RB.022.C Rapid Hemoglobin A1c (HbA1c) Testing

Original Implementation Date : 12/16/2021
Version [C] Date : 3/13/2023
Last Reviewed Date: 3/6/2023

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans lines of business unless noted below.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

Jefferson Health Plans considers Rapid hemoglobin A1c (HbA1c) testing eligible for reimbursement consideration up to 4 times per calendar year when the following criteria are met:

- The test is performed in a Physician's office or clinic setting.
- The device used has been approved by the Food and Drug Administration (FDA) to quantitatively measure the percent Hemoglobin A1c in blood.
- The test is being utilized as a screening measure to diagnose or manage diabetes.
- The member must have a diabetes diagnosis.

POLICY GUIDELINES

1. Prior authorization is not required for participating providers for any medically necessary blood glucose testing.

   NOTE: Although rapid hemoglobin A1c (HbA1c) testing covered by this policy does not require prior authorization, Jefferson Health Plans may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

2. CPT code 83036 should be used to report Rapid Hemoglobin A1c (HbA1c) Testing

3. A diabetes diagnosis must be submitted on the claim.
4. When a provider bills 83036, they must also report one of the following Cat II codes: 3046F, 3051F, 3052F or 3044F.
5. Accepted place of service codes includes: (11), (19), (22), (49), (50).
6. Cost sharing will not apply.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT Code	Description
83036	Hemoglobin; glycosylated (A1C)

Cat II Codes	Description
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)

3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)

HCPCS Code	Description
N/A	

ICD-10 Codes	Description
N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the members' benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

Periodic fasting, laboratory testing, and assessment of self-monitored blood glucose values are essential in the management of diabetic patients. The glycated hemoglobin (HbA1c) is equally important for measuring blood glucose control over time. The HbA1c level is directly proportional to the concentration of glucose over approximately two to three months.

Hemoglobin A1c is typically drawn in a clinical laboratory through venipuncture. However, these results are often not available for two to three days. Several different rapid glycated hemoglobin (HbA1c or A1c) measurement systems also known as, point of care devices, allow HbA1c measurements in the office or clinic. The device displays a digital A1c reading within five minutes of a finger-prick of blood.

CODING

N/A.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by Jefferson Health Plans to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2023 review. Policy and Guidelines sections were revised for clarity purposes.	C	3/13/2023
Effective 1/1/2022 a statement was added to the policy guidelines section for Category II codes. Coding section updated to remove diagnosis codes and add Category II codes.	B	1/1/2022
This is a new policy.	A	11/1/2021

REFERENCES

N/A.