Provider Newsletter

Amerigroup Kansas, Inc.
providers.amerigroup.com/KS
Provider Services: 1-800-454-3730

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Quarter 3

Member rights and responsibilities

At Amerigroup Kansas, Inc., we appreciate your commitment to serving our members and understand the importance of collaboration. In addition, we want to help you stay informed about our members' defined rights and responsibilities. These can be found in the provider manual and on our website at providers.amerigroup.com/KS. To receive a copy in the mail, call Provider Services at 1-800-454-3730.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441 (TTY 711).

Behavioral health update: Patients on antipsychotic medications

Patients on antipsychotic medications are at risk for metabolic adverse effects and lab monitoring is recommended. The American Diabetic Association (ADA) and American Psychiatric Association (APA) established a consensus document that specifies baseline and interval monitoring of glucose and lipid parameters and a review of the patient's medical history and physical measurements, including weight, waist circumference and blood pressure.

The recommendations are as follows: At baseline, the clinician should obtain a medical history, weight (body mass index), waist circumference, blood pressure, fasting glucose or hemoglobin A1C and fasting lipids. The weight should then be measured again at week four and week eight. All of the initial tests should be repeated at week 12 and then annually thereafter. Weight should be monitored every three months.

There are four Healthcare Effectiveness Data and Information Set (HEDIS®) measures that involve antipsychotic medications:

- The first is a measure to verify that those patients diagnosed with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, had a diabetes screening test during the measurement year.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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- The second is a measure to verify that those patients who have both diabetes and schizophrenia had both an LDL-C and HbA1C test during the measurement year.
- The third is a measure to verify that those patients who have both cardiovascular disease and schizophrenia had an LDL-C test during the measurement year.
- The fourth is a measure to verify that those patients with schizophrenia who were dispensed and remained on an antipsychotic medication were compliant with the medication for at least 80 percent of their treatment period.

Availity: New eligibility and benefits functionality and features

The Availity Web Portal launched new eligibility and benefits functionality and features on June 27, 2015. These changes make finding eligibility and benefits easier and faster for you. Here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes the user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).
Menu by benefit type	Located under the Coverage and Benefits tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on each returned eligibility allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Pharmacy management information

Need up-to-date pharmacy information? Log on to our website at providers.amerigroup.com/KS to access our formulary, prior authorization form, processes and preferred drug list. Have questions about the formulary or need a paper copy? Call our Pharmacy department at 1-800-323-4696. Pharmacy technicians are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 10 a.m. to 2 p.m. Central time.

Hypertensive diseases: Navigating the ups and downs of documentation and coding

Blood pressure is the force of blood against the walls of the arteries. Abnormally high pressure or hypertension damages blood vessels, causing them to become scarred, hardened and brittle. The damaged vessels are no longer able to adequately supply blood to the organs and tissues of the body. Hypertenstion can lead to strokes, organ failure or heart attacks when not properly controlled.

Treating hypertension
Hypertension is a chronic condition that requires lifelong treatment for most people. Treatment is aimed at controlling blood pressure and treating underlying or secondary conditions. The American Heart Association recommends blood pressure levels below 120/80 and screenings starting at 20 years of age. Hypertension is typically treated with medications, exercise/diet, stress management and not smoking.

Documentation and coding
The medical record documentation for patients with hypertension should include each of the following:

- Type of hypertension – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- Complications – body system such as heart or kidney that are affected by hypertension.
- Specific conditions – details on the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- Assessment/treatment – all measures aimed at controlling the hypertension or treating symptoms of complication(s)

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

Essential (primary) hypertension 401
Code assignement is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension.

Hypertensive heart disease 402
Assign category 402 hypertensive heart disease when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is futher specified based on the presence of heart failure. Use additional codes from (428.0 - 428.43) to specifiy type of heart failure if known.

