

# Coding and Documentation Guide: Diabetes

Accurate coding and documentation are fundamental to the risk adjustment process and crucial to representing each patient’s complex health profile. Bright HealthCare’s coding and documentation guides equip coders and medical staff with the information needed to support complete and accurate coding and documentation.

## Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on medication lists or physician orders.
- All conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management should be documented and coded.
- Coders cannot code current conditions from problem lists, medical history, or superbills.
- Providers should document all comorbidities and diabetic complications and manifestations. It is important to document and code all systems affected by diabetic manifestations as they illustrate the need for different care management and a higher level of severity.
- Providers should document causal relationships of diabetic complications (i.e., due to, associated with, secondary to, diabetic).
- Coders must verify clinical documentation for all diagnoses using the MEAT tool (monitor, evaluate, assess, treat). One or more MEAT detail is required for each condition requiring or affecting patient care.

Monitor	Evaluate	Assess	Treat
Symptoms Disease progression/ regression Ordering of tests Referencing labs/tests	Test results Medication effectiveness Response to treatment Physical exam findings	Test ordered Counseling Record review Discussion	Medication Therapies Referral Other modalities
<b>MEAT Examples: Diabetes</b>			
Type 1 diabetes — Patient’s A1C 6.8, recommend continuing medications, following healthy diet, and exercise.	Type 1 DM with polyneuropathy — Decreased sensation over lower extremities below the knees.	Type 2 diabetes with hyperglycemia — Patient was counseled concerning the relationship between diabetes control and macrovascular disease.	Type 2 DM with end- stage renal disease — As a result of her diabetes, patient has chronic kidney disease and is currently on dialysis for ESRD.

# Coding and documentation examples

## Case study #1: Complete documentation

**Gender:** F **DOB:** MM/DD/1963

### History of present illness

The patient is a 58-year-old female who presents with a complaint of type 2 diabetes mellitus. Self-referred. Diagnosed at age 47.

**Reason for visit is clearly documented.**

### Problem list/past medical

DIABETES MELLITUS TYPE 2 WITH HYPERGLYCEMIA (E11.65) [2010]

FATIGUE (R53.83)

VITAMIN D DEFICIENCY (E55.9)

INSOMNIA (G47.00)

COLON POLYPS (K63.5)

### Medication history

Accu-Chek FastClix Lancets (1 Daily) Active

### Past surgical history

s/p cholecystectomy [2008]

### Exam

General: Present – alert, well-nourished, no apparent distress

Respiratory: Present – sleep disturbance and snoring.

Not present – dyspnea on exertion and tobacco use.

Cardiovascular: Present – chest pain. Not present – irregular heartbeat, palpitations, and swelling of extremities.

Gastrointestinal: Present – constipation. Not present – GERD.

Female genitourinary: Present – amenorrhea. Not present – change in bladder habits.

Musculoskeletal: Present – joint pain (shoulders).

Not present – low back pain.

Endocrine: Present – blood sugars are running high and monitoring glucose.

### Assessment & plan

Diabetes mellitus type 2 with hyperglycemia (E11.65)

Uncontrolled. A1C 7.1. Patient has been snacking more since the pandemic. Referred patient to one of our certified diabetes educators for diabetes self-management education.

*Jane Doe, MD*

**Assessment and plan clearly states patient has diabetes mellitus type 2 with hyperglycemia.**

**Documentation includes MEAT details: condition status, blood sugar levels and A1C, and education referral.**

**Documentation supports diabetes mellitus type 2 with hyperglycemia (E11.65).**

## Case study #2: Missed opportunity

**Gender:** M **DOB:** MM/DD/1995

### History of present illness

Pt here today to review labs. His ALT is still elevated at 60. It appears that in 2017 his hepatitis panel was negative, his ASL and ALT were elevated, and his abdominal ultrasound was negative for any fatty liver. He was diagnosed in 2019 as a type 1 diabetic with insulin. His hemoglobin A1C was 5.8; it is now 9.1.

### Current medications

Insulin glargine (LANTUS) 100 unit/mL (3 mL) insulin pen injection pen, inject 15 units under the skin every morning, Disp: 3 pen, Rfl: 1

Insulin lispro (Admelog SoloStar U-100 Insulin) 100 unit/mL insulin pen, inject 8 units under the skin 3 times a day before meals, Disp: 3 pen, Rfl: 2

Pen needle, diabetic 32 gauge x 5/16" needle, use with insulin four times a day, Disp 100 each, Rfl: 2

### PFSH

Diabetes mellitus type 1

Fatigue

### Exam

GENERAL: in no acute physical distress

EYES: lids and conjunctiva are normal

E/N/T: normal external ears

RESPIRATORY: normal respiratory rate and pattern with no distress

MUSCULOSKELETAL: normal gait

SKIN: no ulcerations or rashes noted on exposed skin

PSYCHIATRIC: Mood/Affect – appropriate, cooperative, no rapid speech or marked psychomotor impairment. Speech is fluent and thought processes logical; good insight and judgment.

