

THE CHALLENGE: CONDITION RECOGNITION "GAP"

Diabetes mellitus (DM):

The prevalence of DM is 26.6%.¹
Among adults ≥ 20 years of age, as many as 30% of individuals with diabetes were undiagnosed.²

Chronic kidney disease (CKD):

39.4% of people age 60 and older have CKD.³

Peripheral arterial disease (PAD):

Although more than half of patients with PAD in one study had leg symptoms, relatively few had classic claudication.⁴ It is estimated that only 25% of afflicted individuals receive care.⁵

Documentation tips and tools:

For patients age 65 and older, use of a *Clinical Testing Flow Sheet* (see back of this sheet) will facilitate capture of dates and results of the following:

- **Blood pressure, weight and BMI (every visit):** "Adults with treated or untreated BP > 135/80 mm Hg should be screened for diabetes." (USPSTF Recommendation)
 - **Ankle-brachial index (ABI):** ABI is used to screen at risk individuals for asymptomatic lower extremity PAD.⁶
 - **Comprehensive dilated eye exam:** Recommended annually for patients with diabetes; type 1 begin within 5 years of initial diagnosis; type 2 begin soon after the diagnosis.⁷
 - **Comprehensive foot exam:** Foot exam includes inspection, palpation of pedal pulses, testing to detect loss of protective sensation (LOPS). Recommended at least annually.⁷ A peripheral neuropathy screening tool can be obtained from your Optum Healthcare Advocate.
 - **Testing for diabetes:^{7*}**
 1. People with one or more high-risk foot conditions should have a visual inspection of their feet at every clinic visit.⁸
 2. A1C ≥ 6.5%. "The test should be performed in a laboratory using a method that is NGSP-certified and standardized to the DCCT assay." Use of the A1C to diagnose diabetes may not be valid with certain clinical conditions.
 3. Fasting (8 hours): FPG ≥ 126mg/dl
 4. Oral glucose tolerance test (OGTT): Plasma glucose ≥ 200mg/dl 2 hr after 75 gm glucose load
 5. Random plasma glucose ≥ 200 mg/dl in patients with classic hyperglycemic symptoms
 - **Monitoring glucose control with hemoglobin A1C:⁷**
 - Every 3 months: if modifying therapy or if not meeting glycemic goals
 - Twice a year: if meeting treatment goals and stable glycemic control
 - **Diabetic nephropathy screening:** Screen for diabetic nephropathy by testing annually for urine albumin excretion and by determining, at least annually, serum creatinine and estimated GFR.⁷
 - **Fasting lipid profile (at least annually):⁷**
 - Without overt CVD, LDL-C goal <100mg/dl
 - With overt CVD, LDL-C goal of <70mg/dl (using high dose of a statin) is an option¹
- For patients who have been recently diagnosed with diabetes, were determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements, effective January 1, 2011, individual and group diabetes self-management training (DSMT) services are reportable (HCPCS codes G0108 & G0109). For more information, see:

cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DiabetesSvc.pdf

*In the absence of unequivocal hyperglycemia, "Testing for Diabetes" criteria 1 – 3 should be confirmed by repeat testing.

¹Statin contraindicated in pregnancy

¹ "Acute, Complicated and Uncomplicated Diabetes Mellitus" Literature Source (Total Diabetes Mellitus Prevalence Rate): (<http://ccwdata.org/index.php>) Table B.2 Medicare Beneficiary Prevalence for Chronic Conditions for 2000-2008.

² Cowie C.C., Rust K.F., Byrd-Holt D.D., Eberhardt M.S., Flegal K.M., Engelgau M.M., et al., "Prevalence of diabetes and impaired fasting glucose in adults in the U.S. population." *Diabetes Care* June 2006. 29(6): 1263-8.

³ CDC/Department of Health and Human Services. "Prevalence of Chronic Kidney Disease and Associated Risk Factors." *Morbidity and Mortality Weekly Report* 56(08)(2007): 161-165.

⁴ Hirsch A.T., Criqui M.H., Treat-Jacobson D., et al., "Peripheral arterial disease detection, awareness, and treatment in primary care." *JAMA* 286(2001): 1317-24.

⁵ Heart Association Statistics Committee and Stroke Statistics Subcommittee, "Heart Disease and Stroke Statistics." *Circulation* 117(2008): e25-e146.

⁶ ACC/AHA, "Guidelines for the Management of Patients With Peripheral Arterial Disease." *Journal of American College of Cardiology* 47(2006): e1-e192.

⁷ American Diabetes Association: "Standards of Medical Care in Diabetes -- 2010," *Diabetes Care*, January 2010; vol 33: supplement 1.

⁸ Standards of Medical Care in Diabetes—2011 *Diabetes Care* January 2011. vol. 34 no. Supplement 1 S4-S10 Singh N, Armstrong DG, et al.

⁹ *Optum360 ICD-10-CM: Professional for Physicians 2016*. Salt Lake City: 2015.

