Coding Tip Sheet: Diabetes Mellitus

Diabetic Complication	ICD-10-CM Code		Coding Guidelines and Documentation Best Practices
	Type 1	Type 2	
Diabetes Mellitus without Complications	E10.9	E11.9	Use when no other complications of diabetes exist.
Amyotrophy and/or Myasthenia*	E10.44	E11.44	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Arthropathy (other) *	E10.618	E11.618	
Autonomic (poly)neuropathy and/or gastroparesis*	E10.43	E11.43	
Cataract*	E10.36	E11.36	
Charcot's joints and/or neuropathic arthropathy*	E10.610	E11.610	
Chronic Kidney Disease*	E10.22	E11.22	ICD-10-CM Guideline: Use additional code to identify the stage of CKD, supported by documentation.
Circulatory Complication NEC**	E10.59	E11.59	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Dermatitis (diabetic necrobiosis llopoidica)*	E10.620	E11.620	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Foot Ulcer*	E10.621	E11.621	ICD-10-CM Guideline: Use additional code to identify site and severity of ulcer.
Gangrene*	E10.52	E11.52	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Hypoglycemia*	E10.64X	E11.64X	6th character required: E11.641 with coma, E11.649 without coma. 'Uncontrolled' is not an acceptable term. Use the term hypoglycemia for coding and billing purposes.
Hyperglycemia *	E10.65	E11.65	'Uncontrolled' is not an acceptable term for reporting. Use the term hyperglycemia for coding and billing purposes.
Neuropathy or Loss of Protective Sensation (LOPS)*	E10.40	E11.40	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Mononeuropathy*	E10.41	E11.41	
Nephropathy, intercapillary glomerulosclerosis, intracapillary glomerulonephrosis, and/or Kimmelstiel-Wilson disease*	E10.21	E11.21	
Neurologic Complication NEC**	E10.49	E11.49	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Ophthalmologic complication NEC**	E10.39	E11.39	
Oral complication NEC**	E10.638	E11.638	
Other specified complications	E10.69	E11.69	
Periodontal Disease*	E10.630	E11.630	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Peripheral angiopathy (Peripheral Vascular Disease, or PVD)*	E10.51	E11.51	
Polyneuropathy and/or neuralgia*	E10.42	E11.42	
Renal Complication NEC**	E10.29	E11.29	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Renal Tubular Degeneration*	E10.29	E11.29	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Retinopathy (unspecified) *	E10.31x	E11.31x	Diabetes mellitus with unspecified diabetic retinopathy: E11.311 with macular edema, E11.319 without macular edema.
Skin Complication NEC**	E10.628	E11.628	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Skin ulcer NEC**	E10.622	E11.622	

* Causal relationship with diabetes is presumed unless provider specifies condition is unrelated.

**Not Elsewhere Classifiable.

Additional Types of Diabetes: E08- Secondary Diabetes, E09- Secondary Diabetes due to drugs or chemicals, E13- Other specified Diabetes

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General Documentation Best Practices:

- ✓ Create a clear relationship between the condition and any manifestation. Use linking verbiage such as "with, due to or associated with." If conditions are not related, provide clarity in documentation.
- ✓ Do not use questionable language such as "possible, suspect or likely" for outpatient coding and reporting purposes.
- ✓ Document all conditions to the highest known specificity. Use ICD-10-CM codes that correspond to documentation.
- ✓ All conditions that affect the patient's care on the date of service should be documented and addressed in the medical record.
- ✓ All known chronic conditions should be addressed at least once per calendar year.
- ✓ Use **M.E.A.T** for documentation in order to ensure the condition is supported in the medical record:
  - **Monitor** – disease progression, signs and symptoms.
  - **Evaluate** – lab results, response to treatment, review or refill medication.
  - **Assess/Address** – review medical records, counsel with patient.
  - **Treat** – prescribe medication, therapy, referrals.
- ✓ All records should be signed by the health care provider with their credentials. Date of service and patient identifiers should be included on every page of the encounter note.



Sources

AAPC ICD-10-CM Expert 2021: An Official Guide for Hospitals and Physicians.

Poe Bernard, S. (2020) Risk Adjustment Documentation and Coding, Second Edition. Chicago: American Medical Association.

Please refer to official current year ICD-10-CM Guidelines for further information.
This document is for educational purposes only and not meant to replace official guidelines.

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