Hypertensive chronic kidney disease 403
ICD-9 coding guidelines assume a cause and effect relationship when both hypertension and chronic kidney disease (CKD) are documented. Assign codes from category 403 hypertensive chronic kidney disease along with additional codes for the stage of CKD from category 585 chronic kidney disease.

Hypertensive heart and chronic kidney disease 404
When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are as follows:

- Assumed cause and effect for hypertension and chronic kidney disease
- Requires documented cause and effect for hypertension and heart disease

Intructional notes state to use additional codes from 428.0 - 428.43 to specifiy the type of heart failure (if known) and the stage of CKD from category 585 chronic kidney disease.

Secondary hypertension 405
Hypertension caused by underlying conditions such as adrenal gland disorders, kidney disease and drugs are called secondary hypertension. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

AHA Coding Clinic advice
When the provider establishes a linkage or relationship between two conditions, they should be coded as such. The entire record for the date of service should be reviewed to determine whether a relationship between the two conditions exists. The fact that a patient has two conditions that commonly occur together does not necessarily mean that they are related. A different cause may be documented by the provider. If it is unclear whether or not two conditions are related, coders should query the provider (AHA Coding Clinic Q3, 2012.)

Hypertensive diseases in ICD-10
An important change for hypertension is that ICD-10 does not require documentation of the type of hypertension for correct code assignment. Providers will need to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

ICD-10	Description
I10	Essential (primary) hypertension
I11	Hypertensive heart disease (with or without heart failure) Use an additional code from I50 to specify type of heart failure (if present)
I12	Hypertensive chronic kidney disease Use an additional code from N18 to identify stage of chronic kidney disease
I13	Hypertensive heart and chronic kidney disease Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease
I15	Secondary hypertension Requires two codes, one for underlying cause and one from category I15 to identify secondary hypertension Sequencing is based on circumstances of visit and documentation

Home and community based services/autism provider credentialing clarification

Effective immediately, reimbursement is allowed for Kansas Medical Assistance Program (KMAP) enrolled providers who have a signed commitment with KDADS of their intent to complete the state approved training requirement to become a fully qualified autism program provider within six months of receiving a Medicaid provider number. A qualified home and community based services (HCBS)/autism provider must:

- Be state Medicaid enrolled
- Be managed care organization (MCO) credentialed
- Complete state approved training curriculum if Medicaid enrolled
- Have submitted documentation declaring their intent to become an HCBS/Autism waiver provider and complete the state approved curriculum (prior to or within six months of receiving notification of being an approved Medicaid provider) to credential with MCOs.

A provider may credential with the MCO during the training period. The provider may begin providing HCBS/autism waiver services upon receipt of MCO authorization and may be reimbursed for services rendered. Once the provider

has fulfilled the state approved training requirements, Medicaid enrolled providers must submit their completed training certification within 45 days of the completed training in order to be deemed a qualified provider of HCBS/autism services.

Home and community based services members: Billing for certain value-added benefits

Amerigroup offers certain value-added benefits to some members in certain HCBS waivers. Effective April 1, 2015, Amerigroup is changing how providers must bill for some of these services.

All of the services below must be prior authorized by the member's service coordinator. All claims for these services must be submitted directly to Amerigroup. You can submit claims through a Clearinghouse, on Availity or on paper to:

Amerigroup Kansas, Inc.
P.O. Box 61010
Virginia Beach, VA 23466

Please note that prior authorization for these additional benefits should not be requested unless/until the member is close to exhausting the normal benefits.

