Coding & Documentation

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ICD-10 CODING FOR HYPERTENSION AND DIABETES

Q Which ICD-10 codes should I report for a patient who has both hypertension and Type 2 diabetes?

A Report code I10 for hypertension and the appropriate E11.- code for Type 2 diabetes with any documented manifestations. If a causal relationship exists between the two conditions, they still must be coded separately because ICD-10 does not presume a linkage between hypertension and diabetes as it does with some other conditions. To report hypertension as a complication of diabetes, submit I15.2, "Hypertension secondary to endocrine disorders" and E11.- for diabetes, and include a statement in the physician's note indicating the diabetes is the cause of the hypertension.

PHYSICIAN CERTIFICATION OF DIABETIC SHOES

Q What documentation does Medicare require when I am asked to certify the need for diabetic shoes or inserts that a podiatrist ordered for my patient?

A Medicare requires that the physician who is comprehensively treating the patient's diabetes must certify his or her eligibility for diabetic shoes or inserts. The patient must have one or more of the following conditions in one or both feet:

- Previous partial or complete foot amputation,
- History of foot ulceration,
- History of preulcerative calluses,
- Peripheral neuropathy with evidence of callus formation,
- Foot deformity,
- Poor circulation.

If another provider conducts the foot exam and documents at least one of the qualifying foot conditions at an in-person visit within six months of the anticipated delivery of the shoes or inserts, the certifying physician must do the following:

- Obtain a copy of the other provider's medical record,
- Initial, date, and indicate agreement with it as appropriate,
- Sign the certification statement within three months prior to delivery of the shoes or inserts.

Suppliers of diabetic footwear must be able to provide the certifying physician's documentation when required by the Medicare contractor. They may request this information from the certifying physician either at the time of the order or as needed.

UMBILICAL CAUTERIZATION

Q What CPT code should I report for the cauterization of an umbilical granuloma during a well-baby visit for a two-week-old infant?

A Report code 17250, "Chemical cauterization of granulation tissue," in addition to the code for the preventive medicine service (99381 for a new patient or 99391 for an established patient). The work required to identify the umbilical granuloma would not likely meet the key components (history, examination, and medical decision-making) to support billing for a significant, separately identifiable evaluation and management (E/M) service because it would overlap with the preservice work of the cauterization and the history and examination components of the preventive medicine service. You should also report ICD-10 code Z00.111, "Health examination for newborn 8 to 28 days old," for the preventive service claim line and P83.81, "Umbilical granuloma," for the cauterization claim line. National Correct Coding Initiative edits do not bundle codes for preventive E/M services with code 17250, but some payers may require appending modifier 25 to 99381 or 99391 when reporting a procedure on the same date. FPM

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EDITOR'S NOTE:
Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.