LifeWise
Health Plan of Washington

Diabetes Management

APPLICABLE LINES OF BUSINESS

- Commercial
- Medicare

MEASURE DESCRIPTIONS

Patients with a diagnosis of diabetes (Type 1 or 2) who had the following[i]:

Measure	Age	Description
Glycemic Status Assessment for Patients with Diabetes (GSD)	18-75	Most recent glycemic status or glucose management indicator (GMI) was at the following levels during the measurement year: Control: <8% for Commercial, Not in Poor Control: ≤9% for Commercial and Medicare
Eye Exam for Patients with Diabetes (EED)	18-75	A retinal or dilated eye exam in the measurement year, or a negative retinal or dilated eye exam in the year prior, or bilateral eye enucleation any time during the member's history.
Kidney Health Evaluation for Patients with Diabetes (KED	18-75	Received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year
Blood Pressure Control for Patients with Diabetes (BPD)	18-75	Blood pressure adequately controlled during the measurement year (<140/90 mmHg)

EXCLUSIONS

Patients are excluded if they:

- Received hospice or palliative care any time in the measurement year.
- Have evidence of ESRD or dialysis at any time during the patient's history *(only applicable for KED).*
- Are Medicare patients 66 years of age and older who are enrolled in an institutional Special Needs Plan (SNP) or living long-term in an institution.
- Are age 66 or older with advanced illness and frailty (all diabetic measures) or are age 81 and older with frailty (KED only). See the Advanced Illness and Frailty Exclusions Guide for more details.

Blindness is not an exclusion for an eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

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MEDICAL RECORDS

Patient medical records should include:

Glycemic Status Assessment for Patients with Diabetes (GSD):
Glycemic status can be documented using either HbA1c testing or a Glucose Management Indicator (GMI) value.

- The last HbA1c result of the year must be <8% for Commercial (Control) and ≤9% for Commercial and Medicare (Not in Poor Control) to show evidence of diabetes control. HbA1c results should be numeric and include a result date.
- GMI is documented using the estimated average glucose (eAG) from a patient's continuous glucose monitor (CGM) to calculate an A1c value. EMRs can be configured to convert the eAG into an HbA1c value or providers can convert using the American Diabetes Association calculator. Documentation of the CGM date range used to derive the eAG value must be included.

Eye Exam for Patients with Diabetes (EED):
A retinal or dilated eye exam must be performed by an eye care professional annually for patients with positive retinopathy, every two years for patients without evidence of retinopathy, or no exam needed for bilateral eye enucleation any time during the patient's history.

When you receive an eye exam report from an eye care provider for your patient with diabetes:

- Review eye care reports and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate the necessary follow-up.
- Place eye care reports in the patient's medical record. Make sure the date of service, results, and the eye care professional's name and credentials are included for HEDIS compliance.
- If a copy of the report isn't available, document the patient's medical history, the date of the eye exam, the result, and the eye care professional with credentials who conducted the exam. If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.

Kidney Health Evaluation for Patients with Diabetes (KED):
Patients must have both an eGFR and a uACR during the current measurement year. Documentation should include both of the following, reported annually:

- At least one estimated glomerular filtration rate (eGFR)
- At least one urine albumin creatinine ratio (uACR) identified by
    - both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart **OR**
    - a urine albumin creatinine ratio test (uACR)

Blood Pressure Control for Patients with Diabetes (BPD):
The most recent blood pressure reading must be less than 140/90 to show evidence of blood pressure control.

- Document all blood pressure readings and dates obtained. The lowest systolic and lowest diastolic blood pressures from the most recent visit will be used, even if they are not from the same reading.
- Document exact readings; don't round blood pressure readings.
- If the patient is self-reporting blood pressure, document the date of the reading and that it was self-reported by the patient.
- Blood pressure readings can be captured during a telehealth, telephone, e-visit, or virtual visit.

CODING

HbA1c Results (GSD):
When documenting an HbA1c, submit the appropriate CPT® II[ii] result code:

Type	Code	Most recent HbA1c level
CPT® II	3044F	< 7%
CPT® II	3046F	> 9%
CPT® II	3051F	≥ 7% and < 8%
CPT® II	3052F	≥ 8% and ≤ 9%

GMI Results (GSD)
If sharing GMI data electronically with a health plan (not through claims), map GMI to LOINC code 97506-0 with the GMI result value and unit.

Type	Code	Example Result	Result Unit
LOINC	97506-0	150	EAG
LOINC	97506-0	7.5	%

Retinal Eye Exam Results (EED):
When results are received from an optometrist or ophthalmologist, submit the results on a $0.01 claim with the appropriate CPT® code.

