



FOCUS ON: LOWER EXTREMITY DIABETIC MANIFESTATIONS

HOW COMMON ARE LOWER EXTREMITY DIABETIC MANIFESTATIONS?

The prevalence of foot ulcers range from 4% to 10% among persons diagnosed with Diabetes Mellitus.¹ This translates to an annual population-based incidence of 1.0% to 4.1%, and a lifetime incidence up to 25%. Diabetic foot ulcers frequently become infected and are a major cause of hospital admissions and amputations. They also account for more than half of non-traumatic lower limb amputations in this patient population.²

WHAT ARE THE RISK FACTORS FOR LOWER EXTREMITY DIABETIC MANIFESTATIONS?

A complete history and examination is essential to identify patients at risk for diabetic foot complications. This includes an assessment of loss of protective sensation, foot structure, limited joint mobility, vascular status and a history of previous foot ulceration, amputation or Charcot neuroarthropathy.³

A major cause of morbidity in patients with diabetes is foot ulcers leading to amputation. The three major risk factors for development of foot ulcers are distal symmetrical polyneuropathy, peripheral vascular disease and a previous history of ulcers or limb amputations. Secondary risk factors include duration and control of hyperglycemia, male gender, presence of other microvascular complications and tobacco use.⁴ Peripheral neuropathy can lead to sensory loss, motor loss or both. The end result is an insensate foot, which has lost its structural integrity and is exposed to abnormal forces and pressures making it susceptible to traumatic injuries.

Peripheral arterial disease (PAD) is twice as common in persons with diabetes as in persons without and is also a major risk factor for lower extremity amputation.⁵ The ADA recommendation is that a screening ABI should be performed for all diabetic patients >50 years of age; if the results are normal, the test should be repeated every 5 years. A diagnostic ABI should be performed on any patient with symptoms of PAD and a history of diabetes.

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Always Remember⁶...

- When documenting diabetes, be sure to document the type of diabetes. If the type is not documented, the default is type II.
- To state the control status of the diabetes as “controlled,” “uncontrolled” or “out of control.” When a provider documents “poorly controlled,” the index of ICD-9-CM instructs “code to Diabetes, by type, with 5th digit for not stated as uncontrolled.”
- To state the causal relationships that you know to exist when treating your patients (e.g. *diabetic ulcer of the left great toe or ulcer of the left great toe due to diabetes*).
- If a patient has multiple manifestations due to diabetes, each manifestation must be preceded by the word *diabetic* (e.g. *diabetic PVD with diabetic ulcer and not diabetic PVD with ulcer*).
- To code both the etiology *and* the manifestation for each documented diabetic manifestation affecting different systems. The 250.xx code reports the diabetes. The manifestation must be reported with a separate code (e.g. *diabetic PVD - 250.70, 443.81; diabetic ulcer - 250.80, 707.10*).

Documentation and Coding Tips⁶

Coding Example #1:

Diabetic foot ulcer

- 250.80** Diabetes with other specified manifestations, type II or unspecified type not stated as uncontrolled
- 707.15** Ulcer of other part of foot

Coding Example #2:

Diabetic peripheral neuropathy with loss of protective sensation (LOPS) with diabetic toe ulcer

- 250.60** Diabetes with neurological manifestations, type II or unspecified type not stated as uncontrolled
- 357.2** Polyneuropathy in diabetes
- 250.80** Diabetes with other specified manifestations, type II or unspecified type not stated as uncontrolled
- 707.15** Ulcer of other part of foot

Coding Example #3:

PVD due to uncontrolled type II diabetes

- 250.72** Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
- 443.81** Peripheral angiopathy in diseases classified elsewhere

1 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. *Int J Low Extrem Wounds*. 2003;2:4–12.

3 Lavery LA, Armstrong DG, et al. Practical criteria for screening patients at high risk for diabetic foot ulceration. *Arch Intern Med*. 1998;158:158–62

4 Dyck PJ, Kratz KM, Karnes JL, et al. The prevalence by staged severity of various types of diabetic neuropathy, retinopathy, and nephropathy in a population-based cohort: The Rochester Diabetic Neuropathy Study. *Neurology* 1993;43:817-24.

5 Gregg EW, Sorlie P, et al. Prevalence of lower-extremity disease in the US adult population ≥40 years of age with and without diabetes: 1999-2000 national health and nutrition examination survey. *Diabetes Care*. 2004;27:1591–7.

6 2011 Ingenix Professional ICD-9-CM for Physicians. 6th ed. 2 vols. Chicago, IL: Ingenix, 2010. Print.