- Respite care for members in the frail elderly waiver program who do not live alone or in intermediate care facilities for individuals with mental retardation (ICF/MR), assisted living, nursing facility, group home or similar setting: Amerigroup offers up to 56 hours of respite care per calendar year.
  - Providers must bill S5151. One unit = 15 minutes
- Extra respite care for members in the intellectual/developmental disabilities (I/DD) waiver program who do not live alone or in an ICF/MR, assisted living, nursing facility, group home or similar setting: Amerigroup offers up to 15 extra units of overnight respite care per calendar year.
  - Providers must bill S5151. One unit = one night
- Extra respite care for members in the autism waiver program who do not live alone or in an ICF/MR, assisted living, nursing facility, group home or similar setting: Amerigroup offers up to 24 extra hours of respite care per year.
  - Providers must bill S5151. One unit = 15 minutes
- Extra personal assistant services for members in the I/DD waiver program: Amerigroup offers up to three extra days of personal assistant services.
  - Providers must bill S9125. One unit = 15 minutes

Retroactive eligibility authorization process

Effective immediately, Amerigroup adheres to the previously published KMAP Provider bulletin (#13150 – previously published in December 2013) regarding members with retroactive eligibility and their claims for services that require prior authorization.

Amerigroup will review the request for medical necessity. If and when the service is determined to be medically necessary, an authorization will be entered and the claim should then be submitted for payment. If the authorization is denied, you may appeal this decision. Please note that all services that would normally require prior authorization will be reviewed for medical necessity. This includes but is not limited to inpatient and/or outpatient hospital stays, certain durable medical equipment (DME), physical therapy and occupational therapy, and hospice.

If a claim is submitted prior to obtaining authorization, the claim will deny for failure to receive authorization. At that

point, you may appeal the denial by filing a written appeal and attaching medical records for review. Written appeals may be sent to the following address:

Amerigroup Payment Appeals
P.O. Box 61599
Virginia Beach, VA 23466-1599

Amerigroup will no longer override the authorization requirement without determining medical necessity. Effective January 1, 2015, spreadsheet submissions to Provider Relations representatives for retroactive eligible members are no longer accepted.

In cases where the member is made retroactively eligible for KanCare, a waiver program or a nursing facility (prior to claim submission), please contact Amerigroup at 1-800-454-3730 on the next business day to obtain retro-authorization for the applicable service. Specify the request is for a retro eligible member.

ICD-10 update

Providers interested in ICD-10 testing should contact their provider representative to get the process started. Your provider representative will coordinate with you and the Amerigroup ICD 10 testing team to set up a kickoff meeting that will go over the process.

Remember, there is no grace period. Claims with dates of service (DOS) October 1, 2015, and after will be denied if not submitted with the correct ICD-10 code.

Facility providers who have inpatient members with date spans beyond October 1, 2015, will need to split-bill the claim.

- DOS September 30, 2015, and prior to be submitted with the ICD-9 code
- DOS October 1, 2015, and after to be submitted with the ICD-10 code

Amerigroup has determined after reviewing contracts that amendments will not need to be done for diagnosis code restrictions.

ICD-10: From compliance to medical policies

Below is an overview of the ICD-10 update and key information you need to know.

Compliance

- The current implementation date of ICD-10 is October 1, 2015, as mandated by HIPAA.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' or hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about the patient's condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis for correct coding.
- Providers should submit all known conditions on the claim using ICD-10-CM diagnosis codes.

Claims processing

The following information explains the claims processing procedures for claims according to dates of services.

Amerigroup is committed to ensuring providers understand the correct code set to use. The following information applies to claims processing:

- No mixed claims: Consistent with CMS guidelines, mixed claims (claims filed with ICD-9 and ICD-10 codes on the same claim) will not be accepted.
- ICD-10 codes: Claims with ICD-10 codes for DOS or dates of discharge (DOD) prior to October 1, 2015, will not be accepted.
- ICD-9 codes: HIPAA will not allow the use of ICD-9 codes for claims with DOS or DOD on or after October 1, 2015.
- Resubmitting claims: When resubmitting claims, providers should utilize the code set that is valid for the DOS/DOD.

