ICD9 Coding for Endocrinology
All Information is subject to change.

If there is no definitive diagnosis, signs and symptoms should be coded.

ICD-9-CM Official Guidelines for Coding and Reporting
*See Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders

The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.

- On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

Additional information found here

Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)

a. Diabetes mellitus

Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of diabetes mellitus and whether the diabetes is controlled or uncontrolled.  See I.C.3.a.7 for secondary diabetes

1) Fifth-digits for category 250:

The following are the fifth-digits for the codes under category 250:

0  type II or unspecified type, not stated as uncontrolled
1  type I, [juvenile type], not stated as uncontrolled
2  type II or unspecified type, uncontrolled
3  type I, [juvenile type], uncontrolled

The age of a patient is not the sole determining factor; though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is type II.
3) **Diabetes mellitus and the use of insulin**

All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic. Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, the appropriate fifth-digit for type II must be used. For type II patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient’s blood sugar under control during an encounter.

4) **Assigning and sequencing diabetes codes and associated conditions**

When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification (See Section I.A.6., Etiology/manifestation convention). Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has. The corresponding secondary codes are listed under each of the diabetes codes.

(a) **Diabetic retinopathy/diabetic macular edema**

Diabetic macular edema, code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0, Diabetic retinopathy, must be used with code 362.07. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code.

5) **Diabetes mellitus in pregnancy and gestational diabetes**

(a) For diabetes mellitus complicating pregnancy, see Section I.C.11.f., Diabetes mellitus in pregnancy.

**Section I.C.11.f. Diabetes mellitus in pregnancy**

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned code 648.0x, Diabetes mellitus complicating pregnancy, and a secondary code from category 250, Diabetes mellitus, or category 249, Secondary diabetes to identify the type of diabetes. Code V58.67, Long-term (current) use of insulin, should also be assigned if the diabetes mellitus is being treated with insulin.

(b) For gestational diabetes, see Section I.C.11, g., Gestational diabetes.

**Section I.C.11.g. Gestational diabetes**

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes.
after the pregnancy. Gestational diabetes is coded to 648.8x, Abnormal glucose tolerance. Codes 648.0x and 648.8x should never be used together on the same record. Code V58.67, Long-term (current) use of insulin, should also be assigned if the gestational diabetes is being treated with insulin.

6) **Insulin pump malfunction**

(a) **Under dose of insulin due insulin pump failure**
An under dose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal or first listed code, followed by the appropriate diabetes mellitus code based on documentation.

(b) **Overdose of insulin due to insulin pump failure**
The principal or first listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be coded 996.57, Mechanical complication due to insulin pump, followed by code 962.3, Poisoning by insulins and antidiabetic agents, and the appropriate diabetes mellitus code based on documentation.

7) **Secondary Diabetes Mellitus**
Codes under category 249, Secondary diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) **Fifth-digits for category 249:**
A fifth-digit is required for all category 249 codes to identify whether the diabetes is controlled or uncontrolled.

(b) **Secondary diabetes mellitus and the use of insulin**
For patients who routinely use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned. Code V58.67 should not be assigned if insulin is given temporarily to bring a patient’s blood sugar under control during an encounter.

(c) **Assigning and sequencing secondary diabetes codes and associated conditions**
When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. The secondary diabetes codes and the diabetic manifestation codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes. For example, secondary diabetes with diabetic nephrosis is assigned to code 249.40, followed by 581.81.

(d) **Assigning and sequencing secondary diabetes codes and its causes**
The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the reason for the encounter, applicable ICD-9-CM sequencing conventions, and chapter-specific guidelines.
If a patient is seen for treatment of the secondary diabetes or one of its associated conditions, a code from category 249 is sequenced as the principal or first-listed diagnosis, with the cause of the secondary diabetes (e.g. cystic fibrosis) sequenced as an additional diagnosis.

If, however, the patient is seen for the treatment of the condition causing the secondary diabetes (e.g., malignant neoplasm of pancreas), the code for the cause of the secondary diabetes should be sequenced as the principal or first-listed diagnosis followed by a code from category 249.

(i) Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code 251.3, Postsurgical hypoinsulinemia. Assign a code from subcategory 249, Secondary diabetes mellitus and a code from subcategory V88.1, Acquired absence of pancreas as additional codes. Code also any diabetic manifestations (e.g. diabetic nephrosis 581.81).

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning. See section I.C.17.e for coding of adverse effects and poisoning, and section I.C.19 for E code reporting.

I.C.17.e. Adverse Effects, Poisoning and Toxic Effects

The properties of certain drugs, medicinal and biological substances or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

1) Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series. Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

2) Poisoning

(a) Error was made in drug prescription
Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person, use the appropriate poisoning code from the 960-979 series.

(c) **Overdose of a drug intentionally taken**
If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960-979 series).

(c) **Nonprescribed drug taken with correctly prescribed and properly administered drug**
If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(d) **Interaction of drug(s) and alcohol**
When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

(e) **Sequencing of poisoning**
When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, and wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code. See Section I.C.3.a.6.b. if poisoning is the result of insulin pump malfunctions and Section I.C.19 for general use of E-codes.
Additional tips on correct ICD-9-CM coding:

- When coding for outpatient physician services do not code “Possible”, “Rule out”, “Looks like”, “Consistent With”, etc.
- Always code to the highest specificity of ICD-9-CM based on documentation in the patient’s chart.
- All additional and coexisting conditions documented should be reported after the primary diagnosis that affected patient treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- History codes (V10-V19) may be reported when documented and affect patient treatment or management.
- Chronic conditions that are treated on an ongoing basis may be reported as often as they are treated.
- Diagnostic tests should be coded using the final report with a confirmed diagnosis if available. (do not code for the signs and symptoms when there is a definitive diagnosis)
- Routine lab/rad testing is coded with V72.6X and/or V72.8X series.
- Therapeutic services are reported using the diagnosis, condition or reason for the visit first; chronic conditions or other documented diagnoses may be reported also when patient care or management is affected.
- For chemotherapy, radiation therapy, or rehabilitation, the appropriate V Code is reported first and the diagnosis or condition which requires the service is reported second.
- Pre-operative evaluations require a code from category V72.8 – Other Specific Examinations, which is reported first and the reason for the surgery as additional diagnosis.
- The diagnosis for ambulatory surgery should be the diagnosis or condition for which the surgery is being performed.
- If a postoperative diagnosis is confirmed to be different from the pre-operative diagnosis, code the postoperative one.

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