REIMBURSEMENT POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Hemoglobin A1c-TrueCare-PY-1584	07/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Hemoglobin A1c

B. Background
Testing glycated hemoglobin/protein levels are widely accepted as medically necessary for the management and control of diabetes. Glycated hemoglobin A1C/protein levels are used to determine long-term glucose control in diabetes. Glycated hemoglobin levels reflect the average level of glucose in the blood over a 3-month period.

C. Definitions
- **Youth** – After the onset of puberty or after 10 years of age, whichever occurs earlier.

D. Policy
I. A review of medical necessity is not required for glycated hemoglobin (HbA1c)/protein blood testing.

CPT® Code	Description
82985	Glycated protein
83036	Glycated Hemoglobin (HbA1c)

II. Screening
A. TrueCare covers 1 screening test per calendar year for the diagnosis of diabetes per member, when medically necessary. This includes, but is not limited to:
1. prediabetes
2. first-degree relative with diabetes
3. overweight or obese
4. member with HIV

B. For members at risk of metabolic syndrome from prescribed antipsychotic medications, a screening test every 6-12 months will be covered.

C. For members aged 35 and above and with no symptoms of diabetes, 1 screening test every 3 years will be covered.

D. For youth who are overweight or obese AND have 1 or more additional risk factors:
1. maternal history of diabetes or gestational diabetes mellitus (GDM)
2. family history of type 2 diabetes in first- or second-degree relative
3. race and ethnicity (eg, Native American, African American, Latino, Asian American, Pacific Islander)
4. signs of insulin resistance or conditions associated with insulin resistance (eg, acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome)

If tests are normal, 1 screening test every 3 years will be covered. A screening test may be ordered more frequently if BMI is increasing or risk factor profile is deteriorating.

III. Diagnostic Testing
TrueCare considers diagnostic testing for the management of diabetes as medically necessary for the following member groups with the specified frequencies:
A. Members with controlled diabetes, once every 3 months.
B. Members with uncontrolled diabetes may require testing more than 4 times per calendar year.
C. Pregnant women, once per month.

IV. Alternate testing, including glycated protein, may be indicated for monitoring the degree of glycemic control.
A. It is therefore conceivable that a member 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 dependent 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

I. Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT® codes, along with appropriate modifiers, if applicable. 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.

II. All claims for screening tests must be submitted with applicable screening diagnosis codes for claims to process appropriately.

III. TrueCare may request documentation to support medical necessity if testing exceeds the above guidelines.

F. Related Policies/Rules

Overpayment Recovery

G. Review/Revision History

	DATE	ACTION
Date Issued	03/12/2025	Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived		

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

H. References

1. American Diabetes Association Professional Practice Committee. Classification and diagnosis of diabetes: standards of medical care in diabetes - 2024. *Diabetes Care*. 2024;47(Supp. 1):S17-S38. doi:10.2337/dc24-S002
2. Hayward RA, Selvin E. Screening to type 2 diabetes mellitus. UpToDate. Updated December 13, 2023. Accessed December 26, 2024. www.uptodate.com
3. Selvin E. Measurements of chronic glycemia in diabetes mellitus. UpToDate. Updated November 18, 2024. Accessed December 26, 2024. www.uptodate.com
4. US Preventive Services Task Force Recommendation Statement: Screening for Prediabetes and Type 2 Diabetes. *JAMA*. 2021;326(8):736-743. doi:10.1001/jama.2021.12531

Approved by DOM 04/14/2025