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Optometry Coding & Billing Alert

Compliant Coding: Avoid 3 Common Diabetes Coding Mistakes

See your way clear of confusion and keep the feds from eyeing your practice

If you fall down on the job when coding for patients with diabetes, you could be encouraging the feds to scrutinize your claims like kids in a candy store.

The diabetes coding guidelines date back to 1991, yet a huge number of optometry practices continue to code incorrectly for their diabetic patients, experts say. Many physicians don't realize that the way they code for diabetes actually makes a difference, says **Susan Hull, RHIA, CCS**, coding practice manager for the American Health Information Management Association in Chicago.

But diabetes coding certainly does make a difference. Medicare and other plans sometimes base benefits or payment on how the physician codes diabetes, says **Karen Beard**, senior associate with Medical Management Associates in Atlanta. Not only that, but if you make obvious diabetes coding errors, you could be waving a red flag right in front of the feds' eyes.

Here are three common diabetes coding errors and how to avoid them:

1. Using the least-specific code.
The single biggest mistake practices make with diabetes coding is always to use code 250.00, which indicates type II uncomplicated diabetes, Hull says. This is particularly a problem if the physician is reporting a level-four or -five service, because uncomplicated diabetes wouldn't require that degree of attention. That's the kind of mistake that can easily lead your carrier to investigate further.

And some plans won't accept a claim that uses only 250, Beard says. Now that codes are becoming more specific - and more numerous - "we'll see more determination among plans to make sure it goes out to the fourth and fifth digit," she says.

To avoid this problem, practices should encourage physicians to document whether the diabetes is complicated or not, Hull says. Sure, it's easy to incorporate the generic code on a superbill, but you can't just leave it at that. And nonclinical staff members shouldn't make determinations about the appropriate fourth and fifth digit - that's up to the physician, Beard says.

2. Failing to distinguish between insulin dependent and non-insulin dependent diabetes.
Whenever you use 250, you should carry it out to the fifth digit to indicate insulin dependent or non-insulin dependent. A "0" as the fifth digit indicates type II non-insulin dependent, not stated as uncontrolled; a "1" indicates type I insulin dependent, not stated as uncontrolled; a "2" indicates type II non-insulin dependent, uncontrolled; and a "3" indicates type I insulin dependent, uncontrolled.

Keep in mind that the definition of insulin dependent diabetes is "extremely narrow," Hull says. Ensure that the physicians in your practice are fully aware of the "precise definition of insulin dependent versus non-insulin dependent."

Coding the patient's specific type of diabetes fulfills carriers' requirements and provides a critical tool for managing the patient's eye care. For instance, the American Diabetes Association reports that "almost everyone with type I diabetes will eventually have nonproliferative retinopathy (250.51 as the primary diagnosis, and 362.01 as the secondary diagnosis)."

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3. Inappropriate sequencing of codes.

"Diabetes has all kinds of complications, and the rule is that when the diabetes is a cause of a complication, the diabetes code goes first and the complication code goes second," Hull says. This is a rule you should simply commit to memory to avoid errors.

For example, a patient with type I diabetes with glaucoma complications would have the diabetes code, 250.51 (Diabetes with ophthalmic manifestations; type I [insulin dependent type], not stated as uncontrolled), listed first, with the manifestation code for glaucoma, 365.44 (Glaucoma associated with systemic syndromes), listed second.

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