

REIMBURSEMENT POLICY STATEMENT

Michigan Marketplace

Policy Name & Number	Date Effective
Hemoglobin A1c-MI MP-PY-1526	07/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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.

CareSource 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject	2
B. Background	2
C. Definitions.....	2
D. Policy	2
E. Conditions of Coverage	3
F. Related Policies/Rules	3
G. Review/Revision History	3
H. References	4

A. Subject

Hemoglobin A1c

B. Background

Testing glycated hemoglobin/protein levels are widely accepted as medically necessary for the management and control of diabetes. Glycated hemoglobin A1C/protein levels are used to determine long-term glucose control in diabetes. Glycated hemoglobin levels reflect the average level of glucose in the blood over a three-month period.

C. Definitions

- **Youth** – After the onset of puberty or after 10 years of age, whichever occurs earlier.

D. Policy

- I. Prior authorization is not required for glycated hemoglobin (HbA1c)/protein blood testing.

CPT® Code	Description
82985	Glycated protein
83036	Glycated hemoglobin (HbA1c)

II. Screening

- A. HAP CareSource covers ONE screening test, per calendar year, for the diagnosis of diabetes per member, when medically necessary. This includes but is not limited to:
 1. prediabetes
 2. first-degree relative with diabetes
 3. overweight or obese
 4. member with HIV
- B. For members at risk of metabolic syndrome from prescribed antipsychotic medications, a screening test every 6-12 months will be covered.
- C. For members aged 35 and above with no symptoms of diabetes, one screening test every 3 years will be covered.
- D. For overweight or obese youth with one or more additional risk factors:
 1. maternal history of diabetes or gestational diabetes mellitus (GDM)
 2. family history of type 2 diabetes in first- or second-degree relative
 3. race and ethnicity (eg, Native American, African American, Latino, Asian American, Pacific Islander)
 4. signs of insulin resistance or conditions associated with insulin resistance (eg, acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome)

If tests are normal, one screening test every 3 years will be covered. A screening test may be ordered more frequently if BMI is increasing or risk factor profile is deteriorating.

III. Diagnostic Testing

HAP CareSource considers diagnostic testing for the management of diabetes as medically necessary for the following member groups, with the specified frequencies:

- A. Members whose diabetes is controlled, once every 3 months
- B. Members whose diabetes is not controlled may require testing more than 4 times per calendar year.
- C. Pregnant women, once per month

IV. Alternate testing, including glycated protein, may be indicated for monitoring the degree of glycemic control.

- A. It is therefore conceivable that a Member will have both a glycated hemoglobin and glycated protein ordered on the same day.
- B. This should be limited to the initial assay of glycated hemoglobin, with subsequent exclusive use of glycated protein.
- C. These tests are NOT considered to be medically necessary for the diagnosis of diabetes.

E. Conditions of Coverage

- I. Reimbursement is dependent on, but no limited to, submitting approved HCPCS and CPT® codes, along with appropriate modifiers, if applicable. 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 office staff are encouraged to use self-service channels to verify member's eligibility.
- II. All claims for screening tests must be submitted with applicable screening diagnosis codes for claims to process appropriately.
- III. HAP CareSource may request documentation to support medical necessity if testing exceeds the above guidelines in D. III.

F. Related Policies/Rules

Overpayment Recovery

G. Review/Revision History

DATE		ACTION
Date Issued	09/11/2024	Approved at Committee.
Date Revised	03/26/25	Added D.II.B.; approved at Committee.
Date Effective	07/01/2025	

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

Date Archived		
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H. References

1. American Diabetes Association Professional Practice Committee. Classification and diagnosis of diabetes: standards of medical care in diabetes - 2024. *Diabetes Care*. 2024;47(Supp. 1):S17-S38. doi:10.2337/dc24-S002
2. Hayward RA, Selvin E. Screening for type 2 diabetes mellitus. UpToDate. Updated December 18, 2023. Accessed August 13, 2024. www.uptodate.com
3. Selvin E. Measurements of chronic glycemia in diabetes mellitus. UpToDate. Updated August 12, 2024. Accessed August 13, 2024. www.uptodate.com
4. US Preventive Services Task Force Recommendation Statement: Screening for Prediabetes and Type 2 Diabetes. *JAMA*. 2021;326(8):736-743. doi:10.1001/jama.2021.12531