Diabetes with Hyperglycemia

Overview:
Diabetes with hyperglycemia (E10.65 or E11.65) may be recommended when a patient’s most recent hemoglobin A1c was >7.0%.

The CDC and ADA recommend a hemoglobin A1c goal of 7%, but more or less stringent glycemic goals may be appropriate for each individual. Glycemic goals for older adults might reasonably be relaxed as part of individualized care. Diagnosing a patient with diabetes with hyperglycemia does not suggest that their target hemoglobin A1c is <7.0%.

When the diagnosing hyperglycemia, there needs to be evidence such as the most recent HbA1c value or an elevated point of care glucose at the time of the visit. Once blood sugar levels have returned to the patient’s normal range, hyperglycemia should no longer be documented.

Pearl: Documentation stating ‘uncontrolled’ is not synonymous with hyperglycemia. ICD 10 coding for diabetes uncontrolled can mean ‘with hyperglycemia’ or ‘with hypoglycemia’. The documentation needs to be specific to hyperglycemia or hypoglycemia.

Pearl: Including the most recent HgbA1c in your note supports the patient’s hyperglycemic status.

Documentation Examples:

<table>
<thead>
<tr>
<th>Assessment/Plan: Type 2 diabetes with hyperglycemia – A1c 7.4%. At goal of 7.0% – 8.0%. Continue metformin. Congratulated patient and encouraged her to continue with diet and exercise.</th>
<th>Both DM and hyperglycemia are supported, code E11.65 (Type II DM w/ hyperglycemia) would be acceptable.</th>
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Active Management (“MEAT”):

Monitor
- Symptoms
- Disease progression/regression
- Ordering tests

Evaluate
- Test results
- Medication effectiveness
- Response to treatment
- Exam finding

Assess/Address
- Review records
- Counseling
- Documenting status

Treat
- Prescribe/continue medication/stopping
- Surgical/other interventions
- Referral to a specialist

Common Pitfalls:

- Nonspecific diagnosis
- Documentation and reported ICD-10 codes do not match (such as DM without complication and DM with hyperglycemia coded in same visit note)
- Not enough information to indicate active assessment/management
- Not linking data/medications to the relevant condition in the assessment/plan.
- Not addressing both conditions when a single ICD-10 code represents a condition and its complication/manifestation (such as DM with CKD)
- Inappropriately coding acute conditions as chronic

Resources: (1) American Diabetes Association; (2) CDC – All About Your A1C

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