Update to prior authorizations process

Amerigroup has updated prior authorization procedures to accommodate the transition to ICD-10-CM. The updates will ensure that providers understand how to submit prior authorizations according to the date that services are scheduled to be performed. The following information details the process for prior authorizations:

- Starting June 1, 2015, we will begin accepting and processing prior authorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015.
- ICD-9 codes must continue to be used to prior authorize services scheduled through September 30, 2015.
- Existing approved prior authorizations coded in ICD-9 whose effective period spans the ICD-10 date of October 1, 2015, do not need to obtain another authorization that is coded in ICD-10.
- Prior authorizations that span the October 1, 2015, compliance date will be valid for claims submitted using ICD-10 codes.
  - Example: If a DME wheelchair rental authorization coded with ICD-9 was approved for the effective period of April 1, 2015 – April 1, 2016, this authorization will still be valid for claims filed using ICD-10 diagnosis codes with beginning dates of service of October 1, 2015, and later.

Update to medical policies

Amerigroup has worked diligently to ensure that medical policies and clinical utilization management (UM) guidelines have been updated to include proposed ICD-10 coding. We want to ensure that providers understand where to locate medical policies and UM guidelines. Preparing policies and processes for ICD-10 helps ensure providers operate smoothly after October 1, 2015. The updated medical policies are available on the Amerigroup provider website at providers.amerigroup.com. For specific questions regarding medical policies, please contact Provider Services at 1-800-454-3730.

Coding updates and resources for providers

Amerigroup is committed to helping providers transition smoothly to the new ICD-10-CM code set. The resources below provide valuable information in terms of assessment, planning and training to help providers at any stage in the ICD-10-CM implementation process.

- Amerigroup provider home page: This site offers the latest news on ICD-10 and links to industry resources. Visit our provider website at providers.amerigroup.com and look for the ICD-10 news link.
- The Amerigroup newsletter: This communication provides documentation and coding information on ICD-10 and HEDIS in addition to important network updates. Find our newsletter online at providers.amerigroup.com/KS.
- Road to 10: CME Online Tool for Small Practices: This online resource built with the help of providers in small practices is intended to help small medical practices jumpstart their ICD-10 transition. It includes specialty references, access to free Medscape education modules and CME credits for physicians and nurses who complete the learning modules. Use this tool at www.roadto10.org/.

- ICD-10 Monitor: This online news and information source was created to help healthcare providers make informed decisions as they transition to ICD-10. The ICD-10 Monitor hosts weekly live broadcasts where relevant ICD-10 topics are discussed with industry experts called Talk Ten Tuesdays. Visit the site at icd10monitor.com.

ICD-10 coded prior authorizations

The transition to ICD-10 is effective October 1, 2015. But it is not too late to take advantage of the tips and resources that have been made available to you over the last few months.

Here are some helpful reminders for using ICD-10:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnosis codes. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice sees today and understand how ICD-10 impacts them.
- If you rarely see a particular ailment, there's no need to memorize it or convert it to the ICD-10 equivalent diagnosis code on your paper super bill or problem list in your electronic medical record.
- If your practice treats a wide range of medical conditions, use the 80/20 rule to determine which ICD-10 diagnosis codes are most pertinent. This would include family practice, pediatric medicine or internal medicine.

The Centers for Medicare & Medicaid Services offers the Road to ICD-10 – a comprehensive tool where you can explore common codes, primers for clinical documentation, clinical scenarios and additional resources associated by specialty.

Visit www.roadto10.org/to find information on:

- Family practice
- Pediatrics
- OB-GYN
- Cardiology
- Orthopedics
- Internal medicine
- Other specialties

ICD-10 documentation and diagnosis coding tips

ICD-10-CM diagnosis codes

- Contain anywhere from three to seven characters (seventh character extension)
- Character one is alpha
- Character two is numeric
- Characters three to seven are alpha or numeric (alpha digits are not case sensitive)
- Decimal appears after the third digit
- The first three characters make up the ICD-10 category
- Characters four to seven are driven by clinical concepts in documentation

Understanding ICD-10-CM coding

- The current implementation date of ICD-10 is October 1, 2015. Providers and staff should be engaged in ICD-10 coding training now.
- Dates of service or dates of discharge that occur on or after October 1, 2015, must be reported using ICD-10-CM/PCS.
- ICD-10-CM/PCS will not affect physicians', outpatient facilities' or hospital outpatient departments' use of CPT codes on claims. Providers should continue to use CPT codes to report these services.
- ICD-10-CM has greater clinical specificity. The new diagnosis code set allows providers to report many additional details about patient condition(s).
- The added clinical specificity of ICD-10-CM requires health care providers to document all known details about each diagnosis in order to allow the most specific code(s) to be assigned.

