



Wisconsin Physicians Service (WPS) Policy Primer^{1,2}

Carrier B: WI, IL, MI and MN | Legacy A: Former Mutual of Omaha | MAC A: IA, MO, NE and KS | MAC B: IA, MO, NE and KS

Effective Date: 6/1/10

Indications	<ul style="list-style-type: none">■ VSU³ of 3 months' duration that have failed to respond to documented conservative treatment for greater than 2 months' duration.■ Neuropathic DFU⁴ of 4 weeks duration that have failed to respond to conservative treatment for greater than 1 month duration.
Limitations	<ul style="list-style-type: none">■ Limited to 3 separate applications to any given ulcer or more only when utilized with adherence to specific FDA labeling instructions and criteria.■ There should be no fewer than 2 weeks between applications for venous stasis ulcers and there should be no fewer than three (3) weeks between applications for neuropathic diabetic foot ulcers.■ For venous stasis ulcers, two applications of the skin substitute are indicated, or more only if provided for in the FDA labeling. If after 12 weeks of compression treatment and the appropriate number of applications of the skin substitute a 50 percent or greater improvement is noted and documented, one or more subsequent reapplications of the skin substitute will be considered for Medicare coverage. Otherwise, reapplication of the skin substitute is not recommended and will not be reimbursed and other treatment modalities should be considered.■ For neuropathic diabetic foot ulcers, if after nine weeks of treatment and three applications of the skin substitute, satisfactory healing progress is not noted, then reapplication of the skin substitute is not recommended and other treatment modalities should be considered.■ Re-treatment within one (1) year of completion of any given course of skin substitutes for venous stasis ulcers is not covered.
Documentation	<ul style="list-style-type: none">■ The medical record must clearly document that conservative pre-treatment wound management has been tried and failed to induce healing.■ Documentation of the progress of the wound's response to treatment must be made for each service billed. At a minimum this must include current wound size, wound depth, presence and extent of or absence of obvious signs of infection, presence and extent of or absence of necrotic, devitalized or non-viable tissue, or other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown.
Coding	<p>CPT/HCPCS⁵</p> <ul style="list-style-type: none">■ 15340: Tissue cultured allogeneic skin substitute; first 25 sq cm or less■ 15341: Each additional 25 sq cm■ Q4101: Apligraf, per square centimeter <p>ICD 9 CODES</p> <ul style="list-style-type: none">■ VSU: 454.0, 454.2, 459.10, 459.11, 459.81 (these codes may be used alone)■ DFU (Primary diagnosis): *707.10-707.15, 707.19■ DFU (Secondary diagnosis): *249.60, 249.70, 250.60, 250.61, 250.70-250.71, 250.80-250.83

*When billing for wound care for ulcers caused by diabetes, the provider must use both a code primary ICD-9 code from the ulcer of lower limb range (707.10-707.19) and a secondary ICD-9 code from the diabetes range.

¹ Source: www.cms.com ² This document is for informational purposes only. Use of this information does not guarantee coverage or payment for these services by Medicare or other payors. Physicians and other providers should use independent judgment when selecting codes that most appropriately describe the services provided to a patient. Physicians and hospitals are solely responsible for compliance with Medicare and other payors' laws, rules, and requirements. ³ VSU = Venous Stasis Ulcer. ⁴ DFU = Diabetic Foot Ulcer. ⁵ CPT © American Medical Association. All Rights Reserved.

Wisconsin Physicians Service Medicare Apligraf® Sample UB-04 Claim Form

* Anytown Hospital 123 Medical Drive Anytown, NJ 00000		HIC 012345678A		TYPE OF BILL 131	
PATIENT NAME Smith, Jane		PATIENT ADDRESS 111 Maple Avenue Anytown NJ 00000		FEDERAL TAX ID NO 01-2345678	
BIRTH DATE 01011935		OCCURRENCE DATE 01012009		OCCURRENCE PERIOD 01012009	
Jane Smith 111 Maple Avenue Anytown, NJ 00000		VALUE CODES AMOUNT (Table with columns for code and amount)			
636 Apligraf		360 Application, first 25 sq cm		360 Application, each additional 25 sq cm	
Q4101		15340		15341	
01012010		01012010		01012010	
44		1		1	
XXXXX		XXXXX		XXXXX	
636 Apligraf		360 Application, first 25 sq cm		360 Application, each additional 25 sq cm	
Q4101		15340		15341	
01012010		01012010		01012010	
44		1		1	
XXXXX		XXXXX		XXXXX	
Medicare		A987654X		Smith, Jane	
VSU: 454.0, 454.2, 459.10, 459.11, 459.81 (these codes may be used alone)		DFU (Primary diagnosis): *707.10-707.15, 707.19		DFU (Secondary diagnosis): *249.60, 249.70, 250.60, 250.61, 250.70-250.71, 250.80-250.83	
XXX.XX		*When billing for wound care for ulcers caused by diabetes, the provider must use both a code primary ICD-9 code from the ulcer of lower limb range (707.10-707.19) and a secondary ICD-9 code from the diabetes range.			

All dates should be in eight digit format.

Enter appropriate revenue codes for all services provided.
Revenue code 636 should be used when billing for Apligraf.

CPT 15340 and 15341 should be used based on the size of the wound. For example, a wound measuring 30 sq cm, would be billed using 15340 (first 25 sq cm) and 15341 (additional 25 sq cm or part thereof).

Apligraf is supplied in 44 units.

Wisconsin Physicians Service Medicare

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Apligraf®

Sample CMS-1500 Claim Form
Physician Services in an Outpatient Setting

APPROVED CMS-0928-0008

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM														
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> CHAMPUS <input type="checkbox"/> (Sponsor's ID#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID# or ID) <input type="checkbox"/> FICA BLK LUNG <input type="checkbox"/> (ID) <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Jane					3. PATIENT'S BIRTH DATE MM DD YY 12 13 35		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, Jane					
5. PATIENT'S ADDRESS (No., Street) 123 Any Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 123 Any Street							
CITY ANYTOWN			STATE NJ		8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>			CITY ANYTOWN		STATE NJ				
ZIP CODE 00000		TELEPHONE (Include Area Code) (973) 555-1234			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE 00000		TELEPHONE (INCLUDE AREA CODE) (973) 555-1234					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FICA NUMBER				
4. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					5. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					6. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME					10a. RESERVED FOR LOCAL USE					6. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10b. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED _____ DATE _____				
14. DATE OF CURRENT: MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE 1. XXX XX 2. XXX XX										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY 01 01 10 01 01 10 B PLACE of Service 22 C TYPE of Service 15340 D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 15341										20. OUTSIDE LAB? \$ CHARGES				
25. FEDERAL TAX I.D. NUMBER 01-2345678										26. TOTAL CHARGE \$ XXX				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										29. AMOUNT PAID \$				
28. PATIENT'S ACCOUNT NO. 012345678										30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PHS# _____ GRP# _____														

VSU: 454.0, 454.2, 459.10, 459.11, 459.81 (these codes may be used alone)
 DFU (Primary diagnosis): *707.10-707.15, 707.19
 DFU (Secondary diagnosis): *249.60, 249.70, 250.60, 250.61, 250.70-250.71, 250.80-250.83
 *When billing for wound care for ulcers caused by diabetes, the provider must use both a code primary ICD-9 code from the ulcer of lower limb range (707.10-707.19) and a secondary ICD-9 code from the diabetes range.

CPT 15340 and 15341 should be used based on the size of the wound. For example, a wound measuring 30 sq cm, would be billed using 15340 (first 25 sq cm) and 15341 (additional 25 sq cm or part thereof).