### Assessment & plan

Type 1 diabetes mellitus, unspecified

Lab Results:

Pt reports he is taking about 15 units of his long-acting insulin and about 8 units with meals, depending on what his sugars are before each meal. He states that his sugars have been running about 200 in the morning. He does admit that for 4 days, he did not take any insulin. Advised pt to stay on his insulin and monitor his sugars. We will follow up in 1 week when he gets his labs drawn for other parameters and recheck his hemoglobin A1C in 3 months.

*Jane Doe, MD*

**Does patient have any diabetic complications?**

**Note that A1C is 9.1, a clinical indicator of hyperglycemia. Query provider for further clarification.**

**Documentation supports diabetes mellitus type 1, unspecified (E10.9).**

# Coding for diabetes and diabetic complications

## Diabetes code categories and combination codes

The diabetes mellitus codes include combination codes that represent:

- The type of diabetes mellitus
- The body system(s) affected
- The complications affecting the body system(s)

When coding diabetes mellitus, coders should use as many codes from categories E08-E13 as necessary to describe all of the complications and associated conditions of the disease. These categories are listed below:

E08	Diabetes mellitus due to an underlying condition
E09	Drug or alcohol-induced diabetes mellitus
E10	Type 1 diabetes mellitus
E11	Type 2 diabetes mellitus
E13	Other specified diabetes mellitus

## Diabetic complications

Assign as many codes as necessary to describe all documented diabetic complications. Although most ICD-10 diabetes mellitus combination codes include manifestations, some combination codes require an additional code to identify the manifestation completely.

Example: Patient has type 1 diabetes with right foot ulcer and diabetic chronic kidney disease stage 4. Below is the correct coding for this patient's conditions:

E10.621	Type 1 diabetes with foot ulcer
L97.519	Non-pressure chronic ulcer of other part of right foot with unspecified severity
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
N18.4	Chronic kidney disease, stage 4 (severe)

## Diabetes with long-term insulin use

Long-term insulin use (Z79.4) should be documented and coded if applicable. Exception: Do not add Z79.4 with type 1 diabetes mellitus codes, as type 1 diabetes is inherently an insulin-dependent disease.

Example: Patient has type 2 diabetes mellitus. The patient also takes insulin daily. Below is the correct coding for this patient's conditions:

E11.9	Type 2 diabetes mellitus, uncomplicated
Z79.4	Long term (current) use of insulin

# Clinical indicators

Familiarity with diabetes clinical indicators (i.e., testing, treatment, medication, etc.) is helpful in recognizing the potential presence and severity of a condition. **Coders cannot assign diagnosis codes based solely on test results and medication lists**, but these clinical indicators can help highlight opportunities for more complete and accurate documentation.

## Common tests used to diagnose and monitor diabetes

Test	Purpose
Glycated hemoglobin (A1C) test	Most commonly used to diagnose and monitor diabetes
Random blood sugar test	Used when A1C results aren't consistent, the test isn't available, or patient has certain conditions that can make the A1C test inaccurate, such as pregnancy or an uncommon form of hemoglobin (known as hemoglobin variant)
Fasting blood sugar test	
Oral glucose tolerance test	
Blood test	Used to distinguish between type 1 and type 2 diabetes
Urine test	
Initial glucose challenge test	Used to test for gestational diabetes
Follow-up glucose tolerance test	

## Common medications used to treat diabetes

Brand name	Generic	Classification
Humalog	Insulin lispro	Insulin (rapid-acting)
Novolog	Insulin aspart	Insulin (rapid-acting)
Apidra	Insulin glulisine	Insulin (rapid-acting)
Basaglar, Lantus, Toujeo	Insulin glargine	Insulin (long-acting)
Levemir	Insulin detemir	Insulin (long-acting)
Tresiba	Insulin degludec	Insulin (long-acting)
Humulin 70/30, Novolin 70/30	Isophane/regular insulin	Insulin (pre-mixed)
Fortamet, Glumetza	Metformin	Biguanide
DiaBeta, Glynase	Glyburide	Sulfonylurea
Glucotrol	Glipizide	Sulfonylurea
Amaryl	Glimepiride	Sulfonylurea
Prandin	Repaglinide	Glinide
Starlix	Nateglinide	Glinide
Actos	Pioglitazone	Thiazolidinedione
Avandia	Rosiglitazone	Thiazolidinedione
Januvia	Sitagliptin	DPP-4 inhibitor
Onglyza	Saxagliptin	DPP-4 inhibitor
Tradjenta	Linagliptin	DPP-4 inhibitor
Byetta, Bydureon	Exenatide	GLP-1 receptor agonist
Saxenda, Victoza	Liraglutide	GLP-1 receptor agonist
Rybelsus, Ozempic	Semaglutide	GLP-1 receptor agonist
Invokana	Canagliflozin	SGLT2 inhibitor
Farxiga	Dapagliflozin	SGLT2 inhibitor
Jardiance	Empagliflozin	SGLT2 inhibitor