ICD-10-CM official coding guidelines for outpatient services

The outpatient coding guidelines for ICD-10-CM are the same as those found in ICD-9-CM. For guidelines, visit the CDC website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2015.pdf. Listed below are some of the ICD-10-CM guidelines pertinent to outpatient and office visit encounters.

- **ICD-10-CM Section IV.C, Accurate reporting of ICD-10-CM diagnosis codes.** For accurate reporting of ICD-10 diagnosis codes, the documentation should describe the patient's diagnoses, symptoms, problems, or reasons for the encounter. It is acceptable to report the appropriate unspecified code when sufficient clinical information is not known or available about a particular health condition to assign a more specific code.
- **ICD-10-CM Section IV.F. 1-2, Level of detail in coding.** Codes with only three characters are used as the heading of categories in ICD-10-CM and may be further subdivided (require additional characters). Providers must report ICD-10-CM diagnosis codes to the highest number of characters available. Incomplete and/or invalid diagnoses codes are not acceptable for reporting.
- **ICD-10-CM Section IV.H, Uncertain diagnosis**. Do not code diagnoses documented as probable, suspected, questionable, rule out, working, consistent with or other similar terms that indicate uncertainty. Instead, code the conditions to the highest degree of certainty for the encounter/visit.
- **ICD-10-CM Section IV.I, Chronic diseases.** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions. Chronic conditions do not go away and typically always impact care provided. They should be assessed and reported at each visit.
- **ICD-10-CM Section IV.J**, **Code all documented conditions that co-exist**. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and that no longer exist.

Clinical concepts in documentation

Certain clinical concepts appear in ICD-10 coding which may or may not be present in ICD-9. Providers should become familiar with these concepts and ensure that documentation includes all known pertinent details for accurate code assignment in ICD-10. Examples of clinical concepts include:

- Cause and effect
- Laterality
- Timing
- Associated conditions
- Remission status
- Severity
- Episode of care

- Trimester of pregnancy
- Agent and/or organism
- Anatomical location
- Comorbidities
- Depth/stage for wounds and ulcer
- Late effects

New coding conventions

ICD-10-CM has some new coding conventions that are not included in the ICD-9-CM code set. A brief explanation of those follows:

- **Seventh character extension** is required for certain categories in ICD-10 and must always appear in the seventh character field.
- The **dummy placeholder X** may be used in the fifth or sixth character field to ensure that a seventh character is added correctly.

Example: T15.12XS Foreign body in conjunctival sac, left eye, sequel (late effect)

Locating the correct diagnosis code in the ICD-10 code book

- First, locate the documented term in the alphabetic index and then verify the code in the tabular list.
- Use a current ICD-10 code book. Become familiar with the Official ICD-10-CM Coding Guidelines and follow all instructions for the chapter and category related to specific codes including Excludes1and Excludes2 notes.
  - Excludes1 – Not coded here. The codes should never be used at the same time.
  - Excludes2- Not typically included here, but a patient may have both conditions at the same time.
- Reliance on coding software, electronic health records (HER) systems and cheat sheets alone can lead to coding errors.

Locating official coding advice

- The *American Hospital Association (AHA) Coding Clinic*™ is the CMS-approved resource for clarification of ICD-10-CM. Volumes are published quarterly and contain new and/or updated information on the use of ICD-10-CM as well as clarification of previously published coding advice.
- Additional advice on ICD-10-CM can be located on CMS website at http://cms.hhs.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10.

