REIMBURSEMENT POLICY STATEMENT
KENTUCKY MEDICAID

Original Issue Date	Next Annual Review	Effective Date
12/01/2017	12/01/2018	02/01/2018
Policy Name		**Policy Number**
Glycosylated Hemoglobin A1C		PY-0158
Policy Type		
Medical / Administrative / Pharmacy		**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Glycosylated Hemoglobin-A1C

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to Humana – CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

Diabetes mellitus is a disease in which the afflicted patient has blood glucose levels above normal. This is caused by the body's inability to make enough insulin in the pancreas or to efficiently use the insulin it does produce. This causes glucose levels to elevate. Over time, elevated glucose levels can lead to very serious medical complications for the patient, including kidney failure, circulatory and nerve problems, heart disease, or blindness.

The management of diabetes requires regular measurements of blood glucose levels. Glycosylated hemoglobin A1c/protein levels are used to determine long-term glucose control in diabetes. Alternative names for these tests include glycated or glycosylated hemoglobin or Hgb, hemoglobin glycated or glycosylated protein, and fructosamine.

Glycated hemoglobin (equivalent to hemoglobin A1) refers to total glycosylated hemoglobin present in erythrocytes, usually determined by affinity or ion-exchange chromatographic methodology. Hemoglobin A1c refers to the major component of hemoglobin A1, usually determined by ion-exchange affinity chromatography, immunoassay or agar gel electrophoresis. Fructosamine or glycated protein refers to glycosylated protein present in a serum or plasma sample. Glycated protein refers to measurement of the component of the specific protein that is glycated usually by colorimetric method or affinity chromatography.

Glycated hemoglobin in whole blood measures glycemic control over a period of 4 to 8 weeks and is generally considered to be the appropriate monitoring test for patients who are capable of maintaining long-term, stable control of their disease. This testing may be medically necessary every 3 months to establish whether or not their glycemic control has been on average within the target range. More frequent testing, every 1 to 2 months, may be necessary in a patient whose diabetes regimen has undergone changes to improve control, or in whom the provider suspects or has evidence that some other disease or condition may have altered a previously satisfactory level of control (example: post-surgery, or as a result of glucocorticoid therapy). Glycated protein in serum/plasma assesses glycemic control over a period of 1 to 2 weeks. Research indicates that it may be reasonable and necessary to monitor glycated protein monthly in pregnant diabetic women. Glycated hemoglobin/protein test results may be low, indicating significant, persistent hypoglycemia, in nesidioblastosis or insulinoma, conditions which are accompanied by inappropriate hyperinsulinemia. A below normal test value is helpful in establishing the patient's hypoglycemic state in those conditions.

1. Indications
   1.1 Glycated hemoglobin/protein testing is widely accepted as medically necessary for the management and control of diabetes. It is also valuable to assess hyperglycemia, a

history of hyperglycemia or dangerous hypoglycemia. Glycated protein testing may be used in place of glycated hemoglobin in the management of diabetic patients, and is particularly useful in patients who have abnormalities of erythrocytes such as hemolytic anemia or hemoglobinopathies.

1.2 The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. This recommendation applies to adults aged 40 to 70 years who are seen in primary care settings and do not have obvious symptoms of diabetes. Persons who have a family history of diabetes, have a history of gestational diabetes or polycystic ovarian syndrome, or are members of certain racial/ethnic groups (that is, African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders) may be at increased risk for diabetes at a younger age or at a lower body mass index. Clinicians should consider screening earlier in persons with one or more of these characteristics.

1.3 The USPSTF recommends screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation, with an evidence grade of B from the literature to support this recommendation.

2. Limitations

2.1 On a controlled diabetic patient, tests for glycated hemoglobin should be administered no more often than every three months to determine whether the patient's metabolic control has been on average within the target range. For diabetic pregnant women, tests should generally be performed no more often than once a month. Testing for uncontrolled type one or two diabetes mellitus may require testing more than four times a year for situations outlined above, and medical necessity documentation must be made available to support such testing.

2.2 Many methods for the analysis of glycated hemoglobin show significant interference from elevated levels of fetal hemoglobin or by variant hemoglobin molecules. When the glycated hemoglobin assay is initially performed in these patients, the laboratory may inform the ordering physician of a possible analytical interference. Alternative testing, including glycated protein, for example, fructosamine, may be indicated for the monitoring of the degree of glycemic control in this situation. It is therefore conceivable that a patient will have both a glycated hemoglobin and glycated protein ordered on the same day. This should be limited to the initial assay of glycated hemoglobin, with subsequent exclusive use of glycated protein. These tests are not considered to be medically necessary for the diagnosis of diabetes.

2.3 The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for GDM in asymptomatic pregnant women before 24 weeks of gestation.

C. POLICY

I. Prior authorization is not required for participating providers for any medically necessary blood glucose testing.

II. Diagnostic tests for blood glucose levels as referred to in this policy are selected laboratory tests. Material related to diagnostic testing in this policy is included to clarify coverage for diagnostic versus screening indications.

