ICD-10 Part VII - Diabetes and other systemic diseases

1. You should read the Alphabetic Index entries and the Tabular Listing entries of ICD-10-CM:
   a. Always when looking up an unfamiliar code
   b. Never when looking up an unfamiliar code
   c. Never read the Excludes1 and Excludes 2 notes but everything else
   d. Rarely will I need these resources

Always look up any code in both books unless you are positive of your coding choices. If the code for a specific condition is new or unusual, begin with the Alphabetic Index to find where in the Tabular Listing a code can be found. Then review the Tabular Listing for all additional instructions on choosing the proper code.

2. You always need a separate code to indicate the cause (etiology) of a condition (manifestation).
   a. True
   b. False

Some codes, like Diabetes and Sjögrens, have a code that incorporates both the etiology and the manifestation in one code.

3. Herpes simplex corneal lesion would be coded using:
   a. B02.05
   b. B00.52 and H16.013
   c. B00.52
   d. H16.013

While some codes will require you to use the etiology code along with the manifestation of the disease, not all codes will. You must read the Alphabetic Section and the Tabular Listing carefully to ensure you are choosing the CORRECT CODE.

4. An IDDM with moderate background retinopathy OD and severe background retinopathy and Macular edema would be coded using:
   a. E11.339
   b. E11.339 E11.344
   c. E11.339 E11.349 and Z79.4
   d. E11.339 E11.341 and Z79.4
This example does not specify if the patient has Type 1 or Type 2 DM. The instruction manual indicates that when you do not know a specific on a patient to use the NOS code choice.

NOS “Not otherwise specified”
This abbreviation is the equivalent of unspecified.

Under the Chapter 4 details-
**Type of diabetes mellitus not documented**
If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

And even though the codes for the DM retinopathy do not specify an eye, the convention is that when you have two different levels of a condition, like retinopathy distinguished by different codes, you need to code for each level. (As in glaucoma.)

Finally the rules indicate that when a patient is on insulin, you must add the Z79.4 code to indicate this.

**E11 series- for NOS DM or Type 2 DM**

E11.339 to indicate that Moderate BDR is present without macular edema

E11.341 to indicate that Severe BDR is present WITH maculer edema

Z79.4 to indicate the use of Insulin

5. *Diabetes Incipitus would be coded using:*
   a. E11.69
   b. E08.69
   c. **E23.2**
   d. E28.2

This answer is relatively straightford IF you took a moment to look up Diabetes Insipitus in the Alphabetic Index where it clearly points to the E23.2 section of the tabular Listing.

**Diabetes, diabetic (mellitus) (sugar)** E11.9

- - insipidus E23.2
- - nephrogenic N25.1
- - pituitary E23.2
- - vasopressin resistant N25.1
Once you get to the tabular listing under E23.2 you find:

6. **A patient with NIDDM with retinopathy and glaucoma related to the DM could be coded as:**
   a. **E11.319 E11.39** and H40.500
   b. E11.319 and H40.500
   c. E11.339 and H50.500
   d. E 11.39

This example does not specify the eye for either the retinopathy or the glaucoma. Nor does it specify the degree of glaucoma. It does specify that there is no insulin being used.

**E11.3 Type 2 diabetes mellitus with ophthalmic complications**

**E11.31** Type 2 diabetes mellitus with unspecified diabetic retinopathy

**E11.311** Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

**E11.319** Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema

Thus you would use the 11.319- Type 2 DM with unspecified retinopathy. Since there is no mention of Macular edema you would not use the 11.311 which includes macular edema finding. And you have another complication of glaucoma so need to indicate that the glaucoma is related to the DM using the E11.39 code.

The coding instructions further direct you to also code the glaucoma finding.

**E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication**

*Use additional code to identify manifestation, such as:*

diabetic glaucoma (H40-H42)

When you go to the glaucoma section to find the type of glaucoma, you need to code the state is unspecified and the eye as unspecified, thus the H40.500 code.
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H40.5 Glaucoma secondary to other eye disorders
   Code also underlying eye disorder
   One of the following 7th characters is to be assigned to each code in subcategory H40.5 to designate the stage of glaucoma
   0 - stage unspecified
   1 - mild stage
   2 - moderate stage
   3 - severe stage
   4 - indeterminate stage

H40.50 Glaucoma secondary to other eye disorders, unspecified eye
H40.51 Glaucoma secondary to other eye disorders, right eye
H40.52 Glaucoma secondary to other eye disorders, left eye
H40.53 Glaucoma secondary to other eye disorders, bilateral

This is the code you would use if there was NO retinopathy found in your patient with DM.

E11.9 Type 2 diabetes mellitus without complications