Ref No: TN440 | Published On: 15-Dec-2012 | Status: Current

ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - Education Workshop FAQs

The diabetic foot

The diabetic foot is a complication of diabetes often requiring extended hospitalisation for successful treatment (weeks or months). It is characterised by an infected ulcer over a weight-bearing area of the foot, where a number of other factors contribute to the breakdown of the skin and underlying connective tissues and even involvement of the neighbouring bone. The presence of diabetic peripheral sensory neuropathy can result in a painless lesion and possibly develop from total unawareness of injury to the foot due to insensitivity to heat or other form of injury. Compromised circulation decreasing the capacity for response to antibiotics due to poor oxygenation and access of the antibiotics to the ulcerated area. Excessive 'loading' of parts of the foot already subject to breakdown because of poor quality tissue damaged by the diabetic process is an important contributing factor and might be due to changes in gait following amputations to the same or other foot with similar combinations of diabetic complications.

Typically the diabetic foot features an ulcer which does not respond to 'aggressive' traditional treatments with antibiotics, etc and such condition is the leading cause of lower limb amputation in medical practice and patients undergoing such need for amputation have an increased risk of death within five years.

Classification of diabetic foot

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

The text below reinforces the guidelines in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot* and clarifies the sequencing of codes for diabetic foot.

Assign E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes* when:

- 'diabetic foot' is documented in the clinical record, or
- the criteria specified in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, 6. Diabetic foot* are met.

Additional codes for the specific complications of DM or IH should be assigned in accordance with Rule 4a and Rule 4b.

Sequencing of codes for diabetic foot should be determined by:

- ACS 0001 *Principal diagnosis*, with particular attention to:
- the 'after study' principle
- *Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis*
- *Two or more diagnoses that equally meet the definition for principal diagnosis*
- ACS 0002 *Additional diagnoses*.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus with features of insulin resistance

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

If a patient previously had conditions (such as obesity or characteristic dyslipidaemia) which qualified them for assignment of E1-.72 **Diabetes mellitus with features of insulin resistance* but in a more recent episode of care no longer has those qualifying conditions (because they are no longer obese or their dyslipidaemia is controlled by medication) do they still qualify for the assignment of E1-.72 **Diabetes mellitus with features of insulin resistance*?

A:

Clinical advice confirmed that if conditions which previously contributed to the assignment of E1-.72 **Diabetes mellitus with features of insulin resistance* (such as obesity or characteristic dyslipidaemia) are no longer current, then these conditions should no longer be considered as contributing to the criteria for assignment of E1-.72 **Diabetes mellitus with features of insulin resistance*.

Q:

Can test results alone be used to identify characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance*?

A:

No, test results alone cannot be used to identify elevated fasting triglycerides or depressed HDL-cholesterol, as per the guidelines in ACS 0010 *General abstraction guidelines, Test results*. The following guidelines which are also represented in ACS 0401, *3. DM and IH with features of insulin resistance* and ACS 0401, *Figure 1* should be followed in order to identify "characteristic dyslipidaemia":

1. if there is clinician documentation of "dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia",

then seek confirmation that levels of either "elevated fasting triglycerides" (=1.7 mmol/L) or "depressed HDL-cholesterol" (male =1.03, female =1.29) meet the required values for characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance.*

2. if there is NO clinician documentation of dyslipidaemia/hypercholesterolaemia/high cholesterol/ hyperlipidaemia,

then clinician documentation of both "elevated fasting triglycerides" (=1.7 mmol/L) and "depressed HDL-cholesterol" (male =1.03, female =1.29) is required - test results can only be used to confirm the levels meet the required values for characteristic dyslipidaemia in order to assign E1-.72 **Diabetes mellitus with features of insulin resistance.*

Q:

Are there specific diagnostic criteria for characteristic dyslipidaemia for the Indigenous Australian population?

A:

Clinical advice confirmed that there are no population specific criteria for characteristic dyslipidaemia for use in Australia.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus and day only admissions

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

Does diabetes mellitus have to be coded for day only admissions, in particular day only dialysis admissions?

A:

There is no exception to the rule that diabetes mellitus should be coded when documented. Therefore, diabetes mellitus should be coded when documented in same day admissions.

Dialysis admissions

The issue of whether to code diabetes, or any other additional diagnosis, when dialysis episode coding is autogenerated is unique. The following advice was published in Coding Matters, September 2008:

"Q: In day only dialysis admissions, should codes be assigned for any additional diagnoses, e.g. CKD, diabetes etc?

A: As most day only dialysis admissions are autogenerated, it is difficult to assign additional diagnosis codes when the full record is not available at the time of the coding process. Therefore, for day only admissions for dialysis, only assign Z49.1 *Extracorporeal dialysis* for extracorporeal dialysis or Z49.2 *Other dialysis* for peritoneal dialysis together with the appropriate procedure code. Additional diagnosis codes should only be assigned if the conditions meet ACS 0002 *Additional diagnoses*." (Coding Matters, Volume 15, Number 2, September 2008)

Further to the Coding Matters advice above, ACS 0001 *Principal diagnosis, Problems and underlying conditions* states:

"If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code."

Therefore, it is more accurate to state:

"... Additional diagnosis codes should be assigned if the conditions meet the criteria for code assignment as per the guidelines in ACS 0001 *Principal diagnosis, Problems and underlying conditions* or ACS 0002 *Additional diagnoses*".

However, as most day only dialysis admissions are coded using autogenerated software, it is difficult to assign additional diagnosis codes for specific patients. In addition the full record is not always available at the time of the patient's admission to inform the coding process. The NCCC recognises these system issues and accepts, for now, that it will not be possible for many hospitals to comply with ACS 0001 *Principal diagnosis, Problems and underlying conditions* and ACS 0002 *Additional diagnoses* for these episodes.

This advice supersedes the previous advice published in Coding Matters, September 2008 (Volume 15, Number 2), Day only admissions and additional diagnoses, which will be retired on 30 June 2012.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Documentation of diabetes mellitus

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

Can you refer to previous admissions to inform code assignment for diabetes mellitus? How far back in the clinical record can you go for information? Do you use past admissions to gather information about complications of DM to assign codes from E1-.7- **Diabetes mellitus with multiple complications*?

A:

The following statement is included in the *Introduction* to the *Australian Coding Standards* (ACS):

"It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment."

Therefore, previous admissions and correspondence can be used to inform assignment of diabetes mellitus codes. However, previous admissions and correspondence should not be used:

- to assign diabetes mellitus if it has not been documented in the current admission.
- to inform the assignment of diabetes mellitus codes which have contributing conditions which may no longer be relevant or where criteria has changed over previous editions of the classification, e.g. hypertension being used to assign a code for features of insulin resistance.

Q:

Are nurses considered clinicians when it comes to documentation for clinical coding? What documentation is sufficient to warrant coding of DM? Specifically, should a code for DM be assigned by virtue of a nurse checking a 'tick box' on a form such as a pre-admission check list?

A:

The *Introduction* to the *Australian Coding Standards, How to use this document* contains the following guideline:

"The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."

The NCCC supports this guideline and maintains that documentation by any clinician can be used to determine conditions that should be coded. However, clinical coders should also be guided by the following from the *Introduction* to the *Australian Coding Standards*:

"If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code."

While ACS 0401, *Rule 1* specifies that DM should always be coded, general coding and abstraction guidelines should still be followed.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Specific examples from 2012 Diabetes Mellitus Workshop Material: *Scenario J*

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

In *Scenario J*, could I70.23 *Atherosclerosis of arteries of extremities with ulceration* be assigned according to *Rule 4b*?

"**Scenario J** - This 67 year old male presented for below knee amputation as treatment of foot ulcer. Also has Type 2 DM with PVD and neuropathy."

A:

The final code assignment for *Scenario J* is:

E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes*

E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*

E11.40 *Type 2 diabetes mellitus with unspecified neuropathy*

Rule 4b specifies that conditions classified outside of category E09-E14 should only be assigned when the condition meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. In *Scenario J*, there is no evidence that PVD met ACS 0001 or ACS 0002, therefore I70.23 *Atherosclerosis of arteries of extremities with ulceration* was not assigned.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Eradicated conditions and diabetes mellitus

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

If a patient with diabetes mellitus has had a vascular reconstruction procedure for PVD should a Z code be added to indicate the previous surgery even though the PVD is not eradicated?

A:

ACS 0401, *7. Eradicated conditions and DM* advises that a vascular reconstruction procedure may eradicate a manifestation of peripheral arterial disease, such as an ulcer, but does not eradicate the peripheral arterial disease. DM with peripheral arterial disease should be coded with Z95.8 *Presence of other cardiac and vascular implants and grafts* or Z95.9 *Presence of cardiac and vascular implants and grafts, unspecified* to indicate the status of the previous surgery.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Current

Specific examples from 2012 Diabetes Mellitus Workshop Material: *Example 14*

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

In *Example 14*, why isn't I70.23 *Atherosclerosis of arteries of extremities with ulceration* assigned given that the peripheral vascular disease meets *Rule 4b*?

"**EXAMPLE 14**Patient with a history of Type 2 diabetes mellitus, peripheral vascular disease and peripheral neuropathy was admitted for treatment of a left foot ulcer. The foot ulcer was treated with daily dressings. Diabetic educator spoke to the patient in relation to their ongoing insulin medication. The vascular surgeon reviewed the patient's peripheral vascular disease and decided that the patient was unfit for surgery."

A:

The final code assignment for *Example 14* is:

E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes*

E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*

E11.42 *Type 2 diabetes mellitus with diabetic polyneuropathy*

Z92.22 *Personal history of long term (current) use of other medicaments, insulin*

While the PVD meets *Rule 4b*, I70.23 A*therosclerosis of arteries of extremities with ulceration* is not assigned following *Rule 6*, which instructs that multiple codes should not be assigned when the DM code identifies the elements documented in the diagnosis: the PVD is identified in E11.51 and the ulcer is identified in E11.73.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 01-Jul-2015

Diabetic foot

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision.

Q:

With reference to the criteria for coding diabetic foot (ACS 0401, *6. Diabetic foot*) does amputee status meet the criteria at Category 2d when the amputation was due to an injury/trauma not related to diabetes mellitus complications?

A:

Clinical advice confirmed that amputee status of the lower limb, regardless of what caused the amputation, contributes to the criteria for diabetic foot as specified in ACS 0401, *6. Diabetic foot, Category 2d*. This is because prior amputation presents increased risk of contralateral foot lesion (eg ulcer) and other complications (eg excessive loading) associated with diabetic foot.

Q:

With reference to the criteria for coding diabetic foot (ACS 0401, *6. Diabetic foot*) does an ulcer and/or infection of lower limb (not foot) - for example ulcer of calf - meet the criteria at Category 1?

A:

Clinical advice confirmed that the Category 1 of the diabetic foot criteria (ACS 0401, *6. Diabetic foot*) is limited to ulcer and/or infection of the foot region (including heel and toes).

Q:

L97.0 *Ulcer of foot* should not be assigned for foot ulcer in addition to E11.73 *Type 2 diabetes mellitus with foot ulcer due to multiple causes* following ACS 0401, *Rule 6*. However, can L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* be assigned for ulcer of lower limb (not foot) in addition to E11.73?

A:

L97.8 *Ulcer of lower limb, other sites* or L97.9 *Ulcer of lower limb, unspecified* may be assigned, in addition to E11.73, for an ulcer of the lower limb (not foot region: foot, heel, toes) if the ulcer meets ACS 0002 *Additional diagnoses* in its own right.

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2701 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus with multiple microvascular complications

Q:

Using ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision, what are the correct codes to assign for the following scenario:**Scenario**: Patient admitted for acute kidney failure and also has NIDDM (meeting ACS 0002 *Additional diagnosis*) and retinopathy (not meeting ACS 0002 *Additional diagnosis*).

A:

Please refer to the rules in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. In the scenario cited, the correct code assignment applying ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision is:

N17.9 *Acute kidney failure, unspecified*

E11.29 *Type 2 diabetes mellitus with other specified kidney complication*

E11.31 *Type 2 diabetes mellitus with background retinopathy*

E11.71 *Type 2 diabetes mellitus with multiple microvascular and other nonvascular complications*

The acute kidney failure (N17.9) is assigned as the principal diagnosis as it meets ACS 0001 *Principal diagnosis*. The complications of diabetes - acute kidney failure (E11.29) and retinopathy (E11.31) - classified to category E09-E14 are coded to reflect the severity of the diabetes (refer to ACS 0401, *Rule 4a*). The presence of both acute kidney failure and retinopathy qualifies the coding of E11.71 which is sequenced as an additional code (refer to ACS 0401, 4.1 *DM with multiple microvascular and other nonvascular complications*). Retinopathy (H35.0) is not coded as it does not meet ACS 0002 *Additional diagnoses* (refer to ACS 0401, *Rule 4b*).

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: TN428 | Published On: 15-Jun-2012 | Status: Updated | Updated On: 01-Jul-2017

Gestational diabetes mellitus (GDM)

Please refer to ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - 1 July 2012 revision.

Q:

This advice has been deleted from ACS 0401 - 1 July 2012:

"Gestational diabetes may recur in a subsequent pregnancy and when this occurs, assign a code for gestational diabetes, with Z87.5 Personal history of complications of pregnancy, childbirth and the puerperium." *(Source, ACS 0401, Seventh Edition, 1 July 2010, Gestational diabetes mellitus)*

Is the advice still valid?

A:

This advice was removed from ACS 0401 to standardise the assignment of Z87.5 *Personal history of complications of pregnancy, childbirth and the puerperium* in line with ACS 2112 *Personal history*. Z87.5 *Personal history of complications of pregnancy, childbirth and the puerperium* should only be assigned according to the guidelines in ACS 2112 *Personal history*.*See also* ACS 0401, 2. *Specific classification principles for DM and IH, DM and IH in pregnancy, childbirth and the puerperium.*

This advice has a minormodification to correspond with an update in a subsequent edition ofICD-10-AM/ACHI/ACS.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2715 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus and carpal tunnel syndrome

Q:

Is there further clinical advice regarding the following *Coding Matters* advice (2006, Volume 13, No 3)?

"The NCCH was asked to clarify whether carpal tunnel syndrome in a patient with diabetes should be assigned E1-.41 *Diabetes Mellitus with diabetic mononeuropathy* as carpal tunnel syndrome can be regarded as a mononeuropathy. Clinical advice received by the NCCH on this issue indicates that it is still under deliberation and no consensus has been achieved.**Classification**Therefore, until further clinical advice is received, carpal tunnel syndrome in a patient with diabetes should not be coded to diabetic mononeuropathy."

A:

The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and carpal tunnel syndrome. Therefore, assignment of E1-.41 *Diabetes mellitus with diabetic mononeuropathy* is not appropriate for diabetes mellitus and carpal tunnel syndrome.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2715 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus and macular degeneration

Q:

Should E1-.34 **Diabetes mellitus with other retinopathy* be assigned in addition to H35.3 *Degeneration of macula and posterior pole* in a patient with macular degeneration and diabetes mellitus?

A:

The NCCC sought current clinical advice which confirmed that there is no association between diabetes mellitus and macular degeneration. Therefore, assignment of E1-.34 **Diabetes mellitus with other retinopathy* following the index entry *Diabetes, with, maculopathy* is not appropriate for macular degeneration with diabetes mellitus.

Published 15 June 2012,
for implementation 01 July 2012.

Ref No: Q2714 | Published On: 15-Jun-2012 | Status: Current

Diabetes mellitus and additional specific codes

Q:

A code is assigned for diabetes mellitus with peripheral vascular disease (PVD) - the PVD does not meet the criteria for ACS 0002 *Additional diagnoses*. If there is more information about the PVD (eg PVD with rest pain), can a specific PVD code be assigned as an additional code (eg I70.22 *Atherosclerosis of arteries of extremities with rest pain*)?

A:

Please refer to ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* - 1 July 2012 revision. Following ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia, Rule 4b* complications of diabetes classified outside of category E09-E14 are assigned only when that condition meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*. Therefore, if the PVD itself does not meet criteria for coding, an additional code to add specificity for PVD should not be assigned.

Published 15 June 2012,
for implementation 01 July 2012.