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Practice management

Tap, tap: See better patient results, and provider scores, with SMS outreach

A recent study shows automated text messaging to transitional care management (TCM) patients was tied to reduced readmission to the hospital and ED, suggesting that these SMS interventions can go beyond patient-provider convenience and actually improve patient care. They may also boost provider performance ratings — in payer programs and at review websites.

Many previous studies have documented the garden-variety benefits of automated texts to patients, mainly as a spur to keeping appointments. A 2018 study from Roseman University of Health Sciences in Nevada published in *Angle Orthodontist*, for example, followed 1,193 orthodontist appointments with an average no-show rate of 2.43% across three reminder methods (phone call, email, SMS) and found SMS texts pulling the best result at 1.9%.

But there have also been other studies showing text programs can do more for patients than prod them to come to the office. A 2019 paper in the *Journal of Bone and Joint Surgery*, for example, reported that participants in a randomized trial who were given automated messages after primary total knee or hip arthroplasty, reminding them of the home exercise they'd been prescribed as follow-up, “exercised for 8.6 minutes more per day” than those who did not get the intervention.

The power of texts

The new study on TCM services, reported in the journal *Health Affairs* on Oct. 26, 2022, followed post-discharge patients who were given the usual telephone call to initiate a 30-day TCM service by their primary care provider. Eligible

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patients who were reached and agreed to receive automated texts were enrolled; those who were not reached were enrolled on an “opt-out” basis.

These patients “were asked if they had an appointment with their primary care clinician or a specialist within the next two weeks,” the study reports. “If they answered no, their response was escalated back to the practice via the EMR for help in coordinating an appointment as necessary.” Thereafter the patients were given “check-in messages on a tapering schedule” to which they could respond; response options included some (e.g., “I don’t feel well”) that could prompt a provider phone call.

Researchers compared the results with those of a practice that did not employ the messaging and found that “the odds of 30-day use of acute care resources” — that is, readmission to the hospital or ED — “were 41% lower ... at the intervention practice compared with the control practice.”

Providers pleased

This result is no surprise to Jeanette Ball, R.N., client solutions executive at CTG in Buffalo, N.Y.

“Most health centers I work with do in fact have some sort of transitions of care policy, but it is often limited to one call after discharge,” Ball says. “This sort of hybrid model makes great sense. Often patients experience issues after a couple of days when the impact of living at home becomes more clear. I like the human connection followed by follow-up text calls connecting them to help as needed.”

Kimberly Langdon, M.D., an OB/GYN and a writer for the Healthcanal website, also applauds the concept, finding it “especially important for patients who have had a major procedure or operation, such as operative deliveries, and must follow complex home instructions.” In her own OB/GYN practice, Langdon says, she found “text or phone follow-up with post-operative patients resulted in better compliance and prevention of complications because [patients] are well-informed regarding their condition.”

Langdon says in addition to relating relevant information, such as “symptoms to watch out for, dietary restrictions if any, and when to go to the ED,” the SMS interventions can provide the patient “a psychological buffer to alleviate anxiety, because they know they can reach you at any time with questions about their condition.”

Nele Jessel, M.D., chief medical officer at athenahealth, points out another, less-well-noted advantage to text messages: They may relieve patient social anxieties that interfere with care. “Sometimes patients do not feel comfortable asking questions during their appointment or don’t want to admit they really didn’t understand what the provider was talking about and why this is necessary,” Jessel says.

Sue Boisvert, senior patient safety risk manager at The Doctors Company in Napa, Calif., notes that “texting in care management is gaining ground in hospital discharge management and specialties such as behavioral health and substance use treatment,” as seen in text-based interventions such as Text2Quit and Text4Mood.

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Not just for patients

In addition to the care benefit for the patient, automated messaging can give the provider a break.

Those who remember the onset of the pandemic may also recall that, while electronic communications helped bridge the gap between providers and patients, the flood of unmoderated messaging could also be stressful and induce physician burnout ([PBN 5/11/20](#)). In much the same way that online triage allows patients and sub-clinical staff to disintermediate much of the intake process from the provider, automated text messaging can sift out the parts of the care process that don't require clinician perspective.

“Provider burnout came up especially during the pandemic, where everyone had telehealth visits and providers were spending a lot of time replying to emails or replying to text messages,” says Abhi Sharma, chief product officer of healthcare digital platform Loyal in Atlanta. “Things like prescription refills, questions like ‘when do I expect to get my lab results?’ — those can be automated.”

