diabetes: What to document</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TYPE:</strong> Gestational, type 1, type 2, unknown diabetes, abnormal GTT</td>
</tr>
<tr>
<td><strong>TREATMENT:</strong> Insulin, antidiabetic oral medication, diet and exercise</td>
</tr>
<tr>
<td><strong>COMORBIDITIES:</strong> Existing complications of diabetes in pregnant patient</td>
</tr>
</tbody>
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DIABETES
Coder abstraction

Coding complications of diabetes changed with the 2017 guidelines. Now, any comorbidity found under Diabetes/with is considered a complication of diabetes. No linkage language from the provider is required.

Coding tips

• If the type of diabetes is not stated, the guidelines tell us to report diabetes mellitus, type 2, unless the patient has DKA, in which case, the default is type 1.

<table>
<thead>
<tr>
<th>Types of diabetes</th>
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</thead>
<tbody>
<tr>
<td>E08 Secondary diabetes due to Cushing’s, CF, cancer, pancreatitis, malnutrition</td>
</tr>
<tr>
<td>E09 Secondary diabetes due to drugs or chemicals (code also with T36-T65 codes)</td>
</tr>
<tr>
<td>E10 Type 1 diabetes due to autoimmune process in child or young adult</td>
</tr>
<tr>
<td>E11 Type 2 diabetes due to shortage of insulin or poor insulin transport</td>
</tr>
<tr>
<td>E13 Other specified DM due to genetic defect (MODY), pancreatectomy, NEC</td>
</tr>
</tbody>
</table>

• Don’t stop with one code. Use as many codes as are required to describe all the complications of diabetes documented for the patient.

• Document type of treatment. Use a code to describe cases in which the patient is being treated with insulin (Z79.4) or with antidiabetic drugs (Z79.84). Remember, insulin may be given for a short period to bring a patient’s blood sugars under control. This does not qualify as “long-term.” “Long term” describes when the patient is injecting insulin every day, and has a prescription.

• Type 2 with ketoacidosis (DKA)? The ICD will not allow reporting of type 2 diabetes mellitus with DKA, because it is a common mistake and a very rare occurrence. If the provider documents type 2 DM with DKA and cannot be queried or stands by the diagnosis, report the DKA using E13 instead of E11, according to guidance from Coding Clinic for ICD-10-CM.

• Don’t overlook documented hyperglycemia or hypoglycemia. While these conditions were once considered incidental to DM, if they are documented and treated, they should be reported.

• Diabetic gastroparesis is reported as autonomic polyneuropathy (E43.43). Because there are other forms of autonomic polyneuropathy, also report the gastroparesis with K31.84 Gastroparesis. According to Coding Clinic for ICD-10-CM, this will clarify the type of autonomic neuropathy the patient is experiencing. It may be important for reporting of medical necessity.

• Diabetes insipidus (DI) is a completely different disease from diabetes mellitus, with its own code E23.2. (There is no hyperglycemia or glycosuria in DI.)

• Poorly controlled / out-of-control DM is reported as hyperglycemia, according to the ICD-10 Index.

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