Clinical Diagnostic Laboratory Services

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

According to the CMS National Coverage Determination (NCD) manual, coverage excludes routine physical exams and services not deemed necessary for diagnosing or treating illness or injury. This includes screening services, like lab tests done without signs, symptoms, or personal history of disease. A national coverage policy for diagnostic lab tests outlines when these tests are considered reasonable and necessary, rather than screening.

Reimbursement Guidelines

This modification permits clinical diagnostic lab procedures to be accepted if accompanied by a diagnosis code listed on the approved diagnosis code list. If the clinical diagnostic lab procedure is presented as a routine screening service, indicated by a diagnosis code not included on the allowed list, the procedure code will be denied.

Carcinoembryonic Antigen (CEA)

Carcinoembryonic antigen (CEA) is a protein-polysaccharide complex present in certain carcinomas. It serves as an effective biochemical marker for assessing the therapeutic response of specific malignancies. Molina Healthcare Inc provides reimbursement for Carcinoembryonic antigen (CEA) (CPT code 82378) if a claim includes one of the diagnosis codes indicating a malignancy from the approved list. Reimbursement will not be provided when treatment is administered without including one of the ICD-10CM diagnostic codes that accurately reflects the member's condition on the claim.

ICD-10 Codes approved with CPT code 82378 (CEA).pdf

Alpha-fetoprotein (AFP)

Alpha-fetoprotein (AFP) is a polysaccharide identified in certain carcinomas. Its utility as a biochemical marker is recognized for assessing the therapeutic response of specific malignancies. AFP is particularly

valuable in diagnosing hepatocellular carcinoma in high-risk individuals, such as those with alcoholic cirrhosis, viral cirrhosis, hemochromatosis, and alpha 1-antitrypsin deficiency. Additionally, it helps differentiate between patients with benign hepatocellular neoplasms or metastases and those with hepatocellular carcinoma. As a non-specific tumor-associated antigen, AFP is also used to identify germ cell neoplasms of the testis, ovary, retroperitoneum, and mediastinum.

Molina Healthcare INC reimburses for Alpha-fetoprotein; serum (82105) when the diagnosis codes listed on a claim match one of the approved diagnosis codes for this test. Molina Healthcare INC will not provide reimbursement if the treatment rendered does not include one of the ICD-10-CM diagnostic codes on the claim that accurately reflects the member's condition. For the list of ICD-10 Codes approved with CPT code 82105 (AFP), refer to the Attachment Section.

Partial Thromboplastin Time (PTT)

Basic evaluation of plasma coagulation function can be performed using a few straightforward laboratory tests: Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or quantitative fibrinogen determination. The PTT test is an in vitro diagnostic tool used to evaluate the intrinsic coagulation pathway and to monitor heparin therapy. Molina Healthcare INC provides reimbursement for Partial Thromboplastin Time (PTT) (CPT code 85730) when billed with one of the approved diagnosis codes for this test. Molina Healthcare INC will not offer reimbursement if the treatment provided does not include one of the ICD-10-CM diagnostic codes accurately reflecting the member's condition on the claim. For approved ICD-10 codes with CPT code 85730 (PTT), refer to the Attachment Section.

Prostate Specific Antigen (PSA)

Prostate Specific Antigen (PSA), a tumor marker for adenocarcinoma of the prostate, can assist in predicting residual tumors during the post-operative phase of prostate cancer. PSA levels measured three to six months after radical prostatectomy are considered a sensitive indicator of persistent disease. Furthermore, six months after initiating antiandrogen therapy, PSA levels can distinguish between patients with a favorable response and those likely to have a limited response. When used alongside other diagnostic tests for prostate cancer, such as digital rectal examination, PSA can aid in diagnosing prostate cancer. PSA also serves as a valuable marker for monitoring the progress of most prostate tumors once diagnosed. This test is instrumental in managing prostate cancer patients and detecting metastatic or persistent disease following treatment. Molina Healthcare INC reimburses for Prostate Specific Antigen (PSA) (CPT code 84153) if the claim includes an approved diagnosis code from the provided list. However, reimbursement is not provided when the treatment does not include one of the ICD-10-CM diagnostic codes that accurately reflects the member's condition

ICD-10 Codes approved with CPT code 84153 (PSA)