Sharma believes that just as COVID has accustomed many people to “hybrid” work arrangement in which employees aren't always expected at the workplace, patients are ready to accept that “some care can be delivered over the phone, or over a video call, or in a clinic or in a hospital.”

Feedback appreciated

It's clear that any intervention that reduces hospital or ED readmission, or any other negative post-acute results that may be measured by performance programs such as the Quality Payment Program (QPP), has to be good for scores. “In fact, we often have health systems come to us for that express purpose,” says Carrie Kozlowski, co-founder and COO of Upfront Healthcare in Chicago, who says such programs can be put to work “improving outcomes and meaningfully moving the needle on value-based care metrics and Medicare Advantage Star Ratings.”

But you can also ask for and get reviews from patients — as direct feedback and, if you choose, to be posted in social media.

“Regarding patient engagement scores, I have seen practices use follow texts asking the patient to provide an online review if they were happy with the service — and to contact the office if they have concerns,” Boisvert says.

Tomas Henkenhaf, chief marketing officer for dental branding and marketing firm Lumens Dental Corp. in Toronto, has seen this in action: “My experience involves developing programs with our clients which send an SMS message after a patient's appointment to ask about how their experience was,” he says.

If you worry about poor reviews, Henkenhaf says his program handles that: “If the experience was poor, the practitioner can rectify the issue and provide exceptional patient experience,” he says. “This also helps keep a negative review from being left on [your] Google profile.”

Jump start your SMS

If you already have a standard patient-texting solution, check with your vendor to see if it can be modified for a care improvement program — and consider changing it if you can't. “I think most organizations take the ‘off-the-shelf’ solution because they perceive more robust solutions will be harder to implement or take more time,” Kozlowski says. “But that's not the reality.”

Be aware there are some built-in limits to some platforms. For example, Darshak Sanghavi, M.D., a former member of the Obama administration and global CMO at digital health care company Babylon, reminds you that “traditional texting isn't typically integrated with medical records. There are also other limitations such as HIPAA compliance and security to consider.” On the other hand, Sanghavi says, “digital-first organizations” such as Babylon “have the advantage, because they don't need to wait five to 10 years to put new evidence, like that from this study, into practice to provide a more robust level of care.”

You can start small. Sharma gives the example of mammogram alerts: “The patient can be alerted that they need that mammogram when they hit certain criteria, according to pretty standard clinical guidelines,” he says. “But there can be a lot of questions around what to expect, especially for a first-time mammogram patient ... for example, ‘Does it hurt? What do I need to do to prepare?’ — all sorts of anxiety-driven questions.” With some machine learning/AI-enabled features, Sharma says, you can enable automated conversations and “escalate if the patient really needs to talk to a human who can answer that question or call back.” — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- Angle Orthodontist, “Measuring the effectiveness of patient-chosen reminder methods in a private orthodontic practice,” May 2018: www.ncbi.nlm.nih.gov/pmc/articles/PMC8288327/
- Journal of Bone and Joint Surgery, “A Novel, Automated Text-Messaging System Is Effective in Patients Undergoing Total Joint Arthroplasty,” Jan 16, 2019: <https://pubmed.ncbi.nlm.nih.gov/30653044/>
- Health Affairs, “Evaluation of an Automated Text Message–Based Program to Reduce Use of Acute Health Care Resources After Hospital Discharge,” Oct. 26, 2022: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797716#:~:text=In%20this%20cohort%20study%2C%20a,outcomes%20among%20primary%20care%20patients>

Physician payments

CMS posts new +2.4% conversion factor for 2023 Medicare fees

On the heels of the omnibus spending bill that President Biden signed into law Dec. 29, CMS has taken up one of its imperatives to scale down the reduction in Medicare payments. The agency posted a revised conversion factor of \$33.8872, replacing the \$33.0607 amount originally released with the final 2023 Medicare physician fee schedule.

While CMS has yet to make a formal announcement about the conversion factor update, *Part B News* located the new figure in the “CY 2023 PFS Final Rule Impact on Payment for Selected Procedures” file that’s part of the supplementary materials the agency lists among its fee schedule addenda (*see resources, below*).

The updated rate computes to a 2.1% drop in the CF amount between 2022 and 2023, well below the expected 4.5% decrease that was on the books had Congress not intervened. The 2.1% drop also is an improvement over the 2.5% cut that lawmakers touted and appears to lift reimbursement out of that hole by 2.4%, although other potential cost factors remain to be seen.

