

Local Coverage Determination (LCD): GlycoMark Testing for Glycemic Control (L36866)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Noridian Healthcare Solutions, LLC	A and B MAC	02101 - MAC A	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02102 - MAC B	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02201 - MAC A	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02202 - MAC B	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02301 - MAC A	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02302 - MAC B	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02401 - MAC A	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	02402 - MAC B	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	03101 - MAC A	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03102 - MAC B	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03201 - MAC A	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03202 - MAC B	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03301 - MAC A	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03302 - MAC B	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03401 - MAC A	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03402 - MAC B	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03501 - MAC A	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03502 - MAC B	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03601 - MAC A	J - F	Wyoming
Noridian Healthcare Solutions, LLC	A and B MAC	03602 - MAC B	J - F	Wyoming

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LCD Information

Document Information

LCD ID L36866	Original Effective Date For services performed on or after 08/01/2017
LCD Title GlycoMark Testing for Glycemic Control	Revision Effective Date N/A
Proposed LCD in Comment Period N/A	Revision Ending Date N/A
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CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

42 Code of Federal Regulations (CFR) 410.32(a). Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

CMS On-Line Manual, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§80.0, 80.1.1, 80.2. Clinical Laboratory services.

CMS Internet-Only Manuals, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, 60.12 Independent Laboratory Specimen Drawing, 60.2. Travel Allowance.

CMS Internet Online Manual Pub. 100-04 (*Medicare Claims Processing Manual*), Chapter 23 (Section 10) "Reporting ICD Diagnosis and Procedure Codes".

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

This is a non-coverage policy for the GlycoMark® assay (aka 1,5-anhydroglucitol [1,5-AG]; developed by Nippon Kayaku, Co., Ltd).

Current Diabetes Testing

Hemoglobin A1C measurement, reflecting hemoglobin glycation over the erythrocyte life span, is proportional to the mean glucose concentration over the preceding 2-3 months. A1C testing is recommended by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) consensus guideline for pharmacotherapy to control hyperglycemia in type 2 diabetes.¹ In addition to A1C, fasting plasma glucose is used by patients and physicians to monitor diabetes. However, recent evidence strongly suggests that control of post-prandial hyperglycemia (PPG) may be necessary to achieve A1C targets <7%.²

Several landmark clinical trials have convincingly demonstrated that individuals with diabetes are at increased risk of developing microvascular complications including retinopathy, nephropathy and neuropathy, as well as cardiovascular (CV) disease.^{3,4,5} The importance of tight glycemic control for protection against microvascular and CV disease in diabetes was established in the Diabetes Control and Complications Trial (DCCT)/Epidemiology of Diabetes Interventions and Complications (EDIC) study.⁶ The role of glycemic control on microvascular disease in type 2 diabetes was documented in the United Kingdom Prospective Diabetes Study (UKPDS).⁷ In addition, improving glycemic control improves microvascular outcomes, as illustrated by the findings of a meta-analysis of randomized trials (34,912 participants).⁸

Considerable data indicates that elevated PPG levels, even in the absence of fasting hyperglycemia, increases the risk for CV disease^{9,10,11} Numerous epidemiological studies have demonstrated a correlation between risk for CVD and both fasting and postprandial plasma glucose levels or A1C values.¹¹ The United Kingdom Prospective Diabetes Study (UKPDS)³, the Diabetes Control and Complications Trial (DCCT)⁵, the Action to Control Cardiovascular Risk in Diabetes (ACCORD)¹², and the Action in Diabetes and Vascular Disease: Preterax and Diamicon Modified Release Controlled Evaluation (ADVANCE)¹³ were landmark controlled clinical trials that evaluated the benefits of intensive glucose control on diabetes complications. Both the DCCT and UKPDS primary intervention studies also demonstrated long-term macrovascular benefits (>10 year follow-up).^{6,14} These studies illustrate that intensive glycemic control early in the course of diabetes is important in achieving CV benefit and provides guidance in terms of stratification of patients' target glycemic control. The fact that postprandial glucose control is essential to optimize blood glucose levels has been confirmed by randomized controlled trials where therapeutic agents primarily target postprandial hyperglycemia.^{15,16,17}

1,5-AG Assay

Measurement of serum 1,5-anhydroglucitol (1,5-AG) is thought to be a useful index of postprandial hyperglycemia, and is thought to be more robust than hemoglobin A1C (A1C) or fructosamine (used to evaluate glycemic control over 10-14 days).^{18,19} There is evidence that glycemic excursions, an aspect of diabetes control incompletely captured by A1C, may contribute to vascular damage independently of mean glucose concentration (A1C)^{20,21,22} Testing for 1,5-AG has been proposed to be an additional glycemic biomarker to assist clinicians in the management of glycemic control, particularly in patients with moderate to near-normal glycemic control to complement frequent self-monitoring or continuous monitoring of plasma glucose to confirm overall glycemic control.

