Diabetic Complications	ICD-10-CM Code		Coding Guidelines & Documentation Best Practices
	Type 1	Type 2	
Kidney Complications			
Nephropathy, intercapillary glomerulosclerosis, intracapillary glomerulonephrosis, and/or Kimmelstiel-Wilson disease*	E10.21	E11021	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated
Chronic Kidney Disease*	E10.22	E11.22	ICD-10-CM Guideline: Use additional code to identify the stage of CKD, supported by documentation.
Renal Complication NEC+	E10.29	E11.29	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Renal Tubular Degeneration*	E10.29	E11.29	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated
Ophthalmic			
Retinopathy*	E10.31X-E10.35XX	E11.31X-E11.35XX	Use linking language such as "with, due to or associated with" in addition to the code for the complication
Cataract*	E10.36	E11.36	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Ophthalmologic complication NEC+	E10.39	E11.39	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Neurologic			
Neuropathy or Loss of Protective Sensation (LOPS)*	E10.40	E11.40	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Mononeuropathy*	E10.41	E11.41	
Polyneuropathy and/or neuralgia*	E10.42	E11.42	
Autonomic (poly)neuropathy and/or gastroparesis*	E10.43	E11.43	
Amyotrophy and/or Myasthenia*	E10.44	E11.44	
Neurologic Complication NEC+	E10.49	E11.49	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Circulatory			
Peripheral angiopathy (Peripheral Vascular Disease, or PVD)*	E10.51	E11.51	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Gangrene*	E10.52	E11.52	
Other Specified Complications			
Charcot's joints and/or neuropathic arthropathy*	E10.610	E11.610	ICD-10 CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Arthropathy NEC+	E10.618	E11.618	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Dermatitis (diabetic necrobiosis llopoidica)*	E10.620	E11.620	ICD-10 CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Foot Ulcer*	E10.621	E11.621	
Skin ulcer NEC+	E10.622	E11.622	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Skin Complication NEC+	E10.628	E11.628	

Periodontal Disease*	E10.630	E11.630	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Oral complication NEC+	E10.638	E11.638	Use linking language such as “with, due to or associated with” in addition to the code for the complication.
Hypoglycemia*	E10.64X	E11.64X	6th character required: E11.641 with coma, E11.649 without coma. ‘Uncontrolled’ is not an acceptable term. Use the term hypoglycemia for coding and billing purposes.
Hyperglycemia *	E10.65	E11.65	"Uncontrolled" is not an acceptable term. Use the term hyperglycemia for coding and billing purposes.
Other specified complications	E10.69	E11.69	Use linking language such as “with, due to or associated with” in addition to the code for the complication.
Diabetes Mellitus **without** Complications	E10.9	E11.9	Use when no other complications of diabetes exist.

* Causal relationship with diabetes is presumed unless provider specifies condition is unrelated.

+ Not Elsewhere Classifiable.

Additional Types of Diabetes:

E08- Secondary Diabetes, E09- Secondary Diabetes due to drugs or chemicals, E13- Other specified

General Documentation Best Practices:

- ✓ Create a clear relationship between the condition and any manifestation. Use linking verbiage such as “with, due to or associated with.”
- ✓ Do not use questionable language such as “possible, suspect or likely” for outpatient coding and reporting purposes.
- ✓ Document all conditions to the highest known specificity. Use ICD-10-CM codes that correspond to documentation.
- ✓ All conditions that affect the patient’s care on the date of service should be documented and addressed in the medical record.
- ✓ All known chronic conditions should be addressed at least once per calendar year.
- ✓ Use M.E.A.T for documentation in order to ensure the condition is supported in the medical record.
  - Monitor – disease progression, signs, and symptoms
  - Evaluate – lab results, response to treatment, review, or refill medication.
  - Assess/Address – review medical records, counsel with patient.
  - Treat – prescribe medication, therapy, referrals.
- ✓ All records should be signed by the healthcare provider with their credentials. Date of service and patient identifiers should be included on every page of the encounter note.

Sources

Optum ICD-10-CM Expert for Physicians 2024: The complete official code set (October 1, 2023 – September 30, 2024)
Poe Bernard, S. (2020) Risk Adjustment Documentation and Coding, Second Edition