Documenting specificity for accurate ICD-10 coding

Specificity in documentation allows the most accurate ICD-10 codes to be assigned. Accurate and complete coding shows a true picture of each member's health status. As the October 1, 2015, compliance dates draws near, health care providers should begin incorporating additional documentation into patient encounters. The table on the following pages shows some common chronic conditions and the documentation requirements for accurate ICD-10 code assignment.

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Asthma	• **Severity** – Document asthma severity as either intermittent, mild persistent, moderate persistent or severe persistent. • **Type** – Exercise-induced or cough-variant are other types of asthma, documentation should specify type. • **Acute exacerbation** – Documentation should state if the asthma is in acute exacerbation. • **Status asthmaticus** – Acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators. • **Infection** – Superimposed infection may be present. This should clearly be documented by the provider.	J45.20 – J45.998
Hypertension	• **Primary or secondary** – Secondary hypertension is due to an underlying condition. Two codes are required to report secondary hypertension — one to identify the underlying etiology and one from category *I15 Secondary hypertension*. • **Transient** – Temporary elevation of blood pressure that is not a true diagnosis of hypertension. Assign code *R03.0 elevated blood pressure reading without a diagnosis of hypertension.* • **Controlled/uncontrolled** – Describe the status of hypertension and do not change the code assignment. The correct code for these terms describing hypertension is *I10 Essential (primary) hypertension.* • **Complications** – Document all complications showing the cause and effect relationship between the two conditions (i.e. due to hypertension, hypertensive or caused by hypertension). When hypertension and chronic kidney disease appear together, a cause and effect relationship is assumed in ICD-10. The following coding guidance applies to hypertensive complications: – **I11 Hypertensive heart disease** – Use additional code from category *I50 Heart failure* if present. – **I12 Hypertensive chronic kidney disease** – use additional code from category *N18 Chronic kidney disease* to identify the stage. – **I13 Hypertensive heart and chronic kidney disease** – Requires use of additional code from category *I50 Heart failure* if present and use additional code from category *N18 Chronic kidney disease* to identify the stage. – **I60 – I69 Hypertensive cerebrovascular disease** – Code also *I10 Essential (primary) hypertension.* – **H35.0 Hypertensive retinopathy** – Code also *I10 Essential (primary) hypertension.*	I10 – I15.9
Diabetes mellitus (DM)	• **Type** – Providers must document the type of diabetes in ICD-10-CM: – **E08 Diabetes mellitus** – Due to an underlying condition, code first the underlying condition such as, congenital rubella, Cushing's syndrome, pancreatitis, etc.	E08 – E13

Chronic condition	Provider documentation required for correct coding	ICD-10 code
Diabetes mellitus (DM)	– **E09 Drug or chemical induced diabetes mellitus** – Code first poisoning due to drug or toxin, if applicable. Use additional code for adverse effect if applicable, to identify drug. – **E10 Type 1 diabetes mellitus** – Due to pancreatic islet B cell destruction. Also known as juvenile diabetes. – **E11 Type 2 diabetes mellitus** – Use for diabetes not otherwise specified. – **E13 Other specified diabetes mellitus** – Includes that due to genetic defects and secondary diabetes not classified elsewhere. • **Body system affected** – Diabetes may affect multiple body systems. Providers should document each body system in which diabetes has caused complications. Apply as many diabetes codes as needed to fully describe each body system/manifestation documented. • **Complications affecting that body system** – Providers must continue to document the cause and effect relationship between diabetes and any body systems affected by the condition. Some examples include diabetes with neuropathy, diabetic retinopathy, and nephropathy due to diabetes. • **Insulin use** – Document all treatment aimed at diabetes and/or its complications. If insulin is used to treat the patient long term, apply code Z79.4 (Long term, current use of insulin).	E08 – E13