¹⁰ National Kidney Foundation, "KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification." *American Journal of Kidney Disease* 39: 2002 supplement 1.

ICD-10-CM CODING GUIDE⁹

Diabetes

Type 2 Diabetes with complications:

Note: Assign as many E11.- codes as needed to identify all the manifestations

Type 2 diabetes mellitus with diabetic nephropathy	E11.21
Type 2 diabetes mellitus with diabetic chronic kidney disease Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)	E11.22
Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema (code type of retinopathy, if known)	E11.311
Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema (code type of retinopathy, if known)	E11.319
Type 2 diabetes mellitus with diabetic cataract	E11.36
Type 2 diabetes mellitus with diabetic neuropathy, unspecified	E11.40
Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51
Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene	E11.52
Type 2 diabetes mellitus with foot ulcer Use additional code to identify site of ulcer (L97.4-, L97.5-)	E11.621
Type 2 diabetes mellitus with hypoglycemia without coma	E11.649
Type 2 diabetes mellitus with hyperglycemia	E11.65
Type 2 diabetes mellitus with other specified complication Use additional code to identify complication	E11.69
Type 2 diabetes mellitus without complications	E11.9

Chronic kidney disease*

GFR value = mL/min/1.73 m²

CKD is defined as either kidney damage or GFR < 60mL/min/1.73 m² for ≥ 3 months.¹⁰

Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests (for example, untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick) or imaging studies.¹⁰

Stage I: GFR ≥ 90 with kidney damage	N18.1
Stage II: GFR 60–89 with kidney damage	N18.2
Stage III: GFR 30–59	N18.3
Stage IV: GFR 15–29	N18.4
Stage V: GFR less than 15	N18.5
ESRD: requiring chronic dialysis or transplantation	N18.6
Chronic kidney disease, unspecified	N18.9

*Use additional code to identify kidney transplant status (Z94.0), renal dialysis status (Z99.2) or noncompliance with renal dialysis (Z91.15), if applicable.

Peripheral arterial disease

Peripheral arterial disease NOS Peripheral vascular disease NOS Intermittent claudication NOS	I73.9
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Atherosclerosis/Arteriosclerosis of native arteries of the extremities:

with intermittent claudication	I70.21-*
with rest pain	I70.22-*
R leg with ulceration	I70.23-**
L leg with ulceration	I70.24-**
with gangrene	I70.26-**
unspecified	I70.20-*
Atherosclerosis of bypass graft of the extremities, unspecified graft	I70.30-*

*6th characters 1, 2 and 3 represent right, left and bilateral respectively.

**Use additional code to identify severity of ulcer (L97.-, L98.49), if applicable. Additional characters in L97.- report site, laterality (e.g. right, left) and severity. All non-pressure chronic ulcers risk adjust.

Use additional code, if applicable, to identify chronic total occlusion of artery of extremity (I70.92).

Additional resources and materials

- National Diabetes Education Program: ndep.nih.gov
- National Kidney Foundation – GFR calculator: [kidney.org/professionals/kdoqi_gfr_calculator.cfm](http://www.kidney.org/professionals/kdoqi_gfr_calculator.cfm)
- NDEP Foot Care: ndep.nih.gov/publications/PublicationDetail.aspx?PubId=67
- Peripheral Artery Disease Coalition: <http://www.nhlbi.nih.gov/health/educational/pad/>

Clinical testing flow sheet

PATIENT NAME _____

MEDICAL RECORD # _____

SERVICE OR TEST	✓ done in 2016	date _____	date _____	date _____	date _____
EXAMINATION					
BLOOD PRESSURE					
WEIGHT/BMI					
ANKLE-BRACHIAL INDEX					
DILATED EYE EXAM					
FOOT EXAM					
PEDAL PULSES					
VISUAL EXAM					
VIBRATION/REFLEXES					
LABORATORY TESTING					
BLOOD GLUCOSE					
FASTING					
RANDOM					
A1C					
URINE FOR ALBUMIN					
URINE ALBUMIN TO CR					
CALCULATED GFR					
LIPID PROFILE					
TOTAL CHOLESTEROL					
TRIGLYCERIDES					
HDL CHOLESTEROL					
LDL CHOLESTEROL					

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2016: "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required." Thus the bolding of ICD-10-CM codes represents only those fully reportable codes, not categories or subcategories, that map to the 2017 CMS-HCC risk adjustment model for Payment Year 2017.

- Please refer to ICD-10-CM Mappings for all codes that map to risk in this model: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>
- Please refer to 2017 Announcement for risk scores, disease interactions and hierarchy (pp 78-87): <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>



This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 6, 2015, CMS announced the CMS-HCC Risk Adjustment model for payment year 2016 driven by 2015 dates of service. For more information see: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf>, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>, and <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>. Optum™ and its respective marks are trademarks of Optum, Inc. This document is proprietary and confidential; rebranding, public posting, digital downloading is not permitted without the express consent of Optum. All other brand or product names may be registered marks of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.