

# Diabetes Management

## MEASURE DESCRIPTIONS

The percentage of members with diabetes who had the following:

- Glycemic Status Assessment for Patients With Diabetes (GSD): Members 18-75 years of age whose most recent glycemic status (hemoglobin A1c or glucose [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period: Glycemic Status <8.0% or Glycemic Status >9.0%
- Eye Exam for Patients With Diabetes (EED): Members 18-75 years of age who were screened or monitored for diabetic retinal disease. This includes a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement period
- Kidney Health Evaluation for Patients With Diabetes (KED): Members 18-85 years of age who received a kidney health evaluation, defined by both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement period on the same or different dates of service
- Blood Pressure Control for Patients With Diabetes (BPD-E): Members 18-75 years of age whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period<sup>1</sup>

Members with diabetes are identified by either of the following:

- At least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period
- At least one diagnosis of diabetes and at least one diabetes medication dispensing event of insulin or a hypoglycemic antihyperglycemic medication during the measurement period or the year prior to the measurement period

## EXCLUSIONS

Members are excluded if the following apply:

Exclusion	Time frame
<ul style="list-style-type: none"> <li>• Date of death</li> <li>• Hospice or use of hospice services</li> <li>• Palliative care</li> <li>• 66 years of age or older with both frailty and advanced illness; for additional definition information, see the <a href="#">Advanced Illness and Frailty Exclusions Guide</a></li> <li>• Medicare enrollees, 66 years of age and older, in an institutional SNP (I-SNP) or living long-term in an institution (LTI)</li> <li>• <i>KED Only</i> - 81 years of age and older with frailty; for additional definition information, see the <a href="#">Advanced Illness and Frailty Exclusions Guide</a></li> </ul>	Any time during the measurement period
<ul style="list-style-type: none"> <li>• <i>EED Only</i> - Bilateral absence of eyes</li> <li>• <i>EED Only</i> - Bilateral eye enucleation</li> <li>• <i>KED Only</i> - End-stage renal disease (ESRD) or dialysis</li> </ul>	Any time during the member's history through December 31 of the measurement period

## CODING<sup>2</sup>

For exclusions, use the appropriate code:

### Unilateral eye enucleation

CPT®<sup>3</sup> | 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

### ESRD diagnosis

ICD10CM<sup>4</sup> | N18.5, N18.6

### Dialysis procedure

CPT | 90935, 90937, 90945, 90947, 90997, 90999, 99512

HCPCS<sup>5</sup> | G0257, S9339

ICD10PCS | 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

For glycemic status, use the appropriate code:

### HbA1c

CPT II	3044F	< 7.0%
	3051F	≥ 7.0% and < 8.0%
	3052F	≥ 8.0% and ≤ 9.0%
	3046F	> 9.0%

### Glucose management indicator (GMI)

LOINC <sup>6</sup>	97506-0	<p>A GMI value can be documented and shared in data in several ways:</p> <ul style="list-style-type: none"> <li>• Document estimated average glucose (eAG) from a continuous glucose monitor (CGM) in a structured field of the EMR</li> <li>• Use the EMR to convert eAG from a CGM into an A1c value; see conversion details at the American Diabetes Association</li> <li>• Use the EMR to code for LOINC 97506-0 with the value</li> </ul>
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Example	Code	Result	Result Unit
A	97506-0	150	EAG
B	97506-0	7.5	%

For retinal eye exam results, use the appropriate code on a \$0.01 claim when results are received from an optometrist or ophthalmologist:

### Retinal eye exam findings

CPT II	2022F, 2024F, 2026F	Eye exam with evidence of retinopathy
	2023F, 2025F, 2033F	Eye exam without evidence of retinopathy
	3072F	Diabetic retinal screening negative in prior year

### Retinopathy severity level

LOINC	LA18643-9	No apparent retinopathy
	LA18644-7	Mild non-proliferative retinopathy
	LA18645-4	Moderate non-proliferative retinopathy
	LA18646-2	Severe non-proliferative retinopathy
	LA18648-8	Proliferative retinopathy

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, use the appropriate code:

### Kidney evaluations

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

	82570	Urine Creatinine Lab Test
LOINC	102097-3, 50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6	Estimated Glomerular Filtration Rate Lab Test (eGFR)
	100158-5, 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7	Quantitative Urine Albumin Lab Test
	20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5	Urine Creatinine Lab Test
	13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7	Urine Albumin Creatinine Ratio Lab Test

