Cal MediConnect Diabetes

Documentation and coding best practices

Santa Clara Family Health Plan™

Diabetes mellitus: One of the most inaccurately coded chronic conditions

Did you know that 40% of SCFHP's Cal MediConnect (CMC) members are diagnosed with diabetes? You may already be currently treating these patients. To help you correctly code and document, here are some helpful tips and information. **The prevalence and complexity of coding and documenting diabetes necessitates a solid understanding of the official guidelines to ensure accurate code assignment.**

Diabetes mellitus with complication

Diabetes codes are combination codes that include the type of diabetes, the body system affected, and the complications affecting that body system. The ICD-10-CM Official Guidelines for Coding and Reporting assumes a cause-and-effect relationship between diabetes and certain conditions such as cataract, dermatitis, foot ulcer, osteomyelitis, and peripheral angiopathy, because these complications are listed under the word "with" in the Alphabetic Index (see Alphabetic Index in the ICD-10 guide for a complete list of associated complications).

Important note:

- Certain conditions should be coded as related even in the absence of documentation explicitly linking them.
- If documentation clearly states that the conditions are unrelated, then each condition should be coded separately.

For example, the clinician's documentation does not need to state a link between type 2 diabetes and cataract to assign combination code E11.36. However, if there is no cause-and-effect relationship between the diabetes and cataract, it should be documented and coded as such. If the documentation states the diabetes and cataract are unrelated, then use stand-alone codes E11.9 (diabetes without complication) and H26.-(cataract).

Helpful documentation tips

- Document and submit codes to the highest specificity or manifestation (e.g., DM2 with osteomyelitis).
- Do not report COPD if you mean chronic obstructive asthma with acute exacerbation.
- Specify alcohol use, abuse, or dependency.
- For mental health, specify frequency (mild, moderate, severe), episode (single, recurrent), psychoses, and remission status.
- Documenting "history of" or "PMH" indicates the condition no longer exists. Instead use terms such as "with" or "has" when reporting active conditions (79 F with HTN, CAD, CKD 3).

Documentation and coding tips for diabetes with complication

Diabetes mellitus	Documentation and coding
Documentation should specific type (E08-E13)	Type (1, 2, underlying condition, etc.)
If there is a cause-and-effect relationship	Correct: DM w/PVD combination codes E11.51 Incorrect: DM and PVD stand-alone codes E11.9 & 173.9
When the combination code lacks necessary specificity in describing the complication, an additional code should be used	Ulcer site (L97.1-L97.9, L89.41-L98.49) Stage of CKD (N18.1-N18.6)
Diabetes and insulin use	For patients who routinely use insulin, document and code Z79.4, long-term (current) use of insulin
Type 2 diabetes with no associated complication	E11.9 (type 2 diabetes without complications)
Patient diagnosed with prediabetes	R73.09 (other abnormal glucose)

Resources

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For questions about documentation and coding or to schedule an in-person or remote training session, please contact Monday Reynolds, Certified Coder.

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