Urine Culture, Bacterial

A bacterial urine culture is a lab test conducted on a urine sample to identify the likely cause of a suspected urinary tract infection. Typically, a urinalysis is performed before conducting a urine culture. This test can also be used in evaluating and managing other related conditions. The procedure involves using aerobic

agar to isolate bacteria or other organisms that can be cultured, and quantifying the types of presents based on their morphology. Significant isolates may undergo further identification and susceptibility testing as requested by the physician, following documented and communicated laboratory protocols. Molina Healthcare INC reimburses Urine Culture, Bacterial (CPT codes 87086 and 87088), when the claim includes a code from the approved list of diagnosis codes for this test. Reimbursement will not be provided if the treatment does not include one of the ICD-10-CM diagnostic codes accurately representing the member's condition on the claim. For ICD-10 Codes approved with CPT code 87086 and 87088 (Urine Culture, Bacterial), refer to the Attachment Section.

Serum Iron Studies

Serum iron studies are invaluable for evaluating iron metabolism disorders, including iron deficiency and excess. These tests are most accurate when conducted in the morning on a fasting patient, who has avoided medications that might affect iron levels. The primary cause of anemia is iron deficiency. In young children consuming primarily milk, this deficiency often results from inadequate dietary intake. Among adults, it typically stems from blood loss and occasionally from poor diet or malabsorption. Post-major surgery, patients may experience iron-deficient erythropoiesis lasting months to years if not provided with sufficient iron supplementation. High doses of supplemental iron can elevate serum iron levels, and these levels might also be influenced by acute and chronic inflammatory or neoplastic conditions.

Total Iron Binding Capacity (TIBC) indirectly measures transferring, the protein responsible for binding and transporting iron, and is determined by the quantity of iron it can bind. Elevated TIBC and transferring levels indicate iron deficiency, oral contraceptive use, or pregnancy, while decreased levels may suggest malabsorption syndromes or chronic diseases. The percentage saturation represents the ratio of iron to TIBC. Ferritin assays are also beneficial for assessing iron balance, with low levels indicating iron deficiency, which is highly specific. Conversely, high ferritin levels occur in hemosiderosis (iron overload without tissue damage) and hemochromatosis (iron overload with tissue damage), where iron levels are elevated, TIBC and transferrin are normal or reduced, and percent saturation is increased. Serum ferritin is useful for both initiating and monitoring treatment for iron overload.

Transferrin and ferritin are acute phase reactants, which increase in response to stress, inflammation, infection, and tissue injury due to surgery, trauma, or necrosis. Both iron/TIBC (or transferrin) and ferritin are influenced by acute and chronic inflammatory conditions, complicating the interpretation of iron status in affected patients. Molina Healthcare INC covers Serum Iron Studies (CPT codes 82728, 83540, 83550, and/or 84466), provided the claim includes an approved diagnosis code. Claims lacking an approved ICD-10-CM diagnostic code indicating the member's condition will not be reimbursed. For approved ICD-10 Codes with CPT codes 82728, 83540, 83550, and/or 84466 (Serum Iron Studies), refer to the Attachment Section.

Human Chorionic Gonadotropin (hCG)

Human Chorionic Gonadotropin (hCG) is valuable for the monitoring and diagnosing of germ cell tumors in locations such as the ovary, testis, mediastinum, retroperitoneum, and central nervous system. Additionally, hCG is beneficial for observing pregnant patients experiencing vaginal bleeding,

hypertension, or potential fetal loss. Molina Healthcare INC provides reimbursement for Human Chorionic Gonadotropin (hCG) (CPT code 84702) when the claim includes an approved diagnostic code from the list corresponding to this test. However, Molina Healthcare INC will not reimburse claims that do not include one of the ICD-10CM codes accurately reflecting the member's condition.

ICD-10 Codes approved with CPT code 84702 - Human Chorionic Gonadotropin (hCG).pdf

Lipids Testing

Lipoproteins are a category of diverse particles varying in size and density, composed of lipids and proteins. These include cholesterol esters, free cholesterol, triglycerides, phospholipids, and apoproteins A, C, and E. Total cholesterol is the sum of all cholesterol present in different lipoproteins.

Several factors influence blood cholesterol levels, such as age, gender, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, hormone replacement therapy use, and chronic conditions like hypothyroidism, obstructive liver disease, pancreatic diseases (including diabetes), and kidney disease.

