Corporate Medical Policy

Hemoglobin A1c AHS – G2006

File Name: hemoglobin_a1c
Origination: 01/01/2019
Last CAP Review: 02/2020
Next CAP Review: 02/2021
Last Review: 2/2020

Description of Procedure or Service

Glycated hemoglobin results from post-translational attachment of glucose to the hemoglobin in red blood cells at a rate dependent upon the prevailing blood glucose concentration. Therefore, their levels correlate well with glycemic control over the previous 8 to 12 weeks (McCulloch, 2017b). The measurement of hemoglobin A1c is recommended for diabetes management, including screening, diagnosis, and monitoring for diabetes and prediabetes (ADA, 2017).

Diabetes describes several heterogeneous diseases in which various genetic and environmental factors can result in the progressive loss of β-cell mass and/or function that manifests clinically as hyperglycemia (Skyler et al., 2017).

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for measurement of hemoglobin A1c when it is determined the medical criteria or reimbursement guidelines below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member’s benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When measurement of hemoglobin A1c is covered

1. Reimbursement for measurement of hemoglobin A1c is allowed for individuals with a diagnosis of either Type 1 or Type 2 diabetes as follows:
   a) Upon initial diagnosis to establish a baseline value and to determine treatment goals.
   b) Twice a year (every 6 months) in individuals who are meeting treatment goals and who, based on daily glucose monitoring, appear to have stable glycemic control.
   c) Quarterly in individuals who are not meeting treatment goals for glycemic control.
   d) Quarterly in individuals whose pharmacologic therapy has changed.
2. Reimbursement for measurement of hemoglobin A1c is allowed to help in detection and diagnosis of pre-diabetes or Type 2 diabetes in the following populations once every three years:
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a) Asymptomatic individuals who are overweight or obese as defined by the ADA (BMI >25 kg/m2 or BMI >23 kg/m2 in Asian Americans) and who have one or more of the following risk factors:
   i. First degree relative with diabetes; OR
   ii. High-risk race/ethnicity (e.g., African American, Latino or Hispanics, Native American, Asian American, Pacific Islanders); OR
   iii. History of cardiovascular disease; OR
   iv. Hypertension (≥140/90 mmHg or on therapy for hypertension); OR
   v. HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L); OR
   vi. Women with polycystic ovary syndrome; OR
   vii. Physical inactivity; OR
   viii. Other clinical conditions associated with insulin resistance (e.g. Severe obesity, acanthosis nigricans)

b) Women who were previously diagnosed with gestational diabetes

3. Reimbursement is allowed once per year in pre-diabetic individuals, to screen for type 2 diabetes using either a fasting plasma glucose test or hemoglobin A1c test.

4. Reimbursement is allowed once every 3 years for diabetes screening with a hemoglobin A1c determination in children (age 10 years and older OR after the onset of puberty, whichever occurs earlier) with the following characteristics:
   i. Overweight or obese as defined by ADA (BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120% of ideal for height); AND
   ii. Must have one or more of the following additional risk factors:
   iii. Maternal history of diabetes or gestational diabetes mellitus during the child’s gestation; OR
   iv. Family history of type 2 diabetes in first- or second-degree relative; OR
   v. High-risk race/ethnicity (e.g., African American, Latino or Hispanics, Native American, Asian American, Pacific Islanders); OR
   vi. Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, or small-for-gestational-age birth weight)

5. Reimbursement is allowed once per month during pregnancy for measurement of hemoglobin A1c for pregnant individuals.

When measurement of hemoglobin A1c is not covered

Reimbursement is not allowed for measurement of hemoglobin A1c in the following circumstances:

a. in individuals who have been transfused within the past 120 days; OR
b. in individuals with a condition associated with increased red blood cell turnover, such as sickle cell disease, hemodialysis, recent blood loss or transfusion, or erythropoietin therapy; OR
c. in conjunction with measurement of fructosamine; OR
d. to diagnose the acute onset of type 1 diabetes in individuals with symptoms of hyperglycemia; OR
e. as a screening test for cystic fibrosis-related diabetes.