Type	Code	Retinal eye exam findings
CPT® II	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**
CPT® II	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**
CPT® II	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **with** evidence of retinopathy
CPT® II	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; **without** evidence of retinopathy
CPT® II	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **with** evidence of retinopathy
CPT® II	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **without** evidence of retinopathy

Kidney Evaluation (KED):
Submit a claim for an estimated glomerular filtration rate lab test (eGFR), as well as for both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.

Type	Code	Treatment
CPT®	80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rate Lab Test (eGFR)
CPT®	82043	Quantitative Urine Albumin Test

CPT®	82570	Urine Creatinine Lab Test

Blood Pressure Control (BPD):
Submit blood pressure result CPT® II codes with each office visit claim:

Type	Code	Most recent blood pressure
CPT® II	3074F	Systolic < 130 mm Hg
CPT® II	3075F	Systolic 130–139 mm Hg
CPT® II	3077F	Systolic ≥ 140 mm Hg
CPT® II	3078F	Diastolic < 80 mm Hg
CPT® II	3079F	Diastolic 80–89 mm Hg
CPT® II	3080F	Diastolic ≥ 90 mm Hg

TIPS FOR SUCCESS

Patient Care

- Build care gap alerts in your EHR and address these when diabetic patients have clinical visits.
- Review diabetic services needed at each office visit, including during acute care visits.
- Order labs to be completed prior to patient appointments. Ensure uACR labs (e.g., Quantitative Urine Albumin and Urine Creatinine) are scheduled within four days of each other, and pair with HbA1c testing at the same time to reduce patient travel.
- Evaluate and document HbA1c every three to six months. Establish a process to identify and outreach to patients with HbA1c >9 who have not had a test in more than four months.
- Incorporate a Glucose Management Indicator (GMI) into workflows and EMR programming to assess blood sugar control in between HbA1c tests for patients who use a continuous glucose monitor. Document the estimated average glucose (eAG) from a patient's CGM, along with the date range used, and convert this into an HbA1c value. Providers may find this method more expedient as patients don't have to wait 3-6 months for their next A1c test to determine if their care plan is improving blood sugar control. Additionally, any member of the care team can document the GMI, including through a nursing outreach or telehealth visit, with no labs needed. Details on this conversion can be found at the American Diabetes Association website.
- Evaluate and document blood pressure every one to two months, even if performed through a virtual visit with patient self-reported blood pressure. Establish a process to identify and outreach to patients with blood pressure greater than 140/90 who have not had a new BP reported in more than two months.
- Refer patients to an optometrist or ophthalmologist for dilated retinal eye exam annually and explain why it is different than a screening for glasses or contacts.
- Develop a co-management arrangement with in-house or local eye care to share diabetic eye exam outreach lists for direct appointing.
- Have your patients give their eye care professional our Eye examination report for diabetes form and ask them to return it to you.
- Incorporate a retinal camera in primary care with results interpreted by an optometrist or ophthalmologist.
- Prescribe single-pill combination medications whenever possible to assist with medication compliance.
- Reinforce the importance of low sodium diets, increased physical activity, smoking cessation, and medication adherence at every visit.
- Advise patients not to discontinue blood pressure or diabetes medication before contacting your office.

- Prescribe statin therapy to patients with diabetes age 40 to 75 years.
- Address behavioral health and social determinants of health needs that may be creating barriers to self-management.

Taking Blood Pressure Readings

Share these best practices with your team and with patients who are self-reporting blood pressure readings:

- Have the patient sit quietly for up to 10 minutes before taking the reading.
- Advise the patient not to talk during the measurement.
- Have the patient empty their bladder before taking the reading.
- Do not check blood pressure within 30 minutes of smoking, drinking coffee, or exercising.
- Ensure patients don't cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2- 8 mm Hg.
- Use the proper cuff size.
- Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10-12 mm Hg.
- Take it twice. If the patient has a high blood pressure reading at the beginning of the visit, retake it and record both at the end of the visit. Consider switching arms for subsequent readings.

Documentation and Coding

- Partner with your health plan payers to submit electronic data from your EMR.
- Document medical and surgical history in the medical record with dates in structured fields so your EMR can include these in reporting. This will allow the corresponding code to be included in electronic reporting, including claims, to health plans.
- Code for exclusions such as hospice and palliative care.

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[i] National Committee for Quality Assurance. HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans (2023), 169-206