CPT Codes (current procedural terminology codes)

83037  Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use. A1CNow+ is approved for use with either a capillary or venous blood specimen.¹
36416  Collection of capillary blood specimen (e.g., finger, heel, ear stick)
36415  Collection of venous blood by venipuncture.

Note 1: CPT code 83037 may be billed when an A1c test is performed in a provider’s office using a device cleared by the FDA for home use. CPT code 83037 is not intended to report an A1c test result that is obtained in a patient’s home by the patient or family.²

Note 2: The QW modifier should be used when coding for Medicare and Medicaid beneficiaries. The QW modifier (83037QW) indicates that the test and laboratory have received a CLIA¹ Certificate of Waiver. A1CNow+ has been categorized as a waived test under CLIA.³

Note 3: CPT code 83037 became available in 2006 and most insurers utilize this new code. Other insurers continue to use 83036. Check with local insurers to confirm the appropriate CPT billing code.

E & M Codes (evaluation and management codes)

Evaluation and management services can be billed by providers if the particular services are provided and documented in the patient’s medical records. Interpretation of test results is considered to be part of evaluation and management services provided to a patient during an office visit and is not separately billable. For existing patients, codes 99212 – 99215 describe various types of E & M services. The provider should select the appropriate code depending on the complexity of the visit, the services rendered, and the time with the patient.

“Clinic Days” (E & M Code 99211)

If a patient sees a nurse or other non-physician health care professional for the purpose of HbA1c test (for example, to monitor insulin therapy) and the nurse takes vital signs, compares the results with the HbA1c test to predetermined guidelines, and advises the patient accordingly, E & M code 99211 may be billed.

International Classification of Disease (ICD-9-CM) Diagnosis Codes

An appropriate diagnosis (ICD-9-CM) code (or narrative description) must be identified in the patient’s medical record and reported on the claim form to the patient’s insurer, for each service or supply billed under Medicare Part B. When a patient presents with an illness, the provider selects the ICD-9-CM code or codes by the “signs and symptoms” that most accurately describe the patient’s condition.
Certificate of CLIA Waiver

A1CNow+ is classified as a CLIA waived test by the FDA. A CLIA certificate is required any time a clinical laboratory test is performed; however, performance of waived category tests requires only a CLIA Certificate of Waiver. Certificate of Waiver labs must register with Medicare, pay a fee every two years, and agree to follow manufacturer’s instructions in performing clinical lab tests.

To apply for a Certificate of Waiver, go to www.cms.hhs.gov/CLIA, download CLIA application form (CMS-116), follow the instructions provided, and send it to the appropriate state agency. A list of state agency addresses is also available on the internet at www.cms.hhs.gov/CLIA.

Claims Delays or Denials

When insurers deny claims, they generally send a letter listing the reasons for the denial. Inaccurate codes, lack of a QW modifier (for Medicare and Medicaid), and missing information are often the reasons for the claim rejection. In such cases, please correct and resubmit the claim. Insurers may also request that the provider document the medical necessity of the HbA1c test. In this case, the provider may need to submit a letter of medical necessity. Case managers at the A1CNow+ Reimbursement Hotline (866-999-1415) can assist you with answering billing and coding questions.

For assistance with billing and coding, contact the A1CNow+ Reimbursement Hotline: (866) 999-1415


DISCLAIMER: The information is provided to help keep A1CNow+ customers up-to-date on changes in billing for the A1CNow+ test. It is also intended to assist customers in understanding and complying with sometimes complex reimbursement rules, which vary from insurer to insurer. Customers should check with local insurers to confirm that the above information is correct. Continued dialogue with insurers is necessary. There is no guarantee that any of the codes noted above will result in coverage or payment, which will be based on patient condition and the insurer’s policies.