Policy Guidelines

Diabetes is a major health concern in the United States. According to the American Diabetes Association (2017):

- Prevalence: In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes. Approximately 1.25 million American children and adults have type 1 diabetes.
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- Undiagnosed: Of the 29.1 million, 21.0 million were diagnosed, and 8.1 million were undiagnosed.
- Prevalence in seniors: The percentage of Americans age 65 and older remains high, at 25.9%, or 11.2 million seniors (diagnosed and undiagnosed).
- New Cases: 1.4 million Americans are diagnosed with diabetes every year.
- Prediabetes: In 2012, 86 million Americans age 20 and older had prediabetes; this is up from 79 million in 2010.
- Deaths: Diabetes remains the 7th leading cause of death in the United States in 2010, with 69,071 death certificates listing it as the underlying cause of death, and a total of 234,051 death certificates listing diabetes as an underlying or contributing cause of death.
- Multiple comorbidities such as cardiovascular disease (including hyperlipidemia, coronary artery disease, and stroke), renal disease, chronic renal insufficiency, dialysis and transplantation, infections, malignancy, and functional impairment are associated with uncontrolled diabetes.
- Total economic cost of diabetes care in the United States: $245 billion,5 accounting for more than 1 in 5 of all health care dollars spent.

Diabetes can be classified into the following general categories (ADA, 2017):
1. Type 1 diabetes (due to autoimmune β-cell destruction, usually leading to absolute insulin deficiency)
2. Type 2 diabetes (due to a progressive loss of β-cell insulin secretion frequently on the background of insulin resistance)
3. Gestational diabetes mellitus (GDM) (diabetes diagnosed in the second or third trimester of pregnancy that was not clearly overt diabetes prior to gestation)
4. Specific types of diabetes due to other causes, e.g., monogenic diabetes syndromes (such as neonatal diabetes and maturity-onset diabetes of the young [MODY]), diseases of the exocrine pancreas (such as cystic fibrosis), and drug- or chemical-induced diabetes (such as with glucocorticoid use, in the treatment of HIV/AIDS, or after organ transplantation)

The diagnosis of diabetes mellitus is easily established when a patient presents with classic symptoms of hyperglycemia, which include polyuria, polydipsia, nocturia, blurred vision, and, infrequently, weight loss. The frequency of symptomatic diabetes has been decreasing in parallel with improved efforts to diagnose diabetes earlier through screening. Increasingly, the majority of patients are asymptomatic, and hyperglycemia is noted on routine laboratory evaluation, prompting further testing (McCulloch, 2017a).

Diabetes can be diagnosed based on plasma glucose criteria, either the fasting plasma glucose (FPG) or the 2-h plasma glucose (2-h PG) value after a 75-g oral glucose tolerance test (OGTT) or A1C criteria (1.6) (ADA, 2017).

Glycated hemoglobin A1c (HbA1c) testing plays a key role in the management of diabetes. Guidelines on HbA1c testing frequency and treatment modifications aim at supporting the achievement of glycemic targets. However, low adherence to these recommendations among adult patients with type 2 diabetes has been reported. Even when no clear explanation has been found as to why this is the case, the rapid availability of HbA1c testing results has been shown to facilitate diabetes management (Schnell, Crocker, & Weng, 2016).

Analytical Validity
The International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) Working Group on HbA1c Standardization has developed a reference measurement system and the measurement of HbA1c is currently well standardized (Hoelzel et al., 2004), and a sound reference system is in place to ensure continuity and stability of the analytical validity of HbA1c measurement (Weykamp et al., 2008). In contrast, plasma glucose concentration remains difficult.
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to assay with consistent accuracy (Gambino, 2007). HbA1c has greater analytical stability (consistency with repetitive sample testing) and less day-to-day variability than either the fasting plasma glucose (FPG) or 2-h PG (Petersen, Jorgensen, Brandslund, De Fine Olivarius, & Stahl, 2005; Rohlfing et al., 2002). For any given individual, the HbA1c exhibits little short-term biologic variability; its coefficient of variation (CV) is 3.6%, compared to FPG (CV of 5.7%) and 2-h PG (CV of 16.6%) (Malkani & Mordes, 2011; Selvin, Crainiceanu, Brancati, & Coresh, 2007).