For most recent blood pressure results, excluding those taken in an acute inpatient setting or during an ED visit, use the appropriate code:

#### Blood pressure readings

CPT II	3074F	Systolic < 130 mm Hg
	3075F	Systolic 130–139 mm Hg
	3077F	Systolic ≥ 140 mm Hg
	3078F	Diastolic < 80 mm Hg
	3079F	Diastolic 80–89 mm Hg
	3080F	Diastolic ≥ 90 mm Hg

## TIPS FOR SUCCESS

### General

- Review diabetic services needed at each office visit, including during acute care visits
- Order labs to be completed prior to patient appointments
- Monitor patient adherence to prescribed medications
- Address behavioral health and social determinants of health needs that may be creating barriers to self-management
- Set alerts in your EHR for patients who may need follow-up visits and screenings
- Document medical and surgical history in the medical record with dates in structured fields; this will allow the corresponding code to be included in electronic reporting, including claims, to health plans
- Partner with your health plan payers to submit electronic data from your EMR

### Measure-specific

- Glycemic Status Assessment for Patients With Diabetes (GSD)
  - Evaluate and document HbA1c every three to six months with result date and distinct numeric result
  - If the care team documents both a GMI and an HbA1c, or two GMIs, or two HbA1c values on the same date, use the lowest result; if GMI is documented as “unknown,” this cannot be used

- Incorporate GMI into EMR programming to assess blood sugar control for patients who use a CGM; any care team member can record the GMI and no lab work is required
- Eye Exam for Patients with Diabetes (EED)
  - Develop a co-management arrangement with in-house or local eye care to share diabetic eye exam outreach lists for direct appointment scheduling
  - Incorporate an in-house retinal camera with results interpreted by an optometrist or ophthalmologist
  - Inform patients that a diabetic eye exam is not considered "screening" under the Affordable Care Act and may incur a cost-share
  - Refer patients to an optometrist or ophthalmologist for retinal eye exam annually and explain why it is different than a vision exam
  - Remind patients to let their eye care provider know that they have diabetes; this helps ensure appropriate screening and coding takes place
  - Place eye care reports from eye care providers in the patient's medical record. Ensure the date of service, results, and the eye care professional's name and credentials are included; if the name of the eye care provider is unknown, document that an optometrist or ophthalmologist conducted the exam.
  - 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
- Kidney Health Evaluation for Patients with Diabetes (KED)
  - Document at least one eGFR AND at least one uACR; uACR can be identified by both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart OR a uACR
  - Educate patients about kidney disease to improve management of condition (CKD)
- Blood Pressure Control for Patients with Diabetes (BPD)
  - Prescribe single-pill combination medications whenever possible to assist with medication compliance
  - Encourage blood pressure monitoring at home and ask patients to bring a log of their readings to visits
  - Educate patients on the importance of blood pressure control and the complications that may occur when blood pressure is uncontrolled
  - Reinforce the importance of low sodium diets, increased physical activity, smoking cessation, and medication adherence
  - Ensure team members and patients who are self-reporting are following best practices for taking blood pressure readings, which include:
    - Take it twice; if the patient has a high reading at the beginning of the visit, retake it and record both at the end of the visit or consider switching arms for subsequent readings
    - Have the patient empty their bladder and sit quietly for 10 minutes before taking the reading
    - 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
    - Ensure 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
    - Do not check blood pressure within 30 minutes of smoking, drinking coffee, or exercising
    - Use the proper cuff size
  - Document exact 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
  - If the patient is self-reporting blood pressure, document the date of the reading and that it was self-reported
  - Blood pressure readings can be captured during a telehealth, telephone, e-visit, or virtual visit

**Note:** Tip sheets are regularly reviewed and revised with pertinent technical specification updates from NCQA.

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<sup>1</sup> National Committee for Quality Assurance. HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans (2025), 119-148.

<sup>2</sup> This information is not intended as billing or legal guidance or for creating EMR extract files. These codes are proprietary and do not guarantee payment. Not all codes are included, and coding requirements may change. Each code should be used based on medical necessity and supported by proper documentation in the member record.

<sup>3</sup> CPT ® is a registered trademark of the American Medical Association (AMA).

<sup>4</sup> ICD-10 created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization (WHO). Copyright WHO.

<sup>5</sup> HCPCS codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of Centers for Medicare & Medicaid Services, America's Health Insurance Plans, and the Blue Cross Blue Shield Association).

<sup>6</sup> LOINC codes are created and maintained by Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee.