


MEDICAL POLICY	Glycated Hemoglobin and Glycated Protein Testing (All Lines of Business Except Medicare)
Effective Date: 8/1/2022	Medical Policy Number: 267
 8/1/2022	Medical Policy Committee Approved Date: 05/2021; 2/2022; 7/2022
Medical Officer	Date

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

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

APPLIES TO:

All lines of business except Medicare

BENEFIT APPLICATION

Medicaid 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.

POLICY CRITERIA

Note: The following policy criteria are based on the Centers for Medicare & Medicaid (CMS) National Coverage Determination (NCD) for Glycated Hemoglobin/Glycated Protein (190.21) and the Medicare NCD Coding Policy Manual and Change Report (ICD-10-CM).^{1,2}

- I. Glycated hemoglobin (HbA1c, hemoglobin A1c, A1c, or less commonly HbA_{1c}, HgbA1c, Hb1c) may be considered **medically necessary** for any of the following:
 - A. Management and control of diabetes; or
 - B. To assess hyperglycemia, a history of hyperglycemia or dangerous hypoglycemia.

- II. Glycated protein testing may be considered **medically necessary** when used in place of glycated hemoglobin in the management of diabetic patients, and is particularly useful in

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patients who have abnormalities of erythrocytes such as hemolytic anemia or hemoglobinopathies.

Link to [Policy Summary](#)

BILLING GUIDELINES

The following CPT/HCPCS codes are covered when billed with one of the ICD-10 codes included 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 *April 2021 Lab Code List ICD-10 (ZIP)* from the Downloads section. Open either document and look for NCD 190.21 in column A.

CPT/HCPCS CODES

All Lines of Business Except Medicare	
No Prior Authorization Required	
82985	Glycated protein
83036	Hemoglobin; glycosylated (A1C)

DESCRIPTION

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

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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.

POLICY SUMMARY

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.

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 Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

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.

REGULATORY STATUS

Mental Health Parity Statement

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.

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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 6/21/2022.
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 6/21/2022.