Clinical Validity
A1C, FPG, and 2-h PG measure different aspects of glycemia and are frequently discordant for diagnosing diabetes. A1C ≥6.5% identifies fewer individuals as having diabetes than glucose-based criteria, however, a recent study concluded that 12% of patients can be misclassified with respect to diabetes diagnosis due to laboratory instrument error in measuring glucose (Miller et al., 2008). The New Hoorn Study analyzed the diagnostic properties of the A1C, using OGTT as the diagnostic criterion (van ’t Riet et al., 2010). The analysis suggested that an A1C of 5.8% had a sensitivity of 72% and specificity of 91%. This compares with specificity of 24% and sensitivity of 99% for the A1C cut-point of 6.5%. On the other hand, the 6.5% cutpoint had a positive predictive value of 93%, compared with a positive predictive value of only 24% for a cut-point of 5.8% (Malkani & Mordes, 2011).

Clinical Utility
The HbA1c assay provides information about the degree of long-term glucose control (Nathan, Singer, Huxthal, & Goodson, 1984), and has been recommended for the diagnosis and monitoring of diabetes (ADA, 2010; IEC, 2009). Long term blood sugar control has been associated with decreased risk of retinopathy, nephropathy, neuropathy, and cardiovascular disease, peripheral arterial, cerebrovascular disease (Hanssen, Bangstad, Brinchmann-Hansen, & Dahl-Jorgensen, 1992) and myocardial fibrosis in adults with diabetes (Al-Badri et al., 2018). Higher HbA1c variability has been associated with higher all-cause mortality in patients with Type 2 Diabetes (Gu et al., 2018).

A1C may not accurately reflect levels of glycemia in some situations, but in comparison with glucose measurements, it has greater analytic stability and less temporal variability. When choosing a diagnostic test for diabetes, the limitations of each choice must be understood. Clinical judgment and consideration of patient preference are required to appropriately select among the diagnostic alternatives (Malkani & Mordes, 2011)

The GOAL study (Al Mansari et al., 2018) used A1c to assess diabetes control in a real-world practice study aimed to assess predictive factors for achieving the glycemic hemoglobin A1c (HbA1c) at 6 months as targeted by the treating physician in adults with type 2 diabetes.

Applicable Federal Standards
Not applicable.

Guidelines and Recommendations
The American Diabetes Association
The American Diabetes Association (ADA) publishes an extensive yearly guideline encompassing the standards of medical care in diabetes (2018c). The 2018 recommendations state:

Screening for and diagnosis of diabetes (ADA, 2018a):
Criteria for testing for diabetes or prediabetes in asymptomatic adult:
Testing should be considered in overweight or obese (BMI ≥25 kg/m² or ≥23 kg/m² in Asian Americans) adults who have one or more of the following risk factors:
- First-degree relative with diabetes
- High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
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- History of CVD
- Hypertension (≥140/90 mmHg or on therapy for hypertension)
- HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
- Women with polycystic ovary syndrome
- Physical inactivity
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

Patients with prediabetes (A1C ≥5.7% [39 mmol/mol], IGT, or IFG) should be tested yearly.

Women who were diagnosed with GDM should have lifelong testing at least every 3 years.

For all other patients, testing should begin at age 45 years.

If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

Diabetes may be diagnosed based on plasma glucose criteria, either the fasting plasma glucose (FPG) or the 2-h plasma glucose (2-h PG) value after a 75-g oral glucose tolerance test (OGTT) or A1C criteria where A1C ≥6.5% (48 mmol/mol). “The [A1C] test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay… In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing (ADA, 2018a).”

