Glycated Hemoglobin and Glycated Protein Testing

MEDICAL POLICY NUMBER: 267

Effective Date: 8/1/2026

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Next Annual Review: 6/2027

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

I. Glycated hemoglobin (HbA1c, hemoglobin A1c, A1c, or less commonly HbA_{1c}, HgbA1c, Hb1c) may be considered **medically necessary** for either of the following:

   A. Management and control of diabetes; or
   B. To assess hyperglycemia, a history of hyperglycemia or dangerous hypoglycemia.

II. Glycated hemoglobin (HbA1c, hemoglobin A1c, A1c, or less commonly HbA_{1c}, HgbA1c, Hb1c) is considered **not medically necessary** when criterion I. above is not met.

III. Glycated protein testing may be considered **medically necessary** when used in place of glycated hemoglobin in the management of members with diabetes and is particularly useful in members who have abnormalities of erythrocytes such as hemolytic anemia or hemoglobinopathies.

IV. Glycated protein testing is considered **not medically necessary** when criterion II. above is not met.

Link to Policy Summary

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidance resources:

- National Coverage Determination (NCD) for Glycated Hemoglobin/Glycated Protein (190.21)
- NCD Coding Policy Manual and Change Report (ICD-10-CM).[1,2]

BACKGROUND

Glycated Hemoglobin/Protein Measurement

The management of diabetes mellitus requires regular determinations of blood glucose levels. Glycated hemoglobin/protein levels are used to assess 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 assesses glycemic control over a period of 4-8 weeks and appears to be the more appropriate test for monitoring a patient who is capable of maintaining long-term, stable control. Measurement may be medically necessary every 3 months to determine whether a patient's metabolic control has been on average within the target range. More frequent assessments, every 1-2 months, may be appropriate in the patient whose diabetes regimen has been altered to improve control or in whom evidence is present that intercurrent events may have altered a previously satisfactory level of control (for example, post-major surgery or as a result of glucocorticoid therapy). Glycated protein in serum/plasma assesses glycemic control over a period of 1-2 weeks. 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.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

POLICY SUMMARY

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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.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

The following CPT/HCPCS codes are considered not covered when billed with one of the ICD-10 codes that Medicare has included as not medically necessary in the most recent Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM). Available for download at: Lab NCDs – ICD-10. Select the "Lab Code List ICD10 (ZIP)" file option that aligns with the date services were or will be rendered from the Downloads section. Open a spreadsheet and look for NCD 190.12 in column A. This resource can also be accessed directly from the NCD noted above, under "Revision History" and by selecting the applicable "Covered Code List" version. While these services do not require

prior authorization, utilization may be subject to audit and all criteria from NCD 190.12 must be met. Thus, inclusion of a diagnosis (ICD-10) code on this list may not warrant automatic coverage.

CODES*		
CPT	82985	Glycated protein
	83036	Hemoglobin; glycosylated (A1C)

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Centers for Medicare & Medicaid (CMS). National Coverage Determination (NCD) for Serum Iron Studies (190.18). Effective Date of this Version: 11/25/2002. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=90. Accessed 5/27/2026.
2. Centers for Medicare & Medicaid Services. Lab NCDs - ICD-10. April 2020 Lab Code List ICD-10 (ZIP). https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10. Accessed 5/27/2026.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
8/2023	Annual update. No changes
8/2024	Annual update. No changes.
8/2025	Annual update. Add allowed diagnosis code to configuration.
8/2026	Annual update. Add allowed diagnosis code to configuration.