Coding Diabetes Mellitus with Associated Conditions

By Gina Sanvik

There has been some confusion among coding professionals regarding interpretation of the coding guideline of "with." An area that contains many instances of using this guideline in ICD-10-CM is coding Diabetes Mellitus with associated conditions. There are 53 instances of "with" subterm conditions listed under the main term Diabetes.

The ICD-10-CM Official Guidelines for Coding and Reporting states the following at Section I.A.15:

> The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
>
> The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

There was a recent clarification regarding this guideline published in the first quarter 2016 issue of *AHA Coding Clinic* on page 11. According to this clarification, the subterm "with" in the Index should be interrupted as a link between diabetes and any of those conditions indented under the word "with."

Following this guidance as we look to the main term Diabetes in the ICD-10-CM Codebook Index, any of the conditions under the subterm "with" such as gangrene, neuropathy, or amyotrophy (see below for the full list) can be coded without the physician stating that these conditions are linked. The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system.

The following are all the subterms under "with" under the main term Diabetes in the ICD-10-CM Codebook Index:

Subterms Under "With" Under Diabetes Mellitus

To clarify the guidance, for example to accurately assign the code E11.319, type 2 diabetes mellitus with retinopathy, the physician documentation does *not* need to provide a link between the diagnoses of diabetes and retinopathy; this link can be assumed since the retinopathy is listed under the subterm "with." Another example to accurately assign the code E11.40, type 2 diabetes mellitus with neuropathy, the physician documentation does *not* need to provide a link between the diagnoses of diabetes and retinopathy; this link can be assumed since the neuropathy is listed under the subterm "with." This sounds easy enough but it can be confusing figuring out how to interpret this guideline, especially because this was not the case in ICD-9-CM for coding the associated conditions under Diabetes.

An important thing to remember is that if the physician documentation specifies that diabetes mellitus is not the underlying cause of the other condition, then the condition should not be coded as a diabetic complication. With this in mind, the entire record needs to be reviewed. After reviewing the entire record, if it is not clear whether or not two conditions are related, the provider should be queried. Multiple examples of cases in which a query is necessary were published with an article in the February 2013 issue of *Journal of AHIMA*.

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation or is unclear for present on admission indicator assignment

For more examples read the article "Interpreting 'With' in ICD-10-CM," published in the May issue of AHIMA's CodeWrite e-newsletter.

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