- To avoid misdiagnosis or missed diagnosis, the A1C test should be performed using a method that is certified by the NGSP and standardized to the Diabetes Control and Complications Trial (DCCT) assay. Grade B
- Marked discordance between measured A1C and plasma glucose levels should raise the possibility of A1C assay interference due to hemoglobin variants (i.e., hemoglobinopathies) and consideration of using an assay without interference or plasma blood glucose criteria to diagnose diabetes. Grade B
- In conditions associated with increased red blood cell turnover, such as sickle cell disease, pregnancy (second and third trimesters), hemodialysis, recent blood loss or transfusion, or erythropoietin therapy, only plasma blood glucose criteria should be used to diagnose diabetes. Grade B

For management of diabetes:
“The A1C test should be performed using a method that is certified by the NGSP (www.ngsp.org) and standardized or traceable to the Diabetes Control and Complications Trial (DCCT) reference assay. Although point-of-care A1C assays may be NGSP certified, proficiency testing is not mandated for performing the test, so use of point-of-care assays for diagnostic purposes is not recommended but may be considered in the future if proficiency testing is performed, documented, and deemed acceptable (ADA, 2018a).”

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control).
- Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals.
- Point-of-care testing for A1C provides the opportunity for more timely treatment changes.

Children & Adolescents (ADA, 2018b)
The majority of patients diagnosed with autoimmune type 1 diabetes is under the age of 18. “The provider must consider the unique aspects of care and management of children and adolescents with type 1 diabetes, such as changes in insulin sensitivity related to physical growth and sexual maturation, ability to provide self-care, supervision in the child care and school environment, and
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neurological vulnerability to hypoglycemia and hyperglycemia in young children, as well as possible adverse neurocognitive effects of diabetic ketoacidosis (DKA)."

The recommendations concerning hemoglobin A1c for children and adolescents are as follows:

- An A1C goal of <7.5% (58 mmol/mol) is recommended across all pediatric age-groups. Grade E
- Fasting plasma glucose, 2-h plasma glucose during a 75-g oral glucose tolerance test, and A1C can be used to test for prediabetes or diabetes in children and adolescents. Grade B
- Although A1C is not recommended for diagnosis of diabetes in children with cystic fibrosis or symptoms suggestive of acute onset of type 1 diabetes and only A1C assays without interference are appropriate for children with hemoglobinopathies, ADA continues to recommend A1C for diagnosis of type 2 diabetes in this population (ungraded)

Concerning screening of asymptomatic children and adolescents (under the age of 18) for type 2 diabetes or prediabetes, the ADA recommends the following (ADA, 2018a):

- Criteria: Overweight (BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120% of ideal for height) Grade A
- Plus, one or more additional risk factors based on the strength of their association with diabetes as indicated by evidence grades:
  - Maternal history of diabetes or GDM during the child's gestation-Grade A
  - Family history of type 2 diabetes in first- or second-degree relative-Grade A
  - Race/ethnicity (Native American, African American, Latino, Asian American, Pacific Islander)-Grade A
  - Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, or small-for-gestational-age birth weight)-Grade B

The American College of Physicians

The ACP published guidelines (Qaseem et al., 2018) for glycemic control based on A1c which state:

Guidance Statement 1:
Clinicians should personalize goals for glycemic control in patients with type 2 diabetes on the basis of a discussion of benefits and harms of pharmacotherapy, patients’ preferences, patients’ general health and life expectancy, treatment burden, and costs of care.

Guidance Statement 2:
Clinicians should aim to achieve an HbA1c level between 7% and 8% in most patients with type 2 diabetes.

Guidance Statement 3:
Clinicians should consider deintensifying pharmacologic therapy in patients with type 2 diabetes who achieve HbA1c levels less than 6.5%.

The United States Preventive Services Task Force

Screening for Abnormal Blood Glucose and Type 2 Diabetes Mellitus (USPSTF, 2017)

Population Adults aged 40 to 70 years who are overweight or obese

Recommendation Screen for abnormal blood glucose. Offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

Grade: B
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Risk assessment
Risk factors for abnormal glucose metabolism include overweight and obesity or a high percentage of abdominal fat, physical inactivity, and smoking. Abnormal glucose metabolism is also frequently associated with other cardiovascular risk factors, such as hyperlipidemia and hypertension.

