Documentation and Coding Series: Diabetes Mellitus

Posted January 29, 2021

In our annual Blue Review readership survey, many of you asked for more articles on coding. In response, our Coding Compliance department has identified resources to help providers accurately code and document patient conditions. This month we are featuring documentation and coding information on atrial fibrillation and diabetes mellitus. Additional articles in the series will run throughout the year. Let us know what you think by emailing our editorial staff.

High quality documentation and complete, accurate coding may help capture our members' health status and promote continuity of care. Below are resources for coding and documenting diabetes mellitus (DM). This guidance is from the ICD-10-CM Official Guidelines for Coding and Reporting and the resources listed below.

Codes for DM Types
DM types are divided into five categories:

- **E08** DM due to underlying condition
- **E09** Drug or chemical induced DM
- **E10** Type 1 DM
- **E11** Type 2 DM
- **E13** Other specified DM

Sample ICD-10-CM DM Codes	
Type 1 DM without complications	**E10.9**
Type 2 DM without complications	**E11.9**
Type 1 DM with diabetic chronic kidney disease (CKD) • Use additional code to identify CKD stage (N18.1–N18.6)	**E10.22**
Type 2 DM with CKD • Use additional code to identify CKD stage (N18.1–N18.6)	**E11.22**

ICD-10-CM requires **documentation to specify DM with hyper- or hypoglycemia**, instead of controlled or uncontrolled. Without this documentation, **DM unspecified** will be coded.

Specificity Matters
These categories are further divided into subcategories of four, five or six characters. They include the DM type, the body system affected and the complications affecting that body system.

Best Practices

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure documents are signed and dated by a credentialed provider.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Assign as many codes as needed to describe all disease complications. This includes combination codes (such as E11.621 Type 2 DM with foot ulcer) and additional codes (such as CKD stage and ulcer site).
- Assign codes appropriate for the patient's condition.Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam to capture all conditions impacting patient care.

For more resources, see:

- 2020 ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E08–E13)
- Centers for Medicare & Medicaid Services Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance
- Blue Cross and Blue Shield of Illinois (BCBSIL) Medicare Advantage Annual Wellness Visit Guide