The augmented conversion factor is expected to translate to significant changes in 2023 payment levels, as the “selected procedures” document indicates. Prior to congressional intervention, E/M office visit codes **99213** and **99214** were slated for a -4% and -3% cut, respectively, to the non-facility rate in 2023; under the revamped CF, the decrease will be a more muted -1%. Codes 99213 and 99214 were the #13 and #7 most-billed codes among professional fee providers in 2021, according to the latest available Medicare claims data.

Services that were on the rise, such as immunization administration code **90471**, now get a bigger boost. The non-facility payment rate for 90471 shoots up 20% in 2023

under the new CF; previously it was up 17%. And those with modest decreases, such as the EKG code **93000** that was on the hook for a -2% drop, will now stay flat year-to-year. — *Richard Scott* (rscott@decisionhealth.com) ■

RESOURCE

- Final 2023 Medicare physician fee schedule resources: www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1770-f

Compliance

CMS adds 35 codes to the Stark list of designated health services

Remember to add the latest designated health service (DHS) codes to your practice’s compliance plan. For the first time CMS did not release the updated list in the final Medicare physician fee schedule.

CMS published the annual DHS update that went into effect Jan. 1, 2023, on the Physician Self-Referral webpage on Dec. 1, 2022. The update added 35 codes to the list of services that are subject to the Stark rule’s restriction on referrals to an entity with which a physician or the physician’s immediate family member has a financial relationship unless the referrals are covered by a restriction (*see chart, p. 6*).

CMS announced that it would stop publishing the updated list in the final 2022 Medicare physician fee schedule and included a separate comment period for the Stark changes. “On or before December 2nd of each year, we will publish the annual update to the code list and provide a 30-day public comment period using www.regulations.gov,” CMS says.

Comments must be submitted within the 30-day period and CMS anticipates that it will respond to most of the comments by April 1 of the effective year. However, the agency gave itself some wiggle room by announcing that it could take longer to respond to comments that are complicated or require coordination with external parties.

CMS received one comment on the 2023 Stark list during the comment period. The comment focused on remote therapeutic monitoring codes **98975-98978** and **98980-98981**. The commenter notes that the codes can be performed under general, rather than direct supervision, effective Jan. 1, and asked if there is an exception that allows a practice to “outsource clinical personnel to a third party.” The codes were not added to or removed from the

(continued on p. 7)

Benchmark of the week

E/M codes in ED top list of independent dispute resolution services

Emergency department visits (**99281-99288**) topped the list of services that triggered a request for an independent dispute resolution (IDR) during the second and third quarters of 2022, according to a report on the newfangled payment dispute process.

The IDR process is a part of the No Surprises Act (NSA) that allows out-of-network providers and payers to hash out payment for items or services if they aren't satisfied with the outcome of the open negotiation period that is also mandated by the law ([PBN 9/19/22](#)).

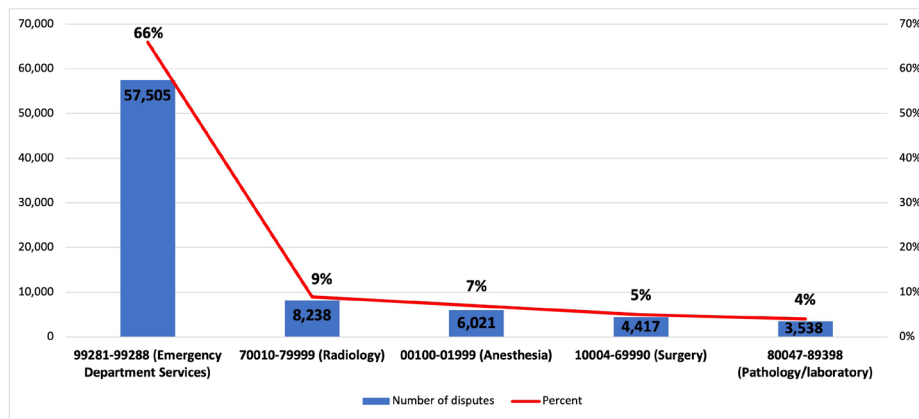
Announced in an email from CMS on Dec. 27, the report was published by the departments of Health and Human Services, Labor and Treasury and covers the time period from April 15 to Sept. 30, 2022.

The IDR report covers a wide variety of details. The first chart below highlights the top five service types that were the subject of an IDR mediation during the covered period. The chart details the total number of disputes and the overall percentage of the service-type disputes as part of the 86,807 total disputed out-of-network emergency and non-emergency services during the time-frame in review.

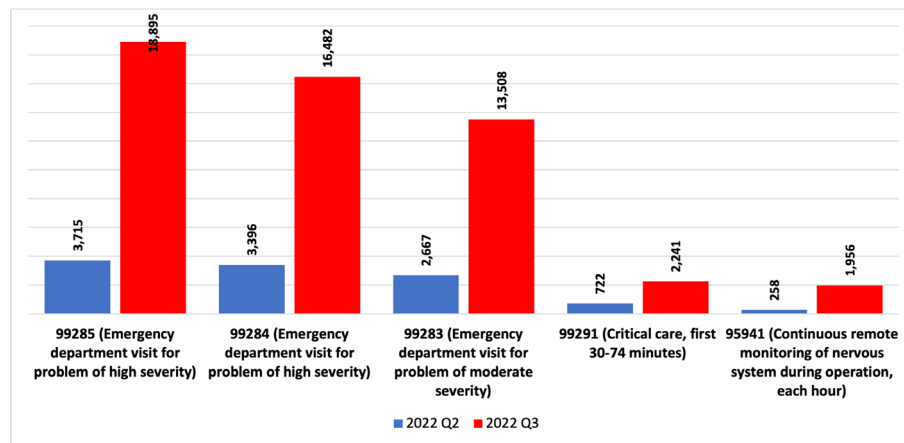
In addition to emergency, radiology and anesthesia services, “approximately 5% of disputes included surgery codes, such as removals of the appendix or gallbladder and treatment of broken bones, and 4% of disputes included codes for pathology and lab. Approximately 4% of disputes included codes for neurology and neuromuscular procedures such as monitoring of the nervous system during an operation,” according to the report.

The second chart focuses on the top five codes submitted for emergency and non-emergency services disputes in Q2 2022 and Q3 2022. The data shows that disputes for all of the top services increased from Q2 to Q3, but disputes of emergency department E/M visits spiked in Q3. – *Julia Kyles, CPC* (jkyles@decisionhealth.com)

Number and percent of disputes by service type, Q2 and Q3, 2022



Number of disputes by code, Q2 and Q3, 2022



Source: *Initial Report on the Independent Dispute Resolution (IDR) Process*: www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

Additions and deletions to the list of designated health services, effective Jan. 1, 2023			
Clinical lab services: Blood component collection services in the 80000 series that are excluded from clinical laboratory services – Added codes		Clinical lab services: Blood component collection services in the 80000 series that are excluded from clinical laboratory services – Deleted codes	
No additions		No deletions	
Clinical lab services: Other codes not in 80000 series included in clinical laboratory services – Added codes		Clinical lab services: Other codes not in 80000 series included in clinical laboratory services – Deleted codes	
0287U	Onc thyr dna&mrna 112 genes	0056U	Hem aml dna gene reargmt
0288U	Onc lung mrna quan pcr 11&3	0208U	Onc mtc mrna xprsn alys 108
0305U	Hem rbc fncly&dfrm shr str		
0306U	Onc mrd nxt-gnrj alys 1 st		
0307U	Onc mrd nxt-gnrj alys sbsq		
0313U	Onc pncrs dna&mrna seq 74		
0314U	Onc cutan mlnma mrna 35 gene		
0315U	Onc cutan sq cll ca mrna 40		
0317U	Onc lung ca 4-prb fish assay		
0318U	Ped whl gen mthyltn alys 50+		
0332U	Onc pan tum gen prflg 8 dna		
0334U	Onc sld orgn tgasa dna 84/+		
0335U	Rare ds whl gen seq feta		
0336U	Rare ds whl gen seq bld/slv		
Physical therapy, occupational therapy, and outpatient speech-language pathology services – Added codes		Physical therapy, occupational therapy, and outpatient speech-language pathology services – Deleted codes	
No additions		No deletions	
Radiology and certain other imaging services – Added codes		Radiology and certain other imaging services – Deleted codes	
0721T	Quan ct tiss charac w/o ct	93875	Extracranial study
0722T	Quan ct tiss charac w/ct	77063	Breast tomosynthesis bi
0723T	Qmrcp w/o dx mri sm anat ses	77067	Scr mammo bi incl cad
0724T	Qmrcp w/dx mri same anatomy		
A9596	Gallium illuccix 1 millicure		
A9601	Flortaucipir inj 1 millicuri		
A9602	Fluorodopa f-18 diag per mci		
A9800	Gallium locametz 1 millicuri		
76883	Us nr&acc strux 1xtr compre		
Radiation therapy services and supplies – Added codes		Radiation therapy services and supplies – Deleted codes	
A9607	Lutetium lu 177 vipivotide	C9734	U/s trtmt, not leiomyomata
Drugs used by patients undergoing dialysis – Added codes		Drugs used by patients undergoing dialysis – Deleted codes	
No additions		No deletions	
Preventive screening tests and vaccines – Added codes		Preventive screening tests and vaccines – Deleted codes	
Q0220	Tixagev and cilgav, 300mg	G0476	Hpv combo assay ca screen
Q0221	Tixagev and cilgav, 600mg	77063	Breast tomosynthesis bi
Q0222	Bebtelovimab 175 mg	77067	Scr mammo bi incl cad
91308	Sarscov2 vac 3 mcg trs-sucr		
91309	Sarscov2 vac 50mcg/0.5ml im		
91310	Sarscov2 vac 5mcg/0.5ml as03		
91311	Sarscov2 vac 25mcg/0.25ml im		
91312	Sarscov2 vac bvl 30mcg/0.3ml		
91313	Sarscov2 vac bvl 50mcg/0.5ml		
91314	Sarscov2 vac bvl 25mcg/.25ml		
91315	Sarscov2 vac bvl 10mcg/0.2ml		

