ICD-10-CM Refresher: Conventions, Infections, Neoplasms, Endocrine System
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Coding 3 to 7 Characters

Alphabetical Index

- Index to Diseases and Injuries
  - No hypertension table
- Neoplasm table is separate
- Table of Drugs and Chemicals
- Index to External Causes

Tabular List

- Within a number of ICD-10-CM chapters, category restructuring and code reorganization have occurred resulting in the classification of certain diseases and disorders different than what is currently seen in ICD-9-CM.
- Example: Gout moved to musculoskeletal system chapter
- Example: Eyes and ears separated from the Nervous system chapter
Hierarchy of Importance

- Conventions
  - General Guidelines
  - Chapter Specific Guidelines

Placeholder ‘X’

- Addition of dummy placeholder ‘X’ is used in certain codes to:
  - Allow for future expansion
    - T42.0x1D Poisoning by hydantoin derivatives, accidental, subsequent
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
    - W11.xxxD Fall from ladder, subsequent

Addition of 7th Character

- Used in certain chapters to provide information about the characteristic of the encounter
- Must always be used in the 7th position
- Can be a letter or a number
  - S02.110B
  - O65.0xx1
- If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid

Chapters with 7th Characters

- Ch 7—Glaucoma
- Ch 13—Gout
- Ch 13—Pathological, stress and fatigue fractures
- Ch 15—Pregnancy
- Ch 19—Injuries
- Ch 20—External causes

7th Character—Injuries

- A, initial encounter, is used while the patient is receiving active treatment for the injury.
- D, subsequent encounter, is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase.
- S, sequelae, is used for complications or conditions that arise as a direct result of an injury (ICD-10-CM coding guideline I.C.19.a).

7th Character for Fractures

- A = initial encounter for closed fracture
- B = initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

D is Default
S is for Sometimes
Stay Away from A
Conventions—Dashes

- ICD-9-CM 250.xx
- ICD-10-CM alpha index utilizes a dash at the end of the code number to indicate the code is incomplete
  - Fracture, pathologic ankle M84.47-
- A dash preceded by a decimal point
  - (.-) indicates an incomplete code in the tabular list. J44.-

Inclusion Notes

Inclusion notes contain terms that are the condition for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of various conditions assigned to that code. The inclusion terms are not necessarily exhaustive (ICD-10-CM coding guideline I.A.11).

‘Includes’ appears at the category level and applies to the entire category. Inclusion notes also appear at subcategory and code levels but ‘includes’ is not there K31.5

Excludes Notes

Excludes 1:
- An excludes 1 note is a pure excludes note. It means “NOT CODED HERE”
- Indicates the code excluded should never be used at the same time as the code above the Excludes 1 notes.
- Is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

Excludes 2
- An excludes 2 note represents “not included here”.
- Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time

Excludes Note Examples

J18.0 Bronchopneumonia, unspecified organism
- Excludes1:
  - hypostatic bronchopneumonia (J18.2)
  - lipid pneumonia (J69.1)
- Excludes2:
  - acute bronchiolitis (J21.-)
  - chronic bronchiolitis (J44.9)

Laterality

- For bilateral sites, the final character of the code indicates laterality
- If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side
- An unspecified code is also provided should the side not be identified in the medical record

Laterality Examples

- M16.0 Bilateral primary osteoarthritis of hip
- M16.11 Unilateral primary osteoarthritis, right hip
- M16.12 Unilateral primary osteoarthritis, left hip
- Z90.10 Acquired absence of unspecified breast
- Z90.11 Acquired absence of right breast
- Z90.12 Acquired absence of left breast
- Z90.13 Acquired absence of bilateral breasts
Sequela

Residual effect (condition produced) after the acute phase of an illness or injury has ended
No time limit on when a sequela code can be used
Exception: instances where the code for the sequela is followed by a manifestation code, or the sequela code has been expanded (at the 4th, 5th or 6th character levels) to include the manifestation(s)
The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect

Other or Other Specified

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM coding guideline I.A.9.a).