For many individuals, high blood cholesterol poses an increased risk of coronary artery disease. Blood levels of total cholesterol and its various components, particularly low-density lipoprotein cholesterol (LDL-C) and high-density lipoprotein cholesterol (HDL-C), are valuable for evaluating and managing cardiovascular and related diseases. The National Heart, Lung, and Blood Institute categorized blood cholesterol levels into desirable, borderline, and high-risk groups in their 1993 report. These categories aid in the assessment and treatment of hyperlipidemia patients. Treatment strategies include dietary changes, physical activity, medication, and significant fat weight loss, especially when combined with diet and exercise.

Molina Healthcare INC reimburses for Lipids Testing (CPT codes 80061, 82465, 83700, 83701, 83704, 83718, 83721, and 84478), provided the claim includes an approved diagnosis code specific to this test. Claims are not reimbursed if they do not include an ICD-10-CM diagnostic code that accurately represents the member's condition.

ICD10-CPT-codes-80061-82465-83700-83701-83704-83718-83721-and-84478-Lipids-Testing.pdf

Thyroid Testing

Thyroid function tests are utilized to identify the presence or absence of hormonal abnormalities in the thyroid and pituitary glands. These abnormalities can be either primary or secondary and may or may not coincide with clinically observable signs and symptoms of thyroid dysfunction. The scientific approach to

evaluating thyroid function has advanced significantly. Tests now offer increased specificity, reducing the number required for diagnosing and managing most thyroid conditions. The assessment usually involves measuring serum sensitive thyroid-stimulating hormone (TSH) levels along with the determination of thyroid hormone levels [free thyroxine (fT-4) or total thyroxine (T4) with Triiodothyronine (T3) uptake]. Additional tests may be necessary to address more complex diagnostic issues or in hospitalized patients, where various factors might affect test results. When conducting a total thyroxine (total T4 or T4 radioimmunoassay) or T3 uptake test, calculating the free thyroxine index (FTI) is beneficial to correct for abnormal outcomes caused by protein binding effects on either total T4 or T3 uptake.

Molina Healthcare offers reimbursement for Thyroid Testing (CPT codes 84436, 84439, 84443, and 84479) provided that the claim includes a code from the approved list of diagnosis codes for this test. Reimbursement will not be made if the treatment does not include one of the ICD-10CM diagnostic codes accurately reflecting the member's condition on the claim.

ICD10-CPT-codes-84436-84439-84443-and-or-84479-Thyroid-Testing.pdf

Prothrombin Time (PT)

Basic plasma coagulation function can be easily evaluated using a few straightforward laboratory tests: Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen assessment. The PT test is an in-vitro lab test that evaluates coagulation. While PTT measures the intrinsic limb of the coagulation system, PT evaluates the extrinsic or tissue factor-dependent pathway. Both tests also assess the common coagulation pathway that involves all reactions after factor X activation. Factors in the extrinsic pathway are produced in the liver, and their production relies on sufficient vitamin K activity. Factor deficiencies may stem from reduced production or increased consumption of coagulation factors. The PT/INR is commonly used to monitor the effects of warfarin and adjust its dosage. Warfarin inhibits the impact of vitamin K on the liver's production of extrinsic pathway factors.

A PT is conveyed in seconds and/or as an international normalized ratio (INR). The INR represents the PT ratio that would occur if the WHO reference thromboplastin was used in the test. Present medical information does not define the role of laboratory PT testing in patients who perform self-monitoring. Therefore, the guidelines for testing apply irrespective of whether the patient is also self-testing PT.

Molina Healthcare INC provides reimbursement for Prothrombin Time (CPT code 85610) when the claim includes a code listed among the approved diagnosis codes for this test. Molina Healthcare INC will not provide reimbursement if the treatment rendered lacks one of the ICD-10CM diagnostic codes accurately reflecting the member's condition on the claim.

ICD10-CPT-codes-85610-Prothrombin-Time.pdf

Tumor Antigen by Immunoassay CA 125

Immunoassay measurements of specific proteins or carbohydrates in the serum are used as tumor markers. Elevated levels of these markers in the serum may indicate the size and grade of a tumor.

This section of the policy specifically relates to the tumor antigen CA 125. These services are not covered for evaluating patients with symptoms suggesting malignancy. The service can be ordered when needed to determine either the presence of recurrent disease or the patient's response to treatment during subsequent treatment cycles.

Molina Healthcare INC reimburses for Tumor Antigen by Immunoassay CA 125 (CPT code 86304) when the claim includes a code from the list of approved diagnosis codes for this test. Molina Healthcare INC will not provide reimbursement if the treatment rendered does not include one of the ICD-10-CM diagnostic codes that accurately reflect the member's condition on the claim.