Source: List of codes effective January 1, 2023, published December 1, 2022

(continued from p. 4)

list, so there is a chance CMS will instruct the commenter to submit a request for an advisory opinion. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES

- List of codes effective Jan. 1, 2023, published Dec. 1, 2022: www.cms.gov/files/document/annual-update-list-cpthcpcs-codes-effective-january-1-2023.pdf
- Physician Self-referral Law: CY 2023 annual update to the list of CPT/HCPCS codes: www.regulations.gov/docket/CMS-2022-0152
- Stark physician self-referral advisory opinions: www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/advisory_opinions

Coding

Master ICD-10-CM coding for various types of diabetes mellitus

Diabetes mellitus is an insidious condition, as it invades the body in many different ways. This chronic disease causes elevated levels of glucose in the blood. If left untreated, this systemic condition leads to serious damage to multiple body systems. Ensure you're capturing your patients' details correctly to depict accurate coding.

Start by checking documentation

An important piece of documentation to support a diagnosis is the patient's A1C test results. A1C, otherwise known as hemoglobin A1C, HbA1c, glycohemoglobin or glycated hemoglobin, is a test used to check a patient's blood sugar levels over a period of three months.

The human body contains multiple types of hemoglobin, including A1A, A1B and A1C, with the names corresponding to the order in which each separates from the protein under chromatography. A1C is the one most commonly monitored in the diagnosis of prediabetes or diabetes.

There are ranges for normal (below 5.7%), prediabetic (5.7% to 6.4%) and diabetic blood sugar levels (6.5% or above), according to the CDC. If this test result is documented without a diagnostic statement from the physician, then the coder must query for more information.

All code categories used to report diabetes mellitus include a "Use Additional Code" notation to also report the patient's use of insulin and oral antidiabetic drugs and/or oral hypoglycemic drugs. This notation is not included in ICD-10-CM code category **E10.-** (Type 1 diabetes mellitus), because all type 1 diabetics must inject insulin.

Review types of diabetes mellitus

There are many different types of diabetes mellitus and each one has specific side effects, subtypes and manifestations. Checking documentation and supporting information for the specific type is imperative to selecting the correct diagnostic code.

- **Pre-diabetes mellitus (R73.03).** Pre-diabetes mellitus is reported with ICD-10-CM code R73.03 (Pre-diabetes). One of the first indicators of a pre-diabetic condition is an A1C level of 5.7% to 6.4%. Coding professionals should note that **R73.09** (Other abnormal glucose) reports a previous diagnosis of diabetes mellitus, which is now considered latent or dormant.
- **Type 1 diabetes mellitus (E10.-).** Type 1 diabetes mellitus is reported using an ICD-10-CM code from category E10.- (Type 1 diabetes mellitus). Additional characters are required and determined by documented manifestations. Type 1 diabetes is a chronic condition and is often tied to a congenital anomaly where the pancreas fails to produce insulin or produces insufficient quantities.
- **Type 2 diabetes mellitus (E11.-).** Type 2 diabetes mellitus is reported using an ICD-10-CM code from category E11.- (Type 2 diabetes mellitus). Additional characters are required to report manifestations. Type 2 diabetes is also a chronic condition that impacts the way the body processes glucose caused by parts of the liver not reacting normally to insulin.