The 1,5-AG test measures the blood level of 1,5-anhydroglucitol, a compound that is ingested in food. Because the compound is not metabolized, a relatively constant blood level is maintained in individuals with blood glucose below 180 mg/dL via urinary excretion and reabsorption. In non-diabetic individuals, the rate of intake of 1,5-AG is matched by the daily excretion rate such that the serum levels and urinary excretion remain constant. When a diabetic's blood glucose exceeds 180 mg/dL, 1,5-AG reabsorption is competitively blocked by glucose and the serum level of 1,5-AG falls. Serum 1,5-AG decreases until glucose level drops below 180 mg/dL when 1,5-AG reabsorption resumes a steady rate. In brief, 1,5-AG levels are inversely proportional to the degree of hyperglycemia.

Proponents of serum 1,5-AG claim that testing reflects hyperglycemia over the past 2 weeks (inter-day excursions) and is recommended by the manufacturer for use in persons with diabetes and A1C <8% to help identify patients with frequent hyperglycemic excursions, and may be useful for estimating within-day glycemic excursion. They specify that serum 1,5-AG correlates with postprandial hyperglycemia in persons with diabetes and A1C <7% and is stated to be more strongly correlated with glucose variability as compared to A1C, fructosamine or glycated albumin over 2 to 3 days in persons with moderate glycemic control (A1C <8%). Data suggests that 1,5-AG is strongly inversely associated with A1C and fasting glucose in persons diagnosed with diabetes but is poorly correlated with fasting glucose and A1C in persons without diabetes. Multiple publications correlate various 1,5-AG end points with continuous glucose monitoring and show potentially improved correlation with glucose fluctuation and A1C in patients with diabetes and A1C <8% than other biomarkers.^{23,24,25,26,27,28} However, the number of studies and the quality of study correlations is poor. Appropriate clinical targets are unclear, as the strongest correlations are observed at the highest glucose concentrations which suggests that the utility of 1,5-AG may primarily be limited to persons with overtly elevated glucose.

In summary, the data to support the use of this test is based on showing correlations over short periods with other early glycemic markers (A1C, fructosamine, or glycated albumin) but is not specific to the intended use population. Comparative studies do not show that 1,5-AG is as good as a 2-hour post prandial blood glucose, or alternative biomarker. At the current time, the relationship of 1,5-AG to long term diabetic complications in a patient with A1C <8% is unknown. Furthermore, no prospective studies have shown that managing 1,5-AG in patients with an A1C of 6.5-8% reduces micro- or macrovascular complications. In addition, there are no definitive guidelines for using alternative biomarkers as adjuncts to standard markers of glycemia, such as A1C, fasting glucose, or self-monitoring blood glucose measures. Long-term prospective studies are lacking, and large cohort studies are warranted to determine whether alternative biomarkers have potential utility for early diagnosis, management of diabetes, and prevention of diabetic complications.

Due to the lack of clinical utility, 1,5-AG testing is not reasonable and necessary for the management of diabetes or the prevention of diabetic complications, and is not covered by Medicare.

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[Coding Information](#)

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

84378 SUGARS (MONO-, DI-, AND OLIGOSACCHARIDES); SINGLE QUANTITATIVE, EACH SPECIMEN

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: N/A

Group 1 Codes:

ICD-10 Codes Description

XX000 Not Applicable

ICD-10 Codes that DO NOT Support Medical Necessity N/A

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[General Information](#)

Associated Information

N/A

Sources of Information and Basis for Decision

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Revision History Information

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Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) [A55528 - Response to Comments: GlycoMark Testing for Glycemic Control](#) LCD(s) [DL36866 - GlycoMark Testing for Glycemic Control](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 06/01/2017 with effective dates 08/01/2017 - N/A [Back to Top](#)

Keywords

- GlycoMark
- Glycemic Control
- 84378
- 1.5-Anhydroglucitol
- Hemoglobin A1C
- 1,5-AG Assay
- Diabetes

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