

# Focus on

## Lower Extremity Diabetic Manifestations

April is Foot Awareness Month



### Quick Facts

- In patients who had diabetes for 11-20 years, 14% had a history of foot ulcer; that prevalence increased to 18.6% in those with >20 years duration of disease — lifetime incidence may be as high as 25%.<sup>1,2</sup>
- Diabetic patients account for 60% of all lower extremity amputations; 85% of these lower extremity amputations are preceded by a foot ulcer.<sup>1,2</sup>
- Diabetics with peripheral neuropathy (PN) or peripheral arterial disease (PAD) have been shown to be three times more likely

### Who is at Risk<sup>2,6</sup>

There is an increased risk of ulcer or amputation in people who have had diabetes ≥10 years, are male, have uncontrolled diabetes, or cardiovascular, retinal, or renal complications.

High risk foot conditions correlated with increased risk of amputation:

- Peripheral neuropathy
- Signs of increased pressure such as erythema or callus
- Bony deformities such as hammer toes
- Peripheral vascular disease
- History of ulcers or amputation
- Severe nail pathology

### Documentation Tips<sup>7</sup>

The cause and effect relationship between the diabetes and the manifestation must be documented in the progress note (e.g., foot ulcer **due to** diabetes or **diabetic** peripheral neuropathy).

Document the control status definitively (e.g., “controlled” or “uncontrolled”). Diabetes documented as “poorly controlled” is coded to “not stated as uncontrolled.”

### Coding Highlights<sup>8</sup>

Correct coding requires that *both* the underlying disease and the manifestation(s) are coded.

The search for amputation status in the Index is: *Absence*, by site, acquired.

to have an amputation compared with diabetic patients without these conditions.<sup>3</sup>

- The five-year survival rate following diabetes related amputation is less than 30%.<sup>3</sup> Prevention and early detection can reduce foot ulcers and amputations by up to 85%.<sup>4</sup>
- The cost of care for diabetic patients with foot ulcers is 5.4 times higher than for diabetic patients without them in the first year following the ulcer.<sup>5</sup>

### Assessment of the Diabetic Foot<sup>2,6</sup>

The yearly diabetic foot exam includes assessment of protective sensation using a 10-g monofilament plus any one of the following: vibration perception using 128-Hz tuning fork, pinprick sensation, or ankle reflexes, along with assessment of bony deformities, vascular status and skin integrity.

In addition to the yearly foot exam, all diabetic patients should receive an initial ankle brachial index (ABI) to screen for PAD. If negative, repeat every five years or sooner if symptomatic.

People with one or more high risk foot conditions should have a visual inspection of their feet at every clinic visit.

### Coding Examples

- Assessment: PAD due to diabetes status post amputated third toe, left foot.  
**250.70** Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled  
**443.81** Peripheral angiopathy in diseases classified elsewhere  
**V49.72** Lower limb amputation status, other toe(s)
- Assessment: Diabetic peripheral neuropathy.  
**250.60** Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled  
**357.2** Polyneuropathy in diabetes
- Assessment: Diabetic foot ulcer.  
**250.80** Diabetes with other specified manifestations  
**707.15** Ulcer of other part of foot

### Guidelines for the Care and Treatment of the Diabetic Foot<sup>2,6</sup>

- Smoking cessation to reduce the risk of vascular disease complications
- Control HgA1c to <7
- LDL goal of <100
- BP <130/80
- Foot exams and screenings
- Podiatric care

Advise patients to examine their feet every day as well as provide education on foot hygiene, nail care and proper footwear to reduce the risk of injury and ulcer formation.

### Tools and Resources Available Through OptumInsight

- “Preventing Diabetes Foot Problems: Instructions, Assessments and Management”
- 10gm monofilaments to test for diabetic neuropathy
- “Screening and Documentation Tool for Diabetes, CKD and PAD”
- Diabetes Coding Tool
- Diabetes Coding Wheel

<sup>1</sup> 2000–2002 Behavioral Risk Factor Surveillance System (BRFSS). <<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5245a3.htm>>. November 14, 2003 / 52(45);1098-1102.

<sup>2</sup> Singh N, Armstrong DG, et al. Preventing foot ulcers in patients with diabetes. *JAMA*. 2005;293:217–28. 2 Dang CN, Boulton AJ. Changing perspectives in diabetic foot ulcer management (2).

<sup>3</sup> Dorsey RR, Eberhardt MS, Gregg EW, Geiss LS. Control of risk factors among people with diagnosed diabetes, by lower extremity disease status. *Prev Chronic Dis* 2009;6(4). <[http://www.cdc.gov/pccd/issues/2009/oct/08\\_0224.htm](http://www.cdc.gov/pccd/issues/2009/oct/08_0224.htm)>.

<sup>4</sup> Bild DE, Selby JV, Pomeroy S, Browner WS, Braveman P, Showstack JA. Lower-extremity amputation in people with diabetes: epidemiology and prevention. *Diabetes Care* 1989;12:24–31.

<sup>5</sup> The Costs of Diabetic Foot: The Economic Case for the Limb Salvage Team. Vickie R. Driver, DPM, MS, Matteo Fabbi, MD, et al. *JAPMA* September 1, 2010 vol. 100 no. 5 335-341.

<sup>6</sup> Standards of Medical Care in Diabetes—2011 *Diabetes Care* January 2011. vol. 34 no. Supplement 1 S4-S10.

<sup>7</sup> The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). “ICD-9-CM Official Guidelines for Coding and Reporting.” *Department of Health and Human Services* DHHS, 2011, October. Web. 21 September 2011. <[http://www.cdc.gov/nchs/data/icd9/icd9cm\\_guidelines\\_2011.pdf](http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf)>.

<sup>8</sup> World Health Organization, Professional: ICD-9-CM for Physicians—Volumes 1 & 2. 2012. Alexandria, VA: Ingenix, 2011, October. Print.