NEC—Not elsewhere classified I25.89
Other forms of chronic ischemic heart disease
4th digit 8

Unspecified

This can be contrasted with “unspecified” codes when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM coding guideline I.A.9.b).

NOS—Not Otherwise Specified J12.9
Viral pneumonia, unspecified (contrast that with J12.89)
4th digit 9

Conventions—Relational Terms

- And—interpreted to mean ‘and/or’ when it appears in a code title within the tabular list
- With—interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the alpha, or an instructional note in the tabular.

Conventions Same as ICD-9

- Parentheses are used in both the Alphabetic Index and Tabular to enclose nonessential modifiers
- Brackets are used in the Alphabetic Index to identify manifestation codes, and in the Tabular List to enclose synonyms, alternative wordings, abbreviations, and explanations
- Colons are used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category
Essential Modifiers

The indented terms are always read in conjunction with the main term.

**Diverticulosis K57.90**
- With bleeding K57.91
- Large intestine K57.30
  - With Bleeding K57.31
    - Small intestine K57.50
    - With bleeding K57.51
  - Small intestine K57.10
    - With Bleeding K57.11
    - Large intestine K57.50

The Usual Basics

- Must use the alpha and the tabular
- Read everything; it all means something
- Code to the level of highest specificity
- Each unique ICD-10-CM diagnosis code may be reported only once for an encounter
- All diagnoses must be confirmed in the medical record or verified by physician

Three Diagnoses coded based on clinician documentation

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stages

SEQUENCING

ICD-10-CM coding guideline I.A.17 states a “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

In contrast, the Code First/Use Additional Code notes provide sequencing order of the codes (underlying condition followed by the manifestation).

Etiology/Manifestation

- Need to follow coding conventions
- Buddy codes—have to be sequenced together with etiology preceding the manifestation
- Conventions
  - Alphabetical index two codes with second one within [italicized brackets] called manifestation
  - Tabular List: Code title in italics (a code in italics in the tabular may NEVER be coded without its cause preceding it).
  - Tabular List: Code first underlying condition at manifestation
  - Tabular List: Use additional code to identify manifestation (not always) at etiology
Teenage Buddy

• “Code, if applicable, any associated condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.
  – L97

So what does ‘teenage buddy’ mean?

• If cause is known, code with buddy preceding...
  • E11.621 Type 2 DM with foot ulcer
  • L97.421 non-PU of left heel and midfoot limited to breakdown of skin
• If cause is unknown, sometimes teenagers can be alone.
  • L97.421 non-PU of left heel and
  • midfoot limited to breakdown of skin

Multiple coding for a single condition

• In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code.
• “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
• Sequencing rule is same as etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

Sequencing

• “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.
  – L89

Sequencing

• Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition.
  – See the specific guidelines for these conditions for further instruction.

Complications

• Code assignment is based on the provider’s documentation of the relationship between the condition and the care and procedure.
• Important to note that not all conditions that occur during or following medical care or surgery are classified as complications.
• There must be a cause and effect relationship between the care provided and the condition and an indication in the documentation that it is a complication. If not clearly documented, query the provider for clarification.
Definitions

- **Localized infection**—An infection that is limited to a specific part of the body and has local symptoms.
- **Septicemia**—Septicemia is bacteria in the blood (bacteremia) that often occurs with severe infections. (No separate code in ICD-10)

Definitions

- **Sepsis**—a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammation throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail. If sepsis progresses to septic shock, blood pressure drops dramatically, may lead to death.