CD-10 Codes approved with CPT code 86304 Tumor Antigen by Immunoassay CA125.pdf

Tumor Antigen by Immunoassay CA 15-3/CA 27.29

Immunoassays are used to measure serum levels of specific proteins or carbohydrates that serve as tumor markers. Elevated serum concentrations of these markers can indicate tumor size and grade. This section of the policy specifically deals with the following tumor antigens: CA 15-3 and CA 27.29. These services are not covered for patients showing signs or symptoms indicative of malignancy. However, the service may be ordered when required to evaluate either the presence of recurrent disease or the patient's response to treatment during subsequent treatment cycles.

Molina Healthcare INC offers reimbursement for Tumor Antigen by Immunoassay CA 15-3/CA 27.29 (CPT code 86300) when the claim includes a code from the approved diagnosis list for this test. The plan will not provide reimbursement if the treatment does not include one of the ICD-10-CM diagnostic codes on the claim that accurately represents the member's condition.

ICD-10 Codes approved with CPT code 86300 Tumor Antigen by Immunoassay CA15-3.CA 27.29.pdf

Tumor Antigen by Immunoassay CA 19-9

The use of immunoassay to measure specific serum protein or carbohydrate levels can act as an indicator for tumors. Higher levels of these markers in the serum may provide information about the tumor's size and grade. This policy section focuses on the tumor antigen CA19-9. These services are not covered for patients showing symptoms or signs of malignancy but can be used to monitor recurrent disease or assess the patient's response to ongoing treatment cycles. Molina Healthcare reimburses for Tumor Antigen by Immunoassay CA 19-9 (CPT code 86301) if the claim includes a relevant diagnosis code from the approved list for this test. Reimbursement will be denied if the treatment does not have an ICD-10-CM diagnostic code that correctly describes the member's condition on the claim.

ICD-10 Codes approved with CPT code 86301 Tumor Antigen by Immunoassay CA 19-9.pdf

Gamma Glutamyl Transferase (GGT)

Gamma glutamyl transferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is primarily used for assessing hepatobiliary function. Unlike other enzymes found in the heart, skeletal muscle, and intestinal mucosa as well as the liver, elevated levels of GGT in serum are generally indicative of liver disease or injury. It is particularly useful in differentiating elevated alkaline phosphatase levels when the source of the increase (bone, liver, or placenta) is unclear. However, a combination of high alkaline phosphatase and normal GGT does not completely rule out liver disease.

In addition to being a specific marker of hepatobiliary function, GGT is also sensitive for detecting hepatocellular damage. Abnormal concentrations typically appear before elevations of other liver enzymes or biliuria are evident. Conditions such as obstruction of the biliary tract, viral infections (e.g., hepatitis, mononucleosis), metastatic cancer, exposure to hepatotoxins (e.g., organic solvents, drugs, alcohol), and use of drugs that induce microsomal enzymes in the liver (e.g., cimetidine, barbiturates, phenytoin, and carbamazepine) can all cause moderate to marked increases in GGT serum concentration. Additionally, some drugs can cause or exacerbate liver dysfunction (e.g., atorvastatin, troglitazone, and others as noted in FDA Contraindications and Warnings).

GGT is useful for diagnosing liver disease or injury, excluding hepatobiliary involvement related to other diseases, and managing patients during the resolution of existing disease or following injury. Molina Healthcare reimburses for Gamma Glutamyl Transferase (CPT code 82977) when the claim includes a code from the list of approved diagnosis codes for this test. Molina Healthcare will not reimburse if the treatment provided does not include one of the ICD-10CM diagnostic codes accurately reflecting the member's condition.

ICD10-CPT-code-82977-Gamma-Glutamyl-Transferase.pdf

Hepatitis Panel/Acute Hepatitis Panel

This panel consists of the following tests:

- Hepatitis A antibody (HAAb), IgM antibody.
- Hepatitis B core antibody (HBcAb), IgM antibody.
- Hepatitis B surface antigen (HBsAg) and.
- Hepatitis C antibody.

