Glycemic control for diabetic patients
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Clinical question
Since ICD-10 does not include "controlled" or "uncontrolled" as part of the base code for patients with diabetes, does glycemic control not matter anymore?

Recommendations
Develop appropriate goals for HbA1c collaboratively with each of your diabetic patients, taking their circumstances into account.

- For patients with type 1 diabetes, pregnant diabetic women, and younger patients with type 2 diabetes who do not have evidence of cardiovascular disease, an HbA1c target of < 7.0% is appropriate.
- For patients with type 2 diabetes over age 60 who have evidence of cardiovascular disease, an HbA1c target of around 7.5% (but not < 7.0%) is more appropriate.
- For older patients who are at risk of cognitive impairment and falls, an HbA1c target of 8–9% is most appropriate.

How could this change my practice?
The highest priority for all diabetic patients is vigorous cardiac risk reduction through smoking cessation, use of statins, use of ACE-inhibitors/ARBs, blood pressure control, and encouragement of healthy eating and regular exercise.

Pushing the average blood glucose level closer to normal (as measured by HbA1c levels < 7.0%) slows down or prevents the development of microvascular disease (diabetic retinopathy, neuropathy, and nephropathy). In older patients with pre-existing atherosclerosis, however, this degree of control may be associated with an increased risk of death and bad cardiovascular outcomes. It may also be associated with cognitive impairment in the elderly.

For all patients, the potential benefits of lower HbA1c need to be weighed against the potential harms of more frequent hypoglycemia, weight gain, and increased cost.

Why did we choose this topic?
With the introduction of ICD-10, we are no longer forced to code diabetic patients as "controlled" or "uncontrolled.” Nonetheless, if you are documenting a discussion with a patient about poor
glycemic control, it is still necessary to capture the patient’s "uncontrolled" status by adding a code that reflects that interaction.

- For example, if your patient’s HbA1c isn’t at goal and you are adjusting therapy to get them closer to the goal, E11.65 for uncomplicated type 2 diabetes with hyperglycemia needs to be added. The extra code credits you with actively addressing the patient’s poor glycemic control.
- If diabetes is well controlled, on the other hand, the E11.9 uncomplicated type 2 diabetes is enough. The coding "rule" is that if "hyperglycemia" or "controlled" are not mentioned in the documentation, the assumption is that the patient’s diabetes is controlled and the E11.65 code is unneeded.

References


Resources
Group Health Type 1 Diabetes Treatment Guideline
Group Health Type 2 Diabetes Screening and Treatment Guideline