Medicare Local Coverage Determination Policy

HbA1c

CPT: 83036 (Hemoglobin; Glycosylated A1C), M1211 (Most Recent Hemoglobin A1C Level > 9.0%)

CMS Policy for Alabama, Georgia, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

Hemoglobin A1c (HbA1c) refers to the major component of hemoglobin A1, *usually determined by ion-exchange affinity chromatography, immunoassay or agar gel electrophoresis*. HbA1c *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)*.

HbA1c is widely accepted as medically necessary for the management and control of diabetes. Performance of the HbA1c test at least two times a year in patients who are meeting treatment goals and who have stable glycemic control is supported by the *American Diabetes Association Standards of Medical Care in Diabetes - 2016* (ADA Standards)[1] . For beneficiaries with stable glycemic control (defined as two consecutive HbA1c results meeting the treatment goals) performing the HbA1c test at least two times a year may be considered reasonable and necessary. The ADA framework for considering treatment goals recognizes that “patient characteristics/health status” are important factors when considering glycemic goals.[2] Beneficiaries eligible for the Medicare home health benefit, for example, often have multiple coexisting chronic illnesses that would support a higher target goal for the HbA1c (e.g., < 8.5%) in order to avoid adverse events (e.g., hypoglycemia-related emergency department visits and acute inpatient hospitalization). *It is also valuable to assess hyperglycemia, a history of hyperglycemia or dangerous hypoglycemia. It is not considered reasonable and necessary to perform HbA1c tests more often than once every three months on a controlled diabetic patient to determine whether the patient's metabolic control has been, on average, within the target range. It is not considered reasonable and necessary for these tests to be performed more frequently than once a month for diabetic pregnant women*.

Testing for uncontrolled type one or two diabetes mellitus (or other causes of severe hyper or hypoglycemia) *may require testing more than four times a year*. Palmetto GBA will allow one additional HbA1c test every three months for a total of 8 tests per year in patients with uncontrolled blood glucose levels. Additional tests beyond that frequency may be reimbursed on appeal with appropriate documentation of medical necessity.

HbA1c may be inaccurate in certain situations including anemia, transfusions, hemoglobinopathies and conditions of rapid red cell turnover. Other tests to assess diabetes, including glucose, glycated protein, or fructosamine levels, may be used and are described in the Lab National Coverage Determination 190.21 (NCD for Glycated Hemoglobin / Glycated Protein). This NCD lists the ICD-10 codes for HbA1c for frequencies up to once every three months. The ICD-10-CM codes for test frequencies exceeding once every 3 months are listed below.

Utilization Guidelines

A. Up to one additional test per 3 month period for Diabetes Mellitus out of control (Group 1).

B. Up to one monthly test for pregnant Type I diabetic patients (Group 3).

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There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**

Code	Description
Group 1	**ICD-10 codes for performing tests at frequencies more than every 3 months. The following codes indicate or imply a condition of hyperglycemia and may be billed alone on the claim.**
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.9	Type 2 diabetes mellitus without complications
Group 2	**The following codes do not, in and of themselves, indicate uncontrolled diabetes and must be used in conjunction with a Group 1 code that indicates a current state of uncontrolled diabetes (hyperglycemia). Secondary (Dual) Diagnoses.**
E11.69	Type 2 diabetes mellitus with other specified complication
R73.01	Impaired fasting glucose
R73.03	Prediabetes
R73.09	Other abnormal glucose
R73.9	Hyperglycemia, unspecified
Group 3	**ICD-10 codes related to pregnancy and can be covered no more frequently than once per month.**
O24.119	Pre-existing type 2 diabetes mellitus, in pregnancy, unspecified trimester

Visit QuestDiagnostics.com/MLCP to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov ▶

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Disclaimer:
This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Quest Diagnostics does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.