Hepatitis is an inflammation of the liver caused by viruses, drugs, toxins, and other etiologies. Viral hepatitis can be attributed to at least five different viruses: hepatitis A, B, C, D, and E. Most cases are due to hepatitis A virus (HAV), hepatitis B virus (HBV), or hepatitis C virus (HCV). In the United States, HAV is the most common cause of hepatitis in children and adolescents. Prior exposure to HAV is indicated by a positive IgG anti-HAV. Acute HAV is diagnosed by IgM anti-HAV, which typically appears within four weeks of exposure and disappears within three months. IgG anti-HAV appears around the same time but persists indefinitely, indicating prior effective immunization or recovery from infection. HAV is primarily spread through fecal-oral exposure, and standard immune globulin may be used as a prophylaxis.

HBV produces three separate antigens (surface, core, and e (envelope) antigens) when it infects the liver, though only hepatitis B surface antigen (HBsAg) is included in this panel. Following exposure, the body responds by producing antibodies to these antigens; one being hepatitis B surface antibody (HBsAb)-IgM antibody. HBsAg is the earliest marker, appearing in serum four to eight weeks after exposure and typically disappearing within six months. If HBsAg remains detectable for more than six months, it indicates chronic HBV infection. HBcAb, both IgG and IgM antibodies, appear next, typically two to three months following exposure. The IgM antibody declines or disappears one to two years after exposure, while IgG usually remains detectable for life. Because HBsAg is present for a relatively short period and usually displays a low titer, a negative result does not exclude an HBV diagnosis. HBcAb, on the other hand, rises to a much higher titer and remains elevated longer, but a positive result is not diagnostic of acute disease, as it may result from a prior infection.

The last marker to appear in a typical infection is HBsAb, which appears in serum four to six months following exposure to infected blood or body fluids. In the U.S., sexual transmission accounts for 30% to 60% of new HBV infections. Acute HBV infection is best diagnosed by documenting positive IgM antibody against the core antigen (HBcAb-IgM) and identifying a positive hepatitis B surface antigen (HBsAg). Chronic HBV infection is diagnosed by identifying a positive HBsAg and demonstrating positive IgG antibody against the core antigen (HBcAb-IgG). Additional tests such as hepatitis B e antigen (HBeAg) and hepatitis B e antibody (HBeAb) are not included in the hepatitis panel but may be important in assessing the infectivity of patients with HBV. Following completion of an HBV vaccination series, HBsAb alone may be used monthly for up to six months, or until a positive result is obtained, to verify an adequate antibody response.

HCV is the most common cause of post-transfusion hepatitis and is responsible for 15% to 20% of all acute hepatitis cases and is the leading cause of chronic liver disease. The most frequently used test to identify HCV measures HCV antibodies, which appear in blood two to four months after infection. False positive HCV results can occur; for example, a recent yeast infection may produce a false positive anti-HCV result. Therefore, positive results are usually confirmed by a more specific technique. Like HBV, HCV spreads exclusively through exposure to infected blood or body fluids. This panel of tests is used for differential diagnosis in patients with symptoms of liver disease or injury. When the time of exposure or the stage of the disease is unknown, a patient with continued symptoms of liver disease despite a completely negative hepatitis panel may need a repeat panel approximately two weeks to two months later to exclude the possibility of hepatitis. Once a diagnosis is established, specific tests can be used to monitor the course of the disease.

Molina Healthcare reimburses for Hepatitis Panel/Acute Hepatitis Panel (CPT code 80074) when the claim includes a code found on the list of approved diagnosis codes for this test. Molina Healthcare will not reimburse treatments without one of the ICD-10-CM diagnostic codes accurately reflecting the member's condition being included on the claim.

ICD-10 Codes approved with CPT code 80074 Hepatitis Panel. Acute Hepatitis Panel.pdf

Digoxin Therapeutic Drug Assay

A digoxin therapeutic drug assay is essential for diagnosing and preventing digoxin toxicity, as well as avoiding underdosage. Monitoring digoxin levels is crucial for patients undergoing digoxin therapy due to the narrow safety margin between therapeutic effects and toxicity or insufficient blood levels. Clinical indications for monitoring include:

- Patients exhibiting symptoms, signs, or ECG changes suggestive of digoxin toxicity
- Those taking medications that affect the absorption, bioavailability, distribution, and/or elimination of digoxin
- Individuals with impaired renal, hepatic, gastrointestinal, or thyroid function
- Patients with pH and/or electrolyte imbalances
- Individuals with unstable cardiovascular status, including myocarditis
- The need for monitoring patient compliance

Further clinical indications involve individuals suspected of accidental or intentional overdose or those with an acceptable cardiac diagnosis where a precise digoxin usage history is unavailable. Although the value of regular serum digoxin level checks is debated, it may be prudent to assess levels annually after achieving a steady state. Additional testing may be warranted if:

- Heart failure status deteriorates
- Renal function declines
- New medications are introduced that could influence digoxin levels
- Signs or symptoms of toxicity emerge

Patients with normal renal function typically reach a steady state in approximately one week; however, those with renal impairment may require 2-3 weeks. Following dosage adjustments or the introduction of medications affecting digoxin levels, it is advisable to recheck levels one-week post-change. In cases of digoxin toxicity, more frequent testing may be necessary based on clinical circumstances.

