Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 6 Steps Promise Diabetes Coding Success

Note: Complications need special attention

Diabetes refers to diabetes mellitus or, less often, to diabetes insipidus, and both conditions are characterized by excessive urination (polyuria). Follow the steps below to untangle confusion, code properly and expect maximum reimbursement every time.

Clue: When physicians use -diabetes- alone, they-re referring to diabetes mellitus. The two main types of diabetes mellitus (insulin-requiring type I diabetes and adult-onset type II diabetes) are distinct and different diseases.

Get Screening Codes Right

Medicare pays physicians for most diabetes screenings. If your physician wants to screen a Medicare patient for diabetes, you should report one of the following lab codes:

- 82947--Glucose; quantitative, blood (except reagent strip). Assign this code when the provider draws the patient's blood to check for glucose after the patient has fasted for 12 hours.

- 82950--... post glucose dose (includes glucose). Report this code when the provider checks the patient's glucose following the patient's ingestion of a dose of glucose.

- 82951--... tolerance test (GTT), three specimens (includes glucose). Use this code when the provider draws blood for a fasting glucose determination, and then following that the patient ingests a glucose solution before having another blood draw at half-hour and one-hour intervals.

Diagnosis: When you report any of the above three codes, list V77.1 (Special screening for diabetes mellitus) as your primary diagnosis code.

Must-have modifier: The three Medicare-approved diabetes-screening tests carry a -waived status.- That means if your office has obtained the Clinical Laboratory Improvement Amendments (CLIA) certification, your physician can perform the tests in the office. Be sure to append modifier QW (CLIA waived test) to the codes.

Medicare requires that you attach modifier TS (Follow-up service) if your physician performs a screening test on a -prediabetes- patient. So, if your provider performs the glucose tolerance test on a prediabetes patient, you would report 82951-QW-TS.

Coverage: You may bill one test every six months for patients with prediabetes. But you should report only one test every 12 months for patients whom the physician has never tested or hasn't diagnosed with prediabetes.

Also, before reporting a screening code, make sure the patient has at least one of these diabetes risk factors: hypertension, dyslipidemia, obesity (with a body mass index greater than or equal to 30 kg/m2), and/or previous identification of elevated impaired fasting glucose or glucose intolerance.

If you-re not reporting the right fourth and fifth digits on 250.xx, you may be undermining patient complexity and thereby billing for lower-level services than your physician provides.

Diabetes patients often have one or multiple complications that require the physician's extra attention and

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consideration, and these added complications can have a significant effect on the E/M level you bill. Use these six steps for definitive diabetes diagnosis coding to ensure that your ICD-9 codes justify the services you bill.

1. Select Fourth Digit First

Coders must determine the fourth digit for 250.xx (Diabetes mellitus) according to the type of diabetic complication the patient suffers from, if any. Diabetes patients may suffer from more than one complication, and if this is the case you should code only the complication relevant to services your physician renders that day.

2. Identify Type for Fifth Digit

The fifth digit provides the final two pieces of information on the patient's diabetic condition: diabetes type (I or II) and whether it is controlled. To select the proper digit, you must know what the following ICD-9 descriptor terms mean:

- Type I: The patient's pancreatic beta cells no longer produce insulin. People with type I diabetes must take insulin. ICD-9 descriptors also refer to type I as -juvenile type- diabetes.

- Type II: The patient's beta cells do not produce sufficient insulin or the beta cells have developed insulin resistance. Unlike people with type I, people with type II may or may not have to take insulin.

- Not stated as uncontrolled: The patient's diabetes is managed sufficiently by diet and/or insulin.

- Uncontrolled: A patient can have uncontrolled diabetes when the physician documents that blood sugar levels are not acceptably stable, when the patient is not in compliance with his diabetes management plan or if the patient is taking medications for another illness that interfere with diabetes management.

First, check your physician's documentation to see what type of diabetes the patient has and if the condition is controlled. Then choose from one of the fifth digits listed with the 250.xx category.

Example: Your physician treats an uncontrolled, type II diabetic suffering from peripheral circulatory disorders. You would report 250.72.

3. Determine if Diabetes Is Primary

Next, ask: Is diabetes the primary or secondary diagnosis? Your physician could treat a patient for a problem not directly related to the diabetes, but you may still need to indicate the patient's complete medical condition with a 250.xx code.

The nature of the presenting problem should govern the diagnosis code. Study these two scenarios to help you determine if you should list diabetes first as the primary diagnosis:

A. Diabetic patient with new foot ulcer: Code the foot ulcer as the primary diagnosis, and list the diabetes mellitus as the secondary diagnosis. Diabetes is secondary because it is a relevant condition that influences the patient's treatment and care, as well as the ulcer's cause. And the patient saw the doctor specifically for the foot ulcer, not for diabetes management. Listing the appropriate 250.xx code can also help justify a higher-level E/M because the condition complicates the physician's treatment plan and requires extra time and more complex decision-making on the physician's part.

B. Diabetic with slow-healing arm laceration: The wound is the primary diagnosis because it is the problem the physician is actively treating. You should report the diabetes as secondary because the condition is causing the wound to heal slowly and also complicates the physician's treatment plan.

4. Mind Your Manifestations

Five diabetes code fourth-digit descriptors require that you report a manifestation diagnosis code as well. Always report

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the manifestation code as a secondary diagnosis. Remember, not all diabetes fourth digits require a manifestation code. The code descriptor tells you if you need one. Here's a partial list of the diabetes codes that require a corresponding manifestation code, paired with some possible diabetic manifestations:

- 250.5x - 366.41 (Cataract associated with other disorders; diabetic cataract)

- 250.6x - 357.2 (Inflammatory and toxic neuropathy, polyneuropathy in diabetes)

- 250.7x - 443.81 (Peripheral angiopathy in diseases classified elsewhere)

Keep in mind: The ICD-9 manual does not list all possible manifestation codes that you might need to choose from when you report one of the 250.xx codes above.
Report them all: If a patient has more than one diabetic complication, you can code the multiple complications and their manifestations on a single claim, making sure to link the manifestations to the correct diabetes codes.

Example: If a physician treats a patient for diabetes with renal manifestations and the patient also has ophthalmic manifestations, report both sets of codes. Usually the prescription management or plan of care needs to consider these other manifestations.

Sequence matters: Remember to report first the particular manifestation your physician treats that day. Or if the physician is dealing with multiple complications, code according to the order in which the physician renders treatment. Finally, if the documentation does not indicate the treatment order, you should report the most prominent or advanced complication and corresponding manifestation first.

5. Insert V Codes for Insulin Pump

V codes are also important for telling the carrier the whole story of a patient's diabetes. Assign V58.67 (Long-term [current] use of insulin) as a secondary code for patients who take insulin on a regular basis.

V codes also come into play for diabetes patients receiving their insulin via insulin pumps. Three V codes apply to different stages of the insulin pump treatment process. When you code an E/M visit concerning an insulin pump, report the appropriate 250.xx code and one of the following insulin pump V codes as a secondary diagnosis:

- V65.46 (Encounter for insulin pump training) for when a patient first considers an insulin pump and receives education about the device.

- V53.91 (Fitting and adjustment of insulin pump) for when the patient first receives the insulin pump from the physician.

- V45.85 (Insulin pump status) for all other follow-up visits associated with the pump.

- 996.57 (Mechanical complication ... due to insulin pump) for reporting insulin pump mechanical complications.

6. Go to 648.8x for Gestational

One type of diabetes you won't find within the 250.xx series is gestational diabetes--a condition that only develops during pregnancy and disappears after delivery. For this type of diabetes, use 648.8x and choose the fifth digit (0-4) to indicate when the condition or complication occurred. Include V58.67 if the physician is treating the gestational diabetes with insulin.

Distinction: For pregnant women who are diabetic (suffering from diabetes before becoming pregnant), you should assign 648.0x as the primary code and then the appropriate 250.xx code to identify the type of diabetes.

Warning: You should never report 648.0x and 648.8x together.

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