Screening tests
Glucose abnormalities can be detected by measuring hemoglobin A1C or fasting plasma glucose or with an oral glucose tolerance test. Diagnosis of IFG, IGT, or type 2 diabetes should be confirmed with repeated testing (the same test on a different day is the preferred method of confirmation).

Screening interval
Evidence on the optimal rescreening interval for adults with an initial normal glucose test is limited. Studies suggest that rescreening every 3 years may be a reasonable approach.

World Health Organization
The 2006 World Health Organization (WHO) criteria define diabetes as an FPG \( \geq 126 \text{ mg/dL} \) (7.0 mmol/L) or a two-hour, post-OGTT value \( \geq 200 \text{ mg/dL} \) (11.1 mmol/L). In 2011, the WHO concluded that an A1C value of \( \geq 6.5 \) percent (48 mmol/mol) can be used as a diagnostic test for diabetes. The Global Report on Diabetes (WHO, 2016) states that: “Glycated haemoglobin (HbA1c) is the method of choice for monitoring glycaemic control in diabetes. An advantage of using HbA1c is that the patient does not need to be in a fasting state. Ideally it should be measured twice a year in people with type 2 diabetes and more frequently in those with type 1 diabetes. However, HbA1c testing is more costly than glucose measurement, and therefore less readily available. If HbA1c testing is not available, fasting or post-meal blood glucose is an acceptable substitute.”

The National Academy of Clinical Biochemistry
The National Academy of Clinical Biochemistry guidelines (NACB, 2011) state:
Laboratories should use only Hb A1c assay methods that are certified by the National Glycohemoglobin Standardization Program (NGSP) as traceable to the DCCT reference. The manufacturers of Hb A1c assays should also show traceability to the IFCC reference method.

Laboratories that measure Hb A1c should participate in a proficiency-testing program, such as the College of American Pathologists (CAP) Hb A1c survey, that uses fresh blood samples with targets set by the NGSP Laboratory Network.

Hb A1c testing should be performed at least biannually in all patients and quarterly for patients whose therapy has changed or who are not meeting treatment goals.

Hb A1c may be used for the diagnosis of diabetes, with values >6.5% being diagnostic. An ngsp-certified method should be performed in an accredited laboratory. Analogous to its use in the management of diabetes, factors that interfere with or adversely affect the Hb A1c assay will preclude its use in diagnosis.

Point-of-care Hb A1c assays are not sufficiently accurate to use for the diagnosis of diabetes.

American Academy of Family Physicians
The AAFP published the revised Summary of Recommendations for Clinical Preventive Services in 2017 that stated that “the AAFP recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. The AAFP noted that “glucose abnormalities can be detected by measuring HgbA1c, fasting plasma glucose, or oral glucose tolerance test. Abnormal results should be confirmed.” The AAFP
further stated that “there is limited evidence on the best rescreening interval for adults with normal results, but screening every 3 years is a reasonable option.”

**American Association of Clinical Endocrinologists/ American College of Endocrinology**

The 2018 Consensus statement from the AACE/ACE on the Management of Type 2 Diabetes states:

The hemoglobin A1C (A1C) target should be individualized based on numerous factors such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation, and adherence. An A1C level of ≤6.5% is considered optimal if it can be achieved in a safe and affordable manner, but higher targets may be appropriate for certain individuals and may change for a given individual over time.

Therapy must be evaluated frequently (e.g., every 3 months) until stable using multiple criteria, including A1C, SMBG records (fasting and postprandial) or continuous glucose monitoring tracings, documented and suspected hypoglycemia events, lipid and BP values, adverse events (weight gain, fluid retention, hepatic or renal impairment, or CVD), comorbidities, other relevant laboratory data, concomitant drug administration, complications of diabetes, and psychosocial factors affecting patient care. Less frequent monitoring is acceptable once targets are achieved.