Type 2 diabetes mellitus is the most common type of diabetes in the U.S., making up 90.9% of adult patients who have diabetes.
- **Secondary diabetes mellitus (E08.-).** Secondary diabetes mellitus is reported using an ICD-10-CM code from category E08.- (Diabetes mellitus due to underlying condition). Secondary diabetes mellitus is a type of diabetes caused by another condition. Diagnoses such as cystic fibrosis, malnutrition, and congenital rubella are known to negatively impact the body's ability to properly process insulin. Additional characters are required to report specific manifestations.

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Coders can use codes from ICD-10-CM code category **E09.-** (Drug- or chemical-induced diabetes mellitus) to report diabetes caused by drug or chemical intake, known more commonly as an adverse reaction. Coding professionals must include additional characters to report specific manifestations.

- **Gestational diabetes mellitus (O24.41).** Gestational diabetes mellitus is reported using an ICD-10-CM code from subcategory O24.41 (Gestational diabetes mellitus in pregnancy). This code reports the development of diabetes mellitus during pregnancy. It requires additional characters identifying how the condition is controlled, whether that be by diet, insulin or oral hypoglycemic drugs.

If a pregnant woman was diagnosed with diabetes mellitus prior to becoming pregnant, the 2023 ICD-10-CM Official Guidelines for Coding and Reporting instruct that coders use a code from category **O24.-** (Diabetes mellitus in pregnancy, childbirth, and the puerperium) first, followed by the appropriate diabetes code from range **E08-E13** (Diabetes mellitus).

- **Other specified diabetes mellitus (E13.-).** Other specified diabetes mellitus is reported using an ICD-10-CM code from category E13.- (Other specified diabetes mellitus) with additional characters to report documented manifestations. This category applies when patients have genetic defects and post-procedural diabetes mellitus.

Manifestations of diabetes mellitus

Diabetes mellitus, due to its involvement with the circulatory system, is a condition that negatively impacts many different body systems. There are consistencies across the multiple code categories, identified with combination codes, and the additional characters to report a fourth character of:

- 1 for a manifestation of ketoacidosis.
- 2 for kidney complications.
- 3 for ophthalmic complications.
- 4 for neurological complications.
- 5 for circulatory complications.
- 6 for other complications such as diabetic arthropathy, foot ulcers, other skin complications.

Treatments for diabetes mellitus

Coders should keep in mind that, when coding for patients who are on hypoglycemics, insulin or other non-insulin medications — with the exception of type

1 diabetics — they may need to include a long-term (current) use code, such as:

- **Z79.4** (Long-term [current] use of insulin).
- **Z79.84** (Long-term [current] use of oral hypoglycemic drugs).
- **Z79.85** (Long-term [current] use of injectable non-insulin antidiabetic drugs).

When an FDA-approved insulin pump is used for remote monitoring, along with live, interactive communication between patient and physician, CPT E/M codes **99457** (Remote physiologic monitoring treatment management services; first 20 minutes) and **99458** (... ; each additional 20 minutes) may be appropriate.

Pancreatic islet transplantations have been investigated as a potential treatment for type 1 diabetes mellitus. The islets of Langerhans, also known as pancreatic islets, include beta cells that generate insulin.

This procedure, an allotransplantation, takes islets with healthy beta cells from a deceased donor's pancreas and places them into a patient with type 1 diabetes mellitus. In addition, researchers are experimenting with whole pancreas transplantation to provide a patient with type 1 diabetes mellitus with a new organ. Possible CPT codes to report the physician's work to perform these transplantations include:

- **0584T** (Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous).
- **0585T** (... ; laparoscopic).
- **0586T** (... ; open).
- **48160** (Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells).
- **48550** (Donor pancreatectomy, with or without duodenal segment for transplantation).
- **48554** (Transplantation of pancreatic allograft).

— *Shelley C. Safian, PhD, RHIA, CCS-P, COC, CPC-I* (pbnfeedback@decisionhealth.com) ■

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