CareSource

REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name	Policy Number	Effective Date
Glycosylated Hemoglobin A1C	PY-0157	03/01/2020-06/30/2021

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: 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.

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A. Subject

Glycosylated Hemoglobin A1C

B. Background

Reimbursement policies are designed to assist you when submitting claims to 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 in this policy does not imply any right to reimbursement or guarantee claims payment.

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

C. Definitions

- **Glycosylated Hemoglobin (A1C)** – a blood test that measures your average blood sugar levels over the past 3 months. It is one of the commonly used tests to diagnose prediabetes and diabetes.
- **Glycated protein** - a blood test that is used to assess glycemic control over a period of 1-2 weeks and long-term control in diabetic patients with abnormalities of erythrocytes.

D. Policy

I. Prior authorization is not required for glycosylated hemoglobin (A1C)/protein blood testing.

Note: Although CareSource does not require a prior authorization for glycosylated hemoglobin (A1C)/protein blood testing, CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

II. CareSource covers one screening test, per calendar year, for the diagnosis of diabetes per member per calendar year when medically necessary.

Note: All claims for screening tests must be submitted with applicable screening diagnosis codes in order for claims to process appropriately.

Preventive CPT/ICD-10	
CPT Code	**Description**
82985	Glycated protein
83036	Hemoglobin; glycosylated (A1C)

ICD-10	Description
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z13.1	Encounter for screening for diabetes mellitus
Z3A.24 - Z3A.49	Specific weeks gestation of pregnancy
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z68.25 - Z68.45	Specific Body mass index

III. 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 four times a year
C. Pregnant women, once per month

Note: CareSource may request documentation to support medical necessity, if testing is in excess of the above guidelines.

Diagnostic CPT/ICD-10	
CPT Code	**Description**
82985	Glycated protein
83036	Hemoglobin; glycosylated (A1C)
ICD-10	**Description**
D13.7	Benign neoplasm of endocrine pancreas
E08.00 - E08.9	Diabetes mellitus due to underlying condition…
E09.00 - E09.9	Drug or chemical induced diabetes mellitus…
E10.10 - E10.9	Type 1 diabetes mellitus with…
E11.00 - E11.9	Type 2 diabetes mellitus with…
E13.00 - E13.9	Other specified diabetes mellitus with…
E15	Nondiabetic hypoglycemic coma
E16.0	Drug-induced hypoglycemia without coma
E16.1	Other hypoglycemia
E16.2	Hypoglycemia, unspecified
E16.3	Increased secretion of glucagon
E16.4	Increased secretion of gastrin
E16.8	Other specified disorders of pancreatic internal secretion
E16.9	Disorder of pancreatic internal secretion, unspecified
E31.0	Autoimmune polyglandular failure
E31.1	Polyglandular hyperfunction
E31.2	Multiple endocrine neoplasia [MEN] syndromes
E31.20	Multiple endocrine neoplasia [MEN] syndrome, unspecified
E31.21	Multiple endocrine neoplasia [MEN] type I
E31.22	Multiple endocrine neoplasia [MEN] type IIA
E31.23	Multiple endocrine neoplasia [MEN] type IIB
E31.8	Other polyglandular dysfunction

E31.9	Polyglandular dysfunction, unspecified
E74.8	Other specified disorders of carbohydrate metabolism
E79.0	Hyperuricemia without signs of inflammatory arthritis and tophaceous disease
E83.10	Disorder of iron metabolism, unspecified
E83.110	Hereditary hemochromatosis
E83.111	Hemochromatosis due to repeated red blood cell transfusions
E83.118	Other hemochromatosis
E83.119	Hemochromatosis, unspecified
E83.19	Other disorders of iron metabolism
E88.02	Plasminogen deficiency
E89.1	Postprocedural hypoinsulinemia
H44.2E1	Degenerative myopia with other maculopathy, right eye
H44.2E2	Degenerative myopia with other maculopathy, left eye
H44.2E3	Degenerative myopia with other maculopathy, bilateral eye
I21.9	Acute myocardial infarction, unspecified
I21.A1	Myocardial infarction type 2
I21.A9	Other myocardial infarction type
K86.0	Alcohol-induced chronic pancreatitis
K86.1	Other chronic pancreatitis
K91.2	Postsurgical malabsorption, not elsewhere classified
L97.101 - L97.929	Non-pressure chronic ulcer of…
L98.415 - L98.418	Non-pressure chronic ulcer of…
L98.425 - L98.428	Non-pressure chronic ulcer of back…
L98.495	Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis
L98.496	Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis
O24.011 - O24.93	Pre-existing type 1 diabetes mellitus, in pregnancy…
O30.001 - O30.93	Pregnancy…
O99.810	Abnormal glucose complicating pregnancy
O99.815	Abnormal glucose complicating the puerperium
R73.01	Impaired fasting glucose
R73.02	Impaired glucose tolerance (oral)
R73.03	Prediabetes
R73.09	Other abnormal glucose
R73.9	Hyperglycemia, unspecified
R78.71	Abnormal lead level in blood
R78.79	Finding of abnormal level of heavy metals in blood
R78.89	Finding of other specified substances, not normally found in blood
R79.0	Abnormal level of blood mineral
R79.89	Other specified abnormal findings of blood chemistry
R79.9	Abnormal finding of blood chemistry, unspecified
T38.3X1A - T38.3X4A	Poisoning by insulin and oral hypoglycemic…
Z01.812	Encounter for preprocedural laboratory examination
Z79.3	Long term (current) use of hormonal contraceptives
Z79.4	Long term (current) use of insulin

Z79.84	Long term (current) use of oral hypoglycemic drugs
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

IV. Alternative testing, including glycated protein, for example, fructosamine, may be indicated for monitoring the degree of glycemic control.
   A. It is therefore conceivable that a patient 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.

V. Reimbursement is based on submitting a claim with the appropriate ICD-10 diagnosis code to match the CPT code listed within this policy. If the appropriate ICD-10 diagnosis code is not submitted with the CPT code, the claim will be denied.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

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F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	12/01/2017	
Date Revised	10/16/2019	Updated references and diagnosis code list
Date Effective	03/01/2020	
Date Archived	06/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. (2015, October). Retrieved 3/12/2020 from www.uspreventiveservicestaskforce.org.
2. Centers for Medicare and Medicaid Services. (2019). NCD 190.21 - Glycated Hemoglobin/Glycated Protein (190.21). Retrieved 3/12/2020 from www.cms.gov.

3. Gestational Diabetes Mellitus, Screening. (2014, January). Retrieved 3/12/2020 from www.uspreventiveservicestaskforce.org.

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