

Diabetes Mellitus: Documentation and Coding:

Example: Progress note: adult diabetes complicated with diabetic peripheral vascular disease
Diagnosis codes: 250.70, 443.81

The most common mistake physicians make in documenting and coding for diabetes is to leave out important and common complications and manifestations of this disease. CMS (The Centers for Medicare and Medicaid Services) is now measuring patient severity and requiring physicians to be more accurate and complete in their diagnosis documentation and coding. Diagnosis codes for diabetes require 5 digits and may require a second code for the diabetic complication.

Don't miss these important diagnoses and be sure to document diabetic complications:

<u>ICD-9</u>	<u>Physician documentation in the medical record</u>
250.0x	diabetes, uncomplicated
250.4x	diabetic nephropathy (also 538.81 nephropathy)
250.5x	diabetic retinopathy (also 362.02 proliferative retinopathy; 362.01 background retinopathy does not impact severity)
250.6x	diabetic neuropathy (also polyneuropathy 357.2)
250.7x	diabetic peripheral vascular disease (also peripheral angiopathy 443.81)
250.8x	other manifestations due to diabetes, e.g. diabetic hypoglycemia

Where x is the fifth digit, selected from one of the following:

- **x=0** adult diabetes, not stated as uncontrolled;
- **x=1** juvenile diabetes, not stated as uncontrolled
- **x=2** adult diabetes, uncontrolled
- **x=3** juvenile diabetes, uncontrolled

Example: The documentation and coding for a diabetic patient might be:

- **Progress note:** uncontrolled adult diabetes with diabetic nephropathy
- **Diagnosis codes:** 250.42, 583.81

Note: If the documentation is "diabetes with microalbuminuria or proteinuria" then a coder cannot assume diabetic nephropathy – the physician has to document "diabetic nephropathy."

Basic principles of diagnosis coding: Every patient should be seen at least once each calendar year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