Sepsis or Severe Sepsis

- ‘A’ codes for sepsis, then code for local infection; sequencing depends on circumstances
  - A40 Streptococcal sepsis
  - A41 Other sepsis
- R65.2- Severe sepsis with or without septic shock if acute organ dysfunction is documented (SIRS)
  - Septic shock refers to circulatory failure associated with sepsis (cannot be primary)
  - Add code(s) for associated organ failure or dysfunction

Sepsis

Sepsis with localized infection (pneumonia, UTI)

- If admitted with sepsis
  - Assign sepsis code first (A40-41)
  - Then localized infection code
  - Severe? Add R65.2-
- If admitted with localized and develops into sepsis
  - Code localized infection first
- This guideline applies more to hospital than home care

Severe Sepsis

- Minimum of two (really three) codes
  - Underlying systemic infection ‘A’ code
  - Code from subcategory R65.2-
  - Additional code for associated organ dysfunction
- Postprocedural sepsis—must be documented by the physician—start with the specific postprocedural infection code
  - T81.4-
  - Use appropriate A40-41 code next.
Coding HIV and AIDS

HIV - Code only confirmed cases
• HIV as principal diagnosis — B20 followed by manifestations of HIV infection
• If reason for admission not related to HIV, code HIV and related diagnoses as secondary
• Z21 is code for asymptomatic HIV (no symptoms, no AIDS, no treatment for any condition for HIV-related illness)

Infectious agents as the cause of diseases classified to other chapters

• Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, use an additional code from Chapter 1 to identify the organism.
• Use an additional code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters.
• DO NOT USE A49 codes!

A vs B Simplified

• A codes are generally coded first (sepsis)
• B codes 95, 96 and 97 are sequenced after what is infected. (These categories are provided for use as supplementary or additional codes to identify the infectious agent in diseases classified elsewhere.)

Infections resistant to antibiotics

• Many bacterial infections are resistant to current antibiotics. Identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.
  – Look up resistance, by, name of drug

MRSA

• When a patient is diagnosed with an infection that is due to methicillin resistant Staph aureus and that infection has a combination code that includes the causal organism, assign the appropriate combo code for the condition.
• If a combo code is appropriate, do not use an additional code B95.62.
• Do not assign a code from Z16.11 to MRSA.
MRSA Examples

• Combo codes
  – Sepsis due to MRSA: A41.02
  – Pneumonia due to MRSA: J15.212
  – Colonization by MRSA: Z22.322
    • Colonization = MRSA screen or nasal swab positive but no active infection (can have active infection at same time)
• Not all are combo codes:
  – UTI caused by MRSA: N39.0, B95.62

Information needed

• Intake:
  – Infection site, any relation to procedure
  – Any sepsis or severe sepsis (identify acute organ failure)
  – Identify infectious organism, any resistance
• Clinician’s assessment:
  – Any current antibiotic treatment
  – Fever, response to antibiotics
  – S/sx residual from any acute organ failure

Identify Neoplasm Behavior

• Benign neoplasms do not transform into cancer
• Potentially malignant neoplasms (pre-cancer) include carcinoma in situ
• Malignant neoplasms are commonly called cancer
• Uncertain—neoplasms where histologic confirmation whether malignant or benign cannot be made
• Unspecified—growth NOS, neoplasm NOS, new growth NOS, tumor NOS
• Mass—not a neoplasm

Neoplasm Table

• Located right after the Alphabetical Index
• The Neoplasm Table should be referenced first (unless histological term documented)
• Classifies by site (topography) with broad groupings for behavior (malignant, benign, etc)
  – Laterality is important!!
• Ex: Lung CA (primary site, right lung) C34.91

Remission

• Leukemia and Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues.
• If the documentation is unclear, as to whether the leukemia has achieved remission, the provider should be queried.
• C90-95, for example
  – 5th digit 0—not having achieved remission, failed remission
  – 5th digit 1—in remission
  – 5th digit 2—in relapse
Guidelines

- If treatment is directed at the malignancy, list the malignancy as principal diagnosis
- Exception to this guideline: if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed as a secondary diagnosis.

