Special Bulletin

For professional providers **February 21, 2023**

Evidence-Based Recommendations for Members with Both Diabetes and CKD

People with diabetes and chronic kidney disease (CKD) are at risk for kidney failure, atherosclerotic cardiovascular disease, heart failure, and premature mortality.

In 2022, the American Diabetes Association (ADA) and the Kidney Disease: Improving Global Outcomes (KDIGO) organization published evidence-based recommendations[1] for treating patients who have both conditions:

- All patients with type 1 diabetes (T1D) or type 2 diabetes (T2D) and CKD should be treated with a comprehensive plan, outlined and agreed to by health care professionals and the patient together.
- An ACE inhibitor (ACEi) or angiotensin II receptor blocker (ARB) is recommended for patients with T1D or T2D who have hypertension and albuminuria, titrated to the maximum antihypertensive or highest tolerated dose.
- A statin is recommended for all patients with T1D or T2D and CKD, moderate intensity for primary prevention of atherosclerotic cardiovascular disease (ASCVD) or high intensity for patients with known ASCVD and some patients with multiple ASCVD risk factors.
- Metformin is recommended for patients with T2D, CKD, and estimated glomerular filtration rate (eGFR) ≥30 mL/min/1.73 m2; the dose should be reduced to 1,000 mg daily in patients with eGFR 30–44 mL/min/1.73 m2 and in some patients with eGFR 45–59 mL/min/1.73 m2 who are at high risk of lactic acidosis.
- A sodium-glucose cotransporter 2 inhibitor (SGLT2i) with proven kidney or cardiovascular benefit is recommended for patients with T2D, CKD, and eGFR ≥20 mL/min/1.73 m2. Once initiated, the SGLT2i can be continued at lower levels of eGFR.
- A glucagon-like peptide 1 (GLP-1) receptor agonist with proven cardiovascular benefit is recommended for patients with T2D and CKD who do not meet their individualized glycemic target with metformin and/or an SGLT2i or who are unable to use these drugs.
- A nonsteroidal mineralocorticoid receptor antagonist (ns-MRA) with proven kidney and cardiovascular benefit is recommended for patients with T2D, eGFR ≥25 mL/min/1.73 m2, normal serum potassium concentration, and albuminuria (albumin-to-creatinine ratio [ACR] ≥30 mg/g) despite maximum tolerated dose of renin-angiotensin system (RAS) inhibitor.

Overcoming Obstacles to Care

Barriers contributing to suboptimal management of CKD in patients with diabetes include low CKD awareness, complexity of care, adhering to treatment regimens, application of guideline-directed management, and obtaining both a urinary albumin (ACR) or albumin to creatine ratio (UACR) and an estimated blood glomerular filtration rate (eGFR) as part of the diabetes check-up.

ACR/UACR and eGFR testing are both a routine part of a diabetes check-up.

CPT codes:

- eGFR: 80047-80048, 80050, and 80053
- ACR Quantitative Urine Albumin: 82043
- Urine Creatine: 82570

Health care systems should include team-based care for patients and focus on both short-term and long-term treatment plans, with behavior evaluation considered in the initial assessment of patients.

References

[1]Diabetes Management in Chronic Kidney Disease: A Consensus Report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO) | Diabetes Care | American Diabetes Association (diabetesjournals.org).

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