Wisconsin Physicians Service Medicare

PLEASE DO NOT STAPLE IN THIS AREA



Apligraf®
 Sample CMS-1500 Claim Form
 Physician Services in an Office Setting

APPROVED CMS-0020-0008

CARRIER

HEALTH INSURANCE CLAIM FORM																			
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's ID#) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (ID# or ID) FICA BLK LUNG <input type="checkbox"/> (ID) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789A														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Jane					3. PATIENT'S BIRTH DATE MM DD YY 12 13 35 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>														
5. PATIENT'S ADDRESS (No., Street) 123 Any Street					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>														
7. INSURED'S ADDRESS (No., Street) 123 Any Street																			
CITY ANYTOWN STATE NJ			8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>			CITY ANYTOWN STATE NJ													
ZIP CODE 00000		TELEPHONE (Include Area Code) (973) 555-1234			9. EMPLOYED? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		4. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		7. EMPLOYER'S NAME OR SCHOOL NAME										
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FICA NUMBER			10a. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED														
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES														
21. DIAGNOSIS OR NATURE 1. XXX XX 2. XXX XX <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> VSU: 454.0, 454.2, 459.10, 459.11, 459.81 (these codes may be used alone) DFU (Primary diagnosis): *707.10-707.15, 707.19 DFU (Secondary diagnosis): *249.60, 249.70, 250.60, 250.61, 250.70-250.71, 250.80-250.83 *When billing for wound care for ulcers caused by diabetes, the provider must use both a code primary ICD-9 code from the ulcer of lower limb range (707.10-707.19) and a secondary ICD-9 code from the diabetes range. </div>										REF. NO.									
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS MODIFIER)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EMG COB		REBILLED FOR LOCAL USE			
01	01	10	01	01	10	11	Q4101					44							
01	01	10	01	01	10	11	15340												
01	01	10	01	01	10	11	15341												
25. FEDERAL TAX I.D. NUMBER 01-2345678 BBN EIN					26. PATIENT'S ACCOUNT NO. 012345678					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ XXX		29. AMOUNT PAID \$		30. BALANCE DUE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #									
SIGNED					DATE					PIN#					GRP#				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Apligraf is supplied in 44 units.

CPT 15340 and 15341 should be used based on the size of the wound. For example, a wound measuring 30 sq cm, would be billed using 15340 (first 25 sq cm) and 15341 (additional 25 sq cm or part thereof).



Model Documentation Form for Wisconsin Physician Services

Pretreatment:

1. Indicate duration of ulcer (**DFU**: greater than one month, **VSU**: greater than three months)
2. Indicate duration of pre treatment conservative /conventional management (by you or the predecessor physician)
_____ months
3. Document exact location of ulcer
4. Indicate appropriate patient diagnosis codes:
VSU: 454.0, 454.2, 459.81, 459.10-459.11
DFU (Primary): 707.10-707.15, 707.19
DFU (Secondary): 249.60, 249.70, 250.60, 250.61, 250.70-250.71, 250.80-250.83
5. Document whether there is a failure to respond to conservative measures (VSU -2 months duration and DFU -1 month duration), including appropriate off-load pressure during treatment
6. Document measurement of the initial ulcer size, size following cessation of conservative management, and size at the beginning of Apligraf treatment
7. For a patient with diabetes, document current medical management and HgbA1C level
8. Document patient's arterial blood supply to the foot as evidenced by a palpable pulse on the foot (either dorsalis pedis or posterior tibial artery), or an ABI of 0.7 or greater
9. Document that wound is clean, free of infection and underlying Osteomyelitis

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Treatment:

10. Document measurement of ulcer (width and length or circumference and depth) immediately prior to application of Apligraf _____sq cm

Wound Size	CPT 15340	CPT 15341
< 25 sq cm	x1	-
26-50 sq cm	x1	x1
51-75 sq cm	x1	x2
76-100 sq cm	x1	x3
> 100 sq cm	x1	Continue based on 25 sq cm or part thereof

11. Document whether this is patient's initial application of Apligraf or a reapplication. (Per FDA-approved labeling, no more than 5 applications per ulcer is permitted. WPS's LCD for Apligraf states use of Apligraf is limited to 3 separate applications to any given ulcer, or more only when utilized with adherence to specific FDA labeling instructions and criteria).
12. For Apligraf reapplications, document time between applications (There should be no fewer than two (2) weeks between applications for VSU and there should be no fewer than three (3) weeks between applications for DFU, except when more frequent applications are either a part of the FDA product specific labeling instructions or are clearly supported by medical record documentation of medically reasonable and necessary indications).
13. Document whether 50 percent or greater improvement was noted (For VSU's, two (2) applications of the skin substitute are indicated. If after twelve (12) weeks of compression treatment, and two (2) applications of the skin substitute, a 50 percent or greater improvement is noted and documented, then re-application of a third skin substitute will be considered for coverage. Otherwise, reapplication of the skin substitute is not recommended, and other treatment modalities should be considered. For neuropathic DFU's, if after nine (9) weeks of treatment, and three (3) applications of the skin substitute, satisfactory healing progress is not noted, then reapplication of the skin substitute is not recommended and other treatment modalities should be considered.).
14. For Apligraf reapplications, document whether prior applications have been successful /satisfactory healing progress noted. Include documentation of the presence and extent of or absence of necrotic, devitalized or non-viable tissue, or other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown.
15. Document wound dressing accompanying the wound treatment during the healing period, as well as compressive therapy and steps to off-load wound pressure.
16. Document patient compliance
17. Document how Apligraf was fixated to the wound
18. Document whether all FDA labeling instructions have been followed

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ICD-9 CM Codes commonly used when billing for Apligraf¹

- 454.0** Varicose veins of lower extremities, with ulcer
- 454.1** Varicose veins of lower extremities, with inflammation
- 454.2** Varicose veins of lower extremities, with ulcer and inflammation
- 459.11** Postphlebotic syndrome with ulcer
- 459.13** Postphlebotic syndrome with ulcer and inflammation
- 459.31** Chronic venous hypertension with ulcer
- 459.33** Chronic venous hypertension with ulcer and inflammation
- 459.81** Other specified disorders of circulatory system, venous (peripheral) insufficiency, unspecified

- 707.10** Ulcer of lower limb, unspecified
- 707.11** Ulcer of thigh
- 707.12** Ulcer of calf
- 707.13** Ulcer of ankle
- 707.14** Ulcer of heel and midfoot (Plantar surface of midfoot)
- 707.15** Ulcer of other part of foot (Toes)
- 707.19** Ulcer of other part of lower limb
- 707.8** Chronic ulcer of other specified sites

- 249.00** Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
- 249.01** Secondary diabetes mellitus without mention of complication, uncontrolled
- 249.10** Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified
- 249.11** Secondary diabetes mellitus with ketoacidosis, uncontrolled
- 249.20** Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified
- 249.21** Secondary diabetes mellitus with hyperosmolarity, uncontrolled
- 249.30** Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified
- 249.31** Secondary diabetes mellitus with other coma, uncontrolled

Continued on next page >

- 249.40** Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified
- 249.41** Secondary diabetes mellitus with renal manifestations, uncontrolled
- 249.50** Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified
- 249.51** Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled
- 249.60** Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified
- 249.61** Secondary diabetes mellitus with neurological manifestations, uncontrolled
- 249.70** Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified
- 249.71** Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled
- 249.80** Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
- 249.81** Secondary diabetes mellitus with other specified manifestations, uncontrolled
- 249.90** Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified
- 249.91** Secondary diabetes mellitus with unspecified complication, uncontrolled
- 250.60** Diabetes With Neurological Manifestations, Type II Or Unspecified Type, not stated as uncontrolled
- 250.61** Diabetes With Neurological Manifestations, Type I (Juvenile Type), not stated as uncontrolled
- 250.62** Diabetes With Neurological Manifestations, Type II Or Unspecified Type, uncontrolled
- 250.63** Diabetes With Neurological Manifestations, Type I (Juvenile Type), uncontrolled
- 250.70** Diabetes With Peripheral Circulatory Disorders, Type II Or Unspecified type, not stated as uncontrolled
- 250.71** Diabetes With Peripheral Circulatory Disorders, Type I (Juvenile Type), not stated as uncontrolled
- 250.72** Diabetes With Peripheral Circulatory Disorders, Type II Or Unspecified type, uncontrolled
- 250.73** Diabetes With Peripheral Circulatory Disorders, Type I (Juvenile Type), uncontrolled
- 250.80** Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
- 250.81** Diabetes with other specified manifestations, type I, not stated as uncontrolled
- 250.82** Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
- 250.83** Diabetes with other specified manifestations, type I, uncontrolled

¹ This brief summary is provided for consideration only. All codes provided herein are for information purposes only and shall not be construed as a statement, promise, or guarantee that these codes are accurate or reimbursement will be received. Coding requirements are subject to change at any time, therefore check with your local payer regularly to verify prior authorization requirements.