

Coding: Your Top Coding Problems Solved

Coding for diabetes and an E&M reminder

By Jennifer Swindle

DESCRIBING DIABETES

There are nearly 40 ICD-9 codes for reporting diabetes disease processes. You have to document very specifically and consistently if you and your staff are going to choose the right one.

Here's how ICD-9 diabetes coding works:

- **The first three digits** are the diagnostic code category "250," indicating diabetes mellitus.
- **The fourth digit** identifies whether clinically significant manifestations exist and, if so, which body system is affected.
- **The fifth digit** indicates the type of diabetes (1 or 2) and whether it is controlled or uncontrolled.

Coders and billers must have all this information to pick the right code.

When documenting, record "Type 1" or "Type 2" diabetes rather than "insulin dependent" or "non-insulin dependent."

It's also important to indicate in the patient's chart whether the diabetes is controlled or uncontrolled. Uncontrolled means that the current treatment regimen does not keep the patient's blood sugar level within an acceptable range. If this is the case, you should include the term "uncontrolled" or some comparable documentation note in the diagnosis portion of the record. Merely listing blood sugar levels is not enough.

DIABETES-CAUSED DISEASE

Before selecting a diagnosis code, make sure your patient's medical record shows when a medical condition is a result of diabetes. For example, for patients with a diabetic cataract, don't list just "cataract." Instead, specify "diabetic cataract." This clarifies that diabetes is the underlying cause.

If another medical condition is caused by diabetes, the diabetes must be coded first because it is the primary disease process. The manifestation is a secondary diagnosis. For example, here's how diagnosis coding breaks down for a patient who has controlled Type 2 diabetes and has developed a diabetic cataract:

- **250.50 is the first diagnosis.** The "250" refers to diabetes mellitus; the "5" indicates an ophthalmic manifestation; and the "0" captures that it is Type 2 and controlled.
- **366.41 is the second diagnosis.** It is reported to explain the "5" in the first diagnosis. The "366" designates a cataract; the "4" indicates that the cataract is associated with another disorder; and the "1" spells out that the other disorder is diabetes.

AND A REMINDER...

Modifier -25 is the most common evaluation and management (E&M) modifier. Use it right, and you'll get paid more.

When to use it: Medicare requires a modifier -25 for an E&M service that is performed on the same day as a procedure that has a "global fee" period. Commercial carriers might also require it for services that have no global period.

The E&M and the procedure don't have to be associated with separate diagnoses. All that matters is that you provide a separate and significant E&M service. That means you did more than the normal pre- and post-operative steps. Your documentation has to support both services.

When not to use it: All procedure visits include a "mini E&M" service. For example, before removing warts, you might ask the patient some questions, look at the area, and discuss the procedure. That is not a separate and significant E&M service; it's part of the procedure. It does not meet documentation guidelines for an office visit.

Many payers believe -25 is widely abused, so they often challenge claims reporting it. If you understand the rules, you're in a better place to battle back.

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