Digoxin is prescribed for treating heart failure caused by systolic dysfunction and for reducing ventricular response in atrial fibrillation or flutter. It may also be indicated for other supraventricular arrhythmias, particularly in the presence of heart failure. Molina Healthcare reimburses for Digoxin Therapeutic Drug Assay Testing (CPT code 80162) when the claim includes an approved diagnosis code. Reimbursement is not provided if the treatment does not encompass one of the ICD-10-CM diagnostic codes accurately reflecting the member's condition.

ICD-10 Codes approved with CPT code 80162 (Digoxin Therapeutic Drug Assay).pdf

ICD-10 Codes approved with CPT code 80162 (Digoxin Therapeutic Drug Assay).pdf

Glycated Hemoglobin/Glycated Protein

The management of diabetes mellitus involves regular measurement of blood glucose levels. Glycated hemoglobin/protein levels are used to monitor long-term glucose control in diabetes. These tests are also known as glycated or glycosylated hemoglobin, Hgb, hemoglobin glycated or glycosylated protein, and fructosamine. Glycated hemoglobin (equivalent to hemoglobin A1) denotes total glycosylated hemoglobin in erythrocytes, typically determined by affinity or ion-exchange chromatography. Hemoglobin A1c, the primary component of hemoglobin A1, is usually measured by ion-exchange affinity chromatography, immunoassay, or agar gel electrophoresis. Fructosamine or glycated protein refers to glycosylated protein in a serum or plasma sample, measured via colorimetric method or affinity chromatography.

Glycated hemoglobin in whole blood evaluates glycemic control over 4-8 weeks and is considered appropriate for monitoring patients capable of maintaining long-term stable control. Measurement may be necessary every 3 months to assess whether a patient's metabolic control remains within the target range. More frequent assessments, every 1-2 months, may be required if a patient's diabetes regimen has changed to improve control or if intercurrent events like post-major surgery or glucocorticoid therapy have affected control levels. Glycated protein in serum/plasma assesses glycemic control over 1-2 weeks and may be monitored monthly in pregnant diabetic women. Low glycated hemoglobin/protein test results can indicate significant, persistent hypoglycemia, such as in nesidioblastosis or insulinoma, which are associated with inappropriate hyperinsulinemia. Below-normal test values help establish a patient's hypoglycemic state in these conditions.

Molina Healthcare reimburses for Glycated Hemoglobin/Glycated Protein Testing (CPT codes 82985 and 83036) if the claim includes a code from the approved diagnosis codes list for this test. Reimbursement will not be provided if the treatment rendered does not include one of the ICD-10-CM diagnostic codes accurately reflecting the member's condition.

ICD10-CPT-codes-82985-and-83036-Glycated-Hemoglobin-Glycated-Protein.pdf

Supplemental Information

State Exceptions

State	Exception
California	California Medicaid uses state specific ICD-10 diagnosis codes lists for CPT codes 86304, 82728, and 84702 which are included in this policy. • California Medicaid ICD-10 Codes approved with CPT code 84702- Human Chorionic Gonadotropin(HCG).pdf • California Medicaid ICD-10 Codes approved with CPT code 86304 Tumor Antigen by ImmunoassayCA125.pdf

	• California-Medicaid-ICD10-Codes-Approved-CPT-code-82728-Serum-Iron.pdf
Kentucky	Kentucky is excluded from this policy based on state requirements.
Washington	Washington Medicaid is excluded from the Thyroid Testing section of the policy based on state requirements.

Definitions

Term	Definition
Screening	The testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present, and the patient has not been exposed to a disease. The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening

References

This policy was developed using.

- individual state Medicaid regulations, manuals & fee schedules
- American Medical Association, Current Procedural Terminology (CPT®) Professional Edition and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets