ACS 0401 Diabetes mellitus and intermediate hyperglycaemia - Education Workshop FAQs

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 *Ulcer of limb, not elsewhere classified* 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 be assigned for ulcer of lower limb (not foot) in addition to E11.73?

A:

L97 *Ulcer of limb, not elsewhere classified* can 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.

(Coding Q&A, June 2012)

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.

(Coding Q&A, June 2012)

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.

(Coding Q&A, June 2012)

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.

(Coding Q&A, June 2012)