Sequencing

- Focus of care on treatment of primary malignancy: list primary site first, followed by any metastatic sites
- Focus of care directed toward the metastatic (secondary) site(s) only: the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

Malignancy vs History

- When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
  - Default on the side of coding the cancer unless you have documentation that the cancer is eradicated.

Primary malignancy previously excised

- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
- Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

Primary malignant neoplasms overlapping site boundaries

- A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion') unless the combination is specifically indexed elsewhere (colon w/rectum-C19).
- For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

Disseminated malignant neoplasm, unspecified

- Code C80.0, Disseminated malignant neoplasm, unspecified, is for use only in cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified.
  - Neoplasm table under “disseminated”
- It should not be used in place of assigning codes for the primary site and all known secondary sites.
Malignancy Site Unknown
- Code C80.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy.
  - Cancer NOS, Malignancy NOS
  - Neoplasm Table under “unknown” site
- Cancer found at kidney but cell type means the cancer originated elsewhere (unknown primary)

Symptoms, Signs, and Ill-Defined Conditions
- Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.
  - Example: weakness

Neoplasm Related Pain
- Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor.
- This code is assigned regardless of whether:
  - Tumor is malignant or benign
  - Pain is acute or chronic

Pathologic fracture due to a neoplasm
- When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.
- If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

Complications Associated with a Neoplasm
- When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.
  - Exception: Anemia

Anemia due to Cancer
- Patient admitted for management of anemia due to cancer. Anemia is the focus of care.
- Guideline: With anemia due to cancer, the cancer is coded first even if the anemia is the focus of care
  - Malignant neoplasm is coded first, then:
    - D63.0 Anemia in neoplastic disease
Anemia due to Chemo

- Patient has anemia due to chemotherapy. Is HH treatment for anemia? Or cancer?
- Guideline: When admission is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect...
- D64.81 Anemia due to antineoplastic therapy
- T45.1x5D Adverse effect of antineoplastics
- Cancer, by site

Complications Associated with a Neoplasm

- When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm:
  - Designate the complication as the principal/first-listed diagnosis.
  - Then code the neoplasm, if not resolved
  - History of neoplasm should be coded if resolved

Z Codes Used with Neoplasms

- Z85.- for personal history of neoplasm
  - Also history, personal, benign neoplasm and History, personal, in situ neoplasm
- Z48.3 Aftercare, following surgery, neoplasm
  - Is the neoplasm resolved after the surgery?
    - If resolved, do not code the neoplasm as current diagnosis.
    - If not resolved or unknown at that time, continue to code the neoplasm.
      - Is aftercare the focus or the neoplasm the focus?
      - Surgical removal — Absence (partial, complete)

Prophylactic Organ Removal

- For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

Example

The patient was admitted to home care after mastectomy of right breast for cancer. The left breast was removed prophylactically because of genetic susceptibility. She will continue chemotherapy. Aftercare is the focus of care with dressing changes.

- Z48.3 Aftercare following surgery for neoplasm
- C50.911 Malignant neoplasm right female breast
- Z40.01 Encounter for prophylactic removal of breast
- Z15.01 Susceptibility to malignant neoplasm of breast
- Z48.01 Surgical dressing changes
- Z90.13 Acquired absence of bilateral breast and nipple
Malignant Neoplasm of Transplanted Organ

- A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86,-, Complications of transplanted organs and tissue, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

Cancer in a Transplanted Organ

- CA in transplanted pancreas
  - T86.891 Other transplant tissue failure
  - C80.2 Malignant neoplasm assoc. w/transplanted organ
  - C25.9 Malignant neoplasm of pancreas, unspecified

Information needed

- Intake:
  - Neoplasm site(s) including laterality
  - Behavior of neoplasm
  - Primary, metastatic
  - If post-op, was neoplasm eradicated? Any further treatment or follow up?
  - Remission? Failed remission? Relapse?
- Clinician assessment:
  - Focus of care
  - Pain associated with neoplasm

Guidelines

- The diabetes mellitus codes are combination codes that include:
  - the type of diabetes mellitus,
  - the body system affected, and
  - the complications affecting that body system.
- As many codes within a particular category as are necessary to describe all of the complications of the disease may be used.
- They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 –E13 as needed to identify all of the associated conditions that the patient has.

Guidelines

- If the type of diabetes mellitus is not documented in the medical record the default is E11,-, Type 2 diabetes mellitus.
- If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned.
- Code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient’s blood sugar under control during an encounter.
**Diabetes Categories**

- **E08 DM due to underlying condition**
  - Code first underlying condition
  - Use additional code to identify insulin use
- **E09 Drug or chemical induced DM**
  - Notice difference between adverse effect and poisoning.
  - Use additional code to identify insulin use Z79.4
- **E10 Type 1 DM**
- **E11 Type 2 DM**
  - Use additional code to identify insulin use
- **E13 Other specified DM**
  - Use additional code to identify insulin use

**Examples**

- The patient has steroid induced diabetes from taking corticosteroids for an upper respiratory infection last year.
  - E09.9 Drug or chemical induced diabetes
  - T38.0x5S Adverse effect of glucocorticoids, sequela
- The patient has diabetes from exposure to Agent Orange during the Vietnam conflict.
  - T53.7x1S Toxic effect of other halogen derivatives of aromatic hydrocarbons, accidental, sequela
  - E09.9 Drug or chemical induced diabetes

**Diabetes 4th characters 0 and 1**

- Diabetes with hyperosmolarity
  - Does not occur with Type 1 DM
    - No choice in Type 1 diabetics (no E10.0-)
- Diabetes with ketoacidosis
  - Does not occur with Type 2 diabetics
    - No choice in Type 2 diabetics (no E11.1-)

**Diabetes 4th Characters**

- **2 as 4th character**
  - R- Renal/Kidney complications
- **3 as 4th character**
  - O- Ophthalmic
- **4 as 4th character**
  - N- Neurological
- **5 as 4th character**
  - C- Circulatory
- **6 as 4th character**
  - O- Other—arthropathy, skin complications, oral complications, hypoglycemia, hyperglycemia and other

**Diabetes 4th characters 7, 8, 9**

- 7—no 4th character 7
- 8—unspecified complications (do NOT use)
- 9—without complications (equivalent to 250.0x)

**Diabetic Manifestation Notables**

- **E11.22**
  - Use additional code note: need stage of CKD
- **E11.3- Macular edema includes the type of retinopathy**
- **E11.4- includes neuropathy unspecified, mononeuropathy, polymyopathy, etc**
  - E11.43 Use additional code note for gastroparesis
- **E11.5 DM with gangrene includes the peripheral angiopathy**
- **E11.610 Includes Charcot’s**
**Diabetic Manifestation Notables**

- E11.6--
  - Use additional code for ulceration
- E11.64 Hypoglycemia
- E11.65 Hyperglycemia
- E11.69 Other manifestations of diabetes
  - Use additional code.

**Special guideline**

- Pancreatic cancer and postpancreatectomy diabetes
  - C25.9 pancreatic cancer
  - E89.1 Postprocedural hypoinsulinemia
  - E13.9 Other specified diabetes
  - Z90.41 Absence of pancreas
  - Z79.4 Long term use of insulin

**Overweight, obesity and other hyperalimentation**

- Overweight with BMI of 27
  - E66.3
  - Z68.27 BMI 27.0-27.9, adult
- The physician must document obesity, overweight before it can be coded. BMI can be coded based on clinician’s documentation.

**Information needed**

- Intake:
  - Type of diabetes, any underlying cause
  - Any complications or manifestation associated with or due to diabetes, stage of CKD (1-5, not unspecified stage)
  - Specific diagnosis of obesity or morbid obesity
- Clinician assessment:
  - Blood sugar
  - Insulin use
  - Height and weight