BlueCross BlueShield of New Mexico

Documentation and Coding

Diabetes Mellitus

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

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

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.

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 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

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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. To fully capture DM, document all related conditions, when applicable. CKD, cataracts, neuropathy, retinopathy, foot ulcers and peripheral vascular disease are examples of conditions that use a combination code to describe the relationship. Sometimes, multiple DM combination codes are needed to paint the whole picture. Long-term (current) medication use codes identify oral hypoglycemic drugs (Z79.84), injectable non-insulin antidiabetic drugs (Z79.85) and insulin (Z79.4).

Tips to Consider

- Include patient demographics, such as name and date of birth, and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure providers sign and date documents.
- Document how each diagnosis was 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 or other yearly preventive exam to capture all conditions impacting member care.

Resources

- **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 Medical Record Checklist and Guidance**
- Our **Medicare Advantage Annual Wellness Visit Guide**

Questions? Contact your Network Representative.