III. Humana – CareSource considers screening for diagnosis of diabetes as medically necessary preventive care for these member groups according to the United States Preventive Services Task Force (USPSTF):

A. Members aged 40 to 70 years who are asymptomatic, and overweight or obese;

B. Members of any age or weight who are asymptomatic, in the following high-risk groups:

1. Immediate family history of diabetes;
2. History of gestational diabetes or polycystic ovarian syndrome.

C. Members of any age and weight who are asymptomatic, in the following high-risk groups:
   1. African Americans
   2. American Indians
   3. Alaskan Natives
   4. Asian Americans
   5. Hispanics and Latinos
   6. Native Hawaiians
   7. Native Pacific Islanders

D. Pregnant women who have reached 24 weeks of gestation.

IV. Humana – CareSource considers regular, ongoing testing for the management of diabetes as medically necessary for the following member groups who have previously been diagnosed with diabetes, with the specified frequencies:
   A. Members whose diabetes is controlled, once every 3 months
   B. Members whose diabetes is not controlled, as medically necessary
   C. Pregnant women, once per month

V. Reimbursement is based on submitting a claim with the appropriate ICD-10 diagnosis code to match the thyroid testing CPT code.

VI. If the appropriate ICD-10 diagnosis code is not submitted with the CPT code, the claim will be denied.

Note: Although a Glycosylated Hemoglobin-A1C does not require a prior authorization, Humana – CareSource may request documentation to support medical necessity. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

D. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting Kentucky Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Kentucky Medicaid fee schedule http://chfs.ky.gov/NR/rdonlyres/B4DAB9C3-EF69-4428-A1F0-D9498A104901/0/2017LabFeeSchedulewith2017codesinredfinalupdated022717web.pdf

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.**

Codes	Description
82985	Glycated protein
83036	Hemoglobin; glycated

ICD-10-CM	Description
D13.7	Benign neoplasm of endocrine pancreas
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma

E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
K86.0	Alcohol-induced chronic pancreatitis
K86.1	Other chronic pancreatitis
K91.2	Postsurgical malabsorption, not elsewhere classified
O24.011	Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
O24.012	Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
O24.013	Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester
O24.912	Unspecified diabetes mellitus in pregnancy, second trimester
O99.810	Abnormal glucose complicating pregnancy
R73.01	Impaired fasting glucose
R73.02	Impaired glucose tolerance (oral)
R73.09	Other abnormal glucose
R73.9	Hyperglycemia, unspecified
R79.0	Abnormal level of blood mineral
T38.3X1A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), initial encounter
T38.3X2A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, intentional self-harm, initial encounter
T38.3X3A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, assault, initial encounter
T38.3X4A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, undetermined, initial encounter
Z79.3	Long term (current) use of hormonal contraceptives
Z79.4	Long term (current) use of insulin
Z79.891	Long term (current) use of opiate analgesic
Z79.899	Other long term (current) drug therapy
Z86.2	Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z86.31	Personal history of diabetic foot ulcer
Z86.32	Personal history of gestational diabetes
Z86.39	Personal history of other endocrine, nutritional and metabolic disease

Related to: Hypertension Diagnoses

ICD-10-CM	Description
I10	Essential (primary) hypertension
I11.0	Hypertensive heart disease with heart failure
I11.9	Hypertensive heart disease without heart failure
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I15.0	Renovascular hypertension
I15.1	Hypertension secondary to other renal disorders
I15.2	Hypertension secondary to endocrine disorders
I15.8	Other secondary hypertension
I15.9	Secondary hypertension, unspecified
N26.2	Page kidney
O10.011	Pre-existing essential hypertension complicating pregnancy, first trimester

O10.012	Pre-existing essential hypertension complicating pregnancy, second trimester
O10.013	Pre-existing essential hypertension complicating pregnancy, third trimester
O10.019	Pre-existing essential hypertension complicating pregnancy, unspecified trimester
O10.412	Pre-existing secondary hypertension complicating pregnancy, second trimester
O10.413	Pre-existing secondary hypertension complicating pregnancy, third trimester
O10.419	Pre-existing secondary hypertension complicating pregnancy, unspecified trimester
O13.3	Gestational [pregnancy-induced] hypertension without significant proteinuria, third trimester
O13.9	Gestational [pregnancy-induced] hypertension without significant proteinuria, unspecified trimester
O16.1	Unspecified maternal hypertension, first trimester
O16.2	Unspecified maternal hypertension, second trimester
O16.3	Unspecified maternal hypertension, third trimester
O16.9	Unspecified maternal hypertension, unspecified trimester

Related to: Pregnancy Diagnoses

Codes	Description
Z33.1	Pregnant state, incidental
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z.34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z.34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z36	Encounter for antenatal screening of mother
O09.00	Supervision of pregnancy with history of infertility, unspecified trimester
O09.292	Supervision of pregnancy with other poor reproductive or obstetric history, second trimester
O09.293	Supervision of pregnancy with other poor reproductive or obstetric history, third trimester
O09.299	Supervision of pregnancy with other poor reproductive or obstetric history, unspecified trimester
O09.30	Supervision of pregnancy with insufficient antenatal care, unspecified trimester
O09.31	Supervision of pregnancy with insufficient antenatal care, first trimester

O09.32	Supervision of pregnancy with insufficient antenatal care, second trimester
O09.70	Supervision of high risk pregnancy due to social problems, unspecified trimester
O09.71	Supervision of high risk pregnancy due to social problems, first trimester
O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy, unspecified trimester
O09.891	Supervision of other high risk pregnancies, first trimester
O30.001	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.002	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.009	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.90	Multiple gestation, unspecified, unspecified trimester

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	12/01/2017	New Policy.
Date Revised		
Date Effective	02/01/2018	

G. REFERENCES

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The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.