OASIS Alert

Diagnosis Coding: PROTECT YOUR REIMBURSEMENT AGAINST THESE COMMON DIABETES CODING MISTAKES

Remember to list V58.67 for type II patients on insulin.

Diabetes may be the diagnosis most often reported in home care settings, but it's also the most misunderstood. Clear up these four most common misconceptions to ensure your agency's claims aren't at risk:

Mistake #1: Reporting diabetes as uncontrolled without proper documentation. Don't pick a fifth digit for 250.xx (Diabetes mellitus) which indicates the diabetes is uncontrolled unless you have specific documentation from the physician to that effect, advises **Joan Usher** with **JLU Health Record Systems** in Pembroke, Mass. If the physician documents that the patient's diabetes is "uncontrolled" or "out of control," you can pick fifth digit "2" for patients with type II diabetes or fifth digit "3" for patients with type I diabetes.

But if the physician describes the patient's diabetes as "poorly controlled," "brittle," or "severe," you must list a fifth digit that reports the patient has diabetes "not stated as uncontrolled." That means fifth digit "0" for type II patients or fifth digit "1" for type I patients. "Control" refers to whether or not the physician is able to keep the glucose levels within acceptable range with a treatment regimen,says consultant **Rhonda Will** with **Fazzi Associates** in Northampton, Mass. "It has nothing to do with how a patient complies with treatment and should not be used just because the patient has documented incidences of high or varying blood sugars."

Mistake # 2: Fear of 250.00. Some coders worry that they shouldn't list 250.00 (Diabetes mellitus without mention of complica- tion; type II or unspecified type, not stated as uncontrolled) as a primary diagnosis because it doesn't demonstrate medical necessity if the patient's diabetes isn't uncontrolled, but that's not so.

If the focus of your care is a patient's new onset of diabetes, a change in your diabetic patient's oral medications, or dietary changes for a patient whose diabetes is controlled by diet, 250.00 is a perfectly acceptable principal diagnosis, Usher says.

And remember that the fifth digit indicating uncontrolled is dependent on physician documentation, so using "0" for not stated as uncontrolled is perfectly acceptable.

For example: Your new patient is a diabetic whose physician has just put him on insulin. Nursing will teach insulin and closely monitor the response to the insulin through glucose checks. Nursing will also give instruction on possible hypoglycemia and help the patient identify the signs and feelings that signal hypoglycemia. For this patient, 250.00 is an appropriate principal diagnoses, says Will.

Mistake #3: Assuming co-morbidities are diabetic manifestations. The only conditions you can assume are manifestations of diabetes in a diabetic patient are osteomyelitis (731.8 -- Other bone involvement in diseases classified elsewhere, followed by 730.x -- Osteomyelitis) and gangrene (785.4), provided there is no documentation from the physician indicating another cause of these conditions, says Will.

For all other co-morbidities, the physician must determine whether there is a relationship between the diabetes and the other diseases or conditions.

Mistake #4: Incorrect sequencing of diabetic manifestations. To code correctly for a diabetic manifestation, you must pair a 250.xx code with the appropriate code for each manifestation.

For example: Your patient has diabetic neuropathy and a diabetic ulcer on his heel. You'll need to list two 250.xx codes

for this patient because the fourth digit will change to match the type of manifestation, Usher says. So for this patient you would list:

• 250.60 (Diabetes mellitus with neurological manifestations; type II or unspecified type, not stated as uncontrolled);

• 357.2 (Polyneuropathy in diabetes);

• 250.80 (Diabetes mellitus with other specified manifestations; type II or unspecified type, not stated as uncontrolled); and

• 707.14 (Ulcer of heel and midfoot).

In this same scenario, it would be incorrect to code the following: 250.60, 357.2, 707.14. This coding is inaccurate and has the potential to be caught in an audit, Usher says. Even worse, if you had additional comorbidities including a case mix code such as hypertension (401.x) listed in M1022f, once the audit corrected the coding to include 250.80, the hypertension code would be bumped out of the first six OASIS diagnosis slots and could reduce your reimbursement as a result.

Mistake #5: Not reporting a type II diabetic's insulin use. If your type II diabetic patient uses insulin to manage his diabetes, you should report V58.67 (Long term [current] use of insulin). This code distinguishes those type II diabetics who use insulin from those type II diabetics who do not need it, Will says. But don't list V58.67 for patients with type I diabetes because all type I patients need insulin, Will says.

You can't list V58.67 in M1020 and there's no requirement as to where it's sequenced in M1022, says **Lisa Selman-Holman,** consultant and principal of **Selman-Holman & Associates** and **CoDR -- Coding**

Done Right in Denton, Texas. But it should be one of the diagnoses you report for a type II diabetic patient on insulin, even if it's coded as the seventh or lower diagnosis, she says.