Diabetes and gangrene coding guidelines icd 10

Diabetes Mellitus

ICD-9 CM	ICD-10 CM
Categories 249-250 (59 Codes)	Categories E08-E13 (200+ Codes)
4th and 5th digit identify manifestation, complication, or type	Combination codes used to identify manifestation and complication
Additional code for manifestation	Type of diabetes is separated by categories in ICD-10 (E10 Type 1, E11 Type 2)
Additional code for insulin dependency V58.67	Z79.4 used for long term insulin use
	Drug induced goes to Drug Code/DRG
	Inadequately controlled, poorly controlled, out of control are assigned to diabetes by type with hyperglycemia

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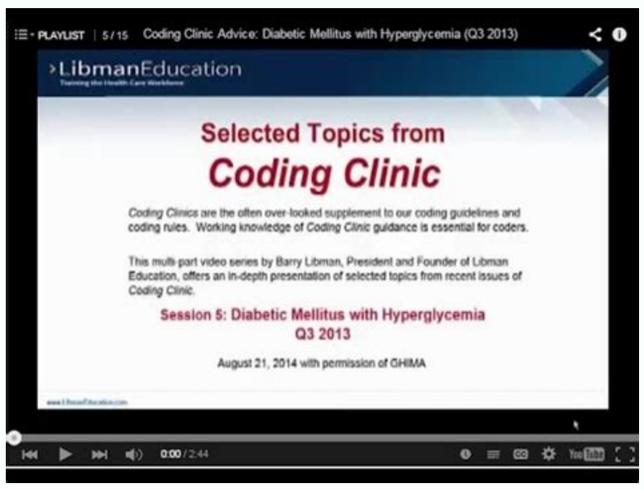
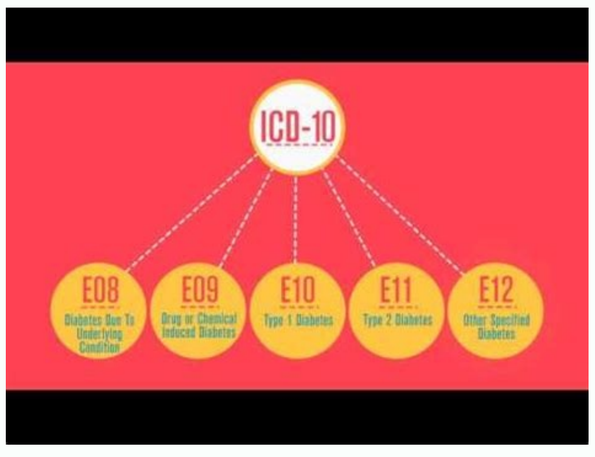
4th Digit in Diabetes Coding

4th Digit	Manifestation
0	No Complication
1	Ketoacidosis
2	Hyperosmolality
3	Coma
4	Renal Manifestations
5	Opthalmological
6	Neurological
7	Peripheral Circulatory
8	Other Specified Manifestations
9	Unspecified Manifestations



Documentation Considerations by Chapters in ICD-10-CM

- **Infectious & Parasitic Disease**
  - New terminology to review
  - Includes the drug resistant classifications
- **Blood & Blood Forming Organ**
  - New terminology to review
  - Greater specificity
- **Endocrine, Nutritional, Metabolic**
  - Greater specificity for diabetes & malnutrition



Diabetes with gangrene icd-10. Icd 10 diabetes coding guidelines.

A 71-year-old male with type 2 diabetes mellitus presented to the Emergency Department with a swollen gangrenous right foot that was diagnosed as gas gangrene. Does the Alphabetic Index subentry for “with gangrene” under the main term “diabetes,” include gas gangrene? If so, should we also report code A48.0 to specify the gangrene as gas gangrene? What are the appropriate code assignments for gas gangrene in a type 2 diabetic patient? ...To read the full article, sign in and subscribe to AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS . The official AHA publication for ICD-10-CM and ICD-10-PCS coding guidelines and advice Current newsletters added each quarter Full Archives - over 3100 articles ALL years/issues back to 1984 organized by year and issue Includes ICD-10-CM/PCS Articles since 2013 Fully searchable through Find-A-Code's Comprehensive Search Codes mentioned in articles are linked to Code Information pages Code Information pages link back to related articles View all the articles associated with any code, right from the code page! Access to this feature is available in the following products:AHA's Coding Clinic® - ICD-10-CM/PCS +Archives Thank you for choosing Find-A-Code, please Sign In to remove ads. Diabetes could be a contributing factor without being the direct cause. In the first article in this series, I compared pressure ulcers and diabetic foot ulcers (the latter are considered non-pressure chronic ulcers in ICD-10-CM). My conclusion was that there is significant overlap, but heel ulcers are prime candidates to be classified as pressure injuries by providers. Ultimately, their documentation will determine whether an ulcer on the foot of a diabetic will be considered a “diabetic foot ulcer” or a pressure ulcer. This article will explore whether they are mutually exclusive conditions. Additionally, I will give you my opinion on the Coding Clinic advice found on pages 3 and 4 of the third-quarter edition. I am not telling you to disregard Coding Clinic. I just subscribe to the rule that if there is a discrepancy between conventions or the Official Guidelines and Coding Clinic, and you are led to a code that does not seem to identify a condition correctly, you might need to go back to the drawing board. A question recently posed was regarding a diabetic patient “with a gangrenous decubitus ulcer of the heel,” diagnosed as “Stage 3 necrotic decubitus ulcer of left heel associated with diabetic neuropathy and peripheral vascular disease.” The question was which condition to use as principal diagnosis (PDx). The reviewer first tried to explain why this was not a diabetic ulcer. She stated that “diabetic ulcers typically involve the foot, starting on the toes and moving upward.” What does this mean? Does upward mean dorsal? Does it mean cranial? When giving advice regarding clinical topics, I strongly recommend being precise in anatomical terms. This advice harkens back to the Coding Clinic published for the first quarter of 2004, wherein a patient had NIDDM, gangrene, and osteomyelitis of a heel decubitus ulcer. The ruling there was that the gangrene and osteomyelitis were related to the pressure ulcer and that “a relationship between DM and osteomyelitis (is assumed) when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes (bold emphasis mine). In this case, the physician indicated that the osteomyelitis was due to the decubitus ulcer, so the osteomyelitis would not be coded as a diabetic complication.” In my opinion, diabetes could be a contributing factor without being the direct cause, and also without being “totally unrelated.” Osteomyelitis develops in the bone afflicted with the decubitus ulcer, but diabetes can contribute to its development. On Oct. 24, 2016, PodiatryToday published an article titled “Essential Tips on ICD-10 and Wound Care Coding.” It specifically referred to this same prototypical patient: “a patient with diabetes, peripheral arterial disease, and neuropathy may develop an ulcer…” It stated that NPUAP provides guidance that this should be considered a diabetic foot ulcer, even if arterial disease and/or pressure played a role in its development. Let’s look at the coding recommendations. The instructions at L89, Pressure ulcer, tell us to: Code first any associated gangrene (I96) Type 2 Excludes list diabetic ulcers, non-pressure chronic ulcers, and varicose ulcers. Does this mean that ulcers can be categorized as both pressure and chronic ulcers at the same time, or is it indicating that a patient may have both simultaneously, but not necessarily at the same site? Our Coding Clinic question points to just such a patient, with multifactorial reasons for ulceration. It does not offend my sensibilities to select the gangrene (I96, Gangrene, not elsewhere classified) as the PDx. However, I strongly object to the characterization that the “gangrene is associated with the pressure ulcer rather than the diabetes mellitus.” Gangrene has to affect a body part (e.g., musculoskeletal system, intestine portion, gallbladder, etc.); it does not occur diffusely, i.e., directly due to diabetes. In the case of an existing ulcer, gangrene (or osteomyelitis) is a progression or complication of that ulcer. I would actually say that “gangrene is associated with the pressure ulcer as well as the diabetes mellitus.” In our case, the provider documented “Stage 3 necrotic decubitus ulcer of left heel associated with diabetic neuropathy and peripheral vascular disease.” The provider declared the ulcer to be a decubitus/pressure ulcer, so it should be registered as such (be sure the POA designation is accurate!). Clinically, diabetes renders a patient more prone to develop gangrene and infection. There is an obvious clinical relationship. Peripheral vascular disease and peripheral neuropathy, also more common in diabetes, contribute to the development and severity of ulcers and gangrene. This provider actually connected the dots for us, aligning gangrene with the decubitus and also with the diabetic neuropathy and PVD by utilizing that “associated with” phrase. My objection is that the Coding Clinic direction is to use E11.51, Type 2 DM with diabetic peripheral angiopathy without gangrene. Not only does it not make clinical sense, but it doesn’t adhere to coding rules, either. I96 has an Excludes 2 for gangrene in diabetes mellitus, and the Alphabetic Index instructs us that Type 2 diabetes “with gangrene” goes to E11.52, according to the assumptive rule. The coding guidelines remind us of the “basic rule of coding…that further research must be done when the title of the code suggested by the Alphabetic Index clearly does not identify the condition correctly.” How can a patient with a principal diagnosis of gangrene have a condition specified as “without gangrene” in the same encounter? (As an aside, E11.40 has the title of Type 2 DM with diabetic neuropathy, unspecified, not “with neurological complications.”) In conclusion, I believe the correct depiction of this patient would be expressed with the following coding schema: I96 Gangrene, not elsewhere classified L89.623 Pressure ulcer of left heel, stage 3 E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified I will leave it to coders to determine whether the Excludes 2 suggests that a code for Type 2 DM with foot ulcer should also be picked up. Similarly, this scenario might emerge if one were to query the provider and get the response that the ulcer could be due to pressure and/or the diabetes. It reminds me of CKD in a patient with hypertension and diabetes. You assumptively use the code for hypertensive CKD and diabetic CKD, and no one cries foul. But it makes my head hurt trying to reconcile how one could have a “non-pressure” and “pressure” ulcer at the same time at the same site. This would call for an L97 and an L89 code, according to the “use additional code” instruction. Both of these codes would serve the purpose of specifying site and depth/extent of the ulcer. I only find Excludes 2 notes, not Excludes 1, so it would seem that it is not prohibited, but it seems redundant. The bottom line is that not all ulcers on a diabetic foot are categorized as diabetic foot ulcers. Heel ulcers may be considered pressure injuries/ulcers if the provider thinks that was the primary etiology. Our job is to accurately depict how sick and complex each patient is. We need to use as many codes as it takes to give a complete picture of the clinical situation. I think the important thing is to capture preventable pressure ulcers when present, and to avoid contradiction

(gangrene without gangrene) in the coding. Program Note: Listen to Dr. Remer every Tuesday on Talk Ten Tuesday, 10 a.m. ET. Comment on this article Skip to content Oct. 31, 2016 / By Sue Belley, RHIA A 47-year-old patient was admitted to the hospital with a chief complaint of an ulcer at the base of his left great toe. Patient has a history of diabetes mellitus, type 2, nephropathy with CKD stage 3, GERD, asthma and esophagitis. The patient's medications include insulin, a proton pump inhibitor and a steroid inhaler. After examination, it was determined that this was a diabetic foot ulcer with exposure of the fat layer. The wound was cultured and the patient was placed on IV antibiotics. Two days later the patient was taken to the Operating Room for an excisional debridement of the ulcer down to the bone. The patient was discharged from the hospital on day #5 with a diagnosis of poorly controlled diabetes mellitus with diabetic foot ulcer and acute osteomyelitis. The patient is sent home with IV antibiotic therapy and instructions to follow up in outpatient Wound Clinic for outpatient treatment of the ulcer. Please assign diagnosis and procedure codes for this scenario. ANSWERS E11.621 Type 2 diabetes mellitus with foot ulcer L97.522 Non-pressure chronic ulcer of other part of left foot with fat layer exposed E11.65 Type 2 diabetes mellitus with hyperglycemia Z79.4 Long term (current) use of insulin E11.69 Type 2 diabetes mellitus with other specified complication M86.172 Other acute osteomyelitis, left ankle and foot Z79.2 Long term use of antibiotics E11.21 Type 2 diabetes mellitus with diabetic nephropathy E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease N18.3 Chronic kidney disease, stage 3 K21.0 Gastro-esophageal reflux disease with esophagitis J45.909 Unspecified asthma, uncomplicated Z79.51 Long term use of inhaled steroids 0KBW0ZZ Excision of left foot muscle open approach BLOG RESPONSE This month's scenario provides us with an opportunity to examine the updated Guideline A.15 "With" in the FY 2017 ICD-10-CM Official Guidelines for Coding and Reporting effective October 1, 2016. The updated guideline states that "the classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related." In this scenario, the nephropathy, chronic kidney disease and osteomyelitis are not explicitly linked to diabetes mellitus by the provider. However, these three conditions are indexable under the main term, Diabetes, subterm, With, which is a perfect example of the classification presuming a causal relationship. The same goes for GERD and esophagitis. These diagnoses are not linked in the provider documentation but the index presumes a causal relationship (see Disease, Gastroesophageal, With esophagitis). Sue Belley, RHIA is a clinical content development manager with the consulting services business of 3M Health Information Systems.

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