The 2015 guidelines (Garber et al., 2015) on screening for diabetes state:

There is a continuum of risk for poor health outcomes in the progression from normal glucose tolerance to overt T2D. Screening should be considered in the presence of risk factors for DM (Grade C; BEL 3). Individuals at risk for DM whose glucose values are in the normal range should be screened every 3 years; clinicians may consider annual screening for patients with 2 or more risk factors (Grade C; BEL 3).

The following criteria may be used to diagnose DM (Grade B; BEL 3):
- FPG concentration (after 8 or more hours of no caloric intake) ≥126 mg/dL, or
- Plasma glucose concentration ≥200 mg/dL 2 hours after ingesting a 75-g oral glucose load in the morning after an overnight fast of at least 8 hours, or
- Symptoms of hyperglycemia (e.g., polyuria, polydipsia, polyphagia) and a random (casual, nonfasting) plasma glucose concentration ≥200 mg/dL, or
- A1C level ≥6.5% Glucose criteria (i.e., FPG or 2-h glucose after a 75-g oral glucose load) are preferred for the diagnosis of DM. The same test—plasma glucose or A1C measurement—should be repeated on a different day to confirm the diagnosis of DM. However, a glucose level ≥200 mg/dL in the presence of DM symptoms does not need to be confirmed (Grade B; BEL 3).

Prediabetes may be identified by the presence of impaired glucose tolerance (IGT), which is a plasma glucose value of 140 to 199 mg/dL 2 hours after ingesting 75 g of glucose, and/or impaired fasting glucose (IFG), which is a fasting glucose value of 100 to 125 mg/dL (Table 6) (Grade B; BEL 2). A1C values between 5.5 and 6.4% inclusive should be a signal to do more specific glucose testing (Grade D; BEL 4). For prediabetes, A1C testing should be used only as a screening tool; FPG measurement or an oral glucose tolerance test (OGTT) should be used for definitive diagnosis (Grade B; BEL 2). Metabolic syndrome based on National Cholesterol Education Program IV Adult Treatment Panel III criteria should be considered a prediabetes equivalent (Grade C; BEL 3).

**State and Federal Regulations, as applicable**

The FDA has issued a 510(k) Premarket clearance to over 128 hemoglobin A1C test systems as a device used to measure the percentage concentration of hemoglobin A1c in blood. Measurement of hemoglobin A1c is used as an aid in the diagnosis of diabetes mellitus and as an aid in the identification of patients at risk for developing diabetes mellitus.
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**Billing/Coding/Physician Documentation Information**

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: 82985, 83036, 83037, 82947*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**Scientific Background and Reference Sources**


ADA. (2017). Standards of Medical Care in Diabetes-2017. *Diabetes Care, 40*(Suppl 1), S4-s5. doi:10.2337/dc17-S003


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Specialty Matched Consultant Advisory Panel review 2/2020

Policy Implementation/Update Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/19</td>
<td>New policy developed. BCBSNC will provide coverage for measurement of hemoglobin A1c when it is determined to be medically necessary because the medical criteria and guidelines are met. Medical Director review 4/1/2019. Policy noticed 4/1/2019 for effective date 6/1/2019. (an)</td>
</tr>
<tr>
<td>10/29/19</td>
<td>Wording in the Policy, When Covered, and/or Not Covered section(s) changed from Medical Necessity to Reimbursement language, where needed (gm)</td>
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<tr>
<td>12/10/19</td>
<td>Coding section updated to reflect new and deleted codes per Avalon Q3 CAB update. When covered section #5 added “Reimbursement is allowed once per month during pregnancy for measurement of hemoglobin A1c for pregnant individuals.” When not covered section – removed pregnancy from bullet b and removed panel testing of biochemical markers for type 2 diabetes risk. (eel)</td>
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<tr>
<td>03/10/20</td>
<td>Specialty Matched Consultant Advisory Panel review 2/19/2020. No change to policy statement. (eel)</td>
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