healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Diabetes Cost-sharing Waiver		
Policy Number:	PO-RE-126v2		
Effective Date:	1/01/2025	**Last Approval Date:**	12/03/2025

I. Policy Description

This policy outlines Healthfirst's reimbursement guidelines regarding the waiver of cost-sharing for Essential Plan (EP) and Qualified Health Plan (QHP) members diagnosed with Type 1, Type 2, or Gestational Diabetes. The intention of this policy is to promote access to necessary healthcare services and support for individuals managing diabetes. By waiving cost-sharing for specific services, Healthfirst aims to enhance diabetes management, improve health outcomes, and reduce long-term healthcare costs.

The information below applies to the following lines of business:

- Essential Plan (EP)
- Qualified Health Plan (QHP)

Reimbursement Guidelines

1. Member eligibility for cost-sharing waiver.
   - Eligible Covered Members:
     - Essential Plans, Qualified Health Plan (QHP) Bronze, Gold, Silver or Platinum Leaf Plans, and Leaf Premier Plans.
   - Non-Eligible Members:
     - Members enrolled Green Leaf and Off Exchange QHP Plans

2. Waived Cost-Sharing Services:
   - Cost-sharing will be waived for the following in-network services when a diagnosis of Type 1, Type 2 or Gestational Diabetes diagnosis is listed as the primary diagnosis on the UB04 or CMS 1500 claim form:
     - Primary Care Office Visits: All visits to primary care providers for diabetes management and follow-up.
     - Annual Dilated Retinal Examinations: Comprehensive eye exams to monitor and prevent complications related to diabetes.
     - Diabetic Foot Examinations: Routine foot exams to assess for complications due to diabetes.
     - Diabetes Self-Management Education Services: Educational programs aimed at empowering individuals with diabetes to manage their condition effectively.

- Laboratory Procedures: Tests necessary for the diagnosis and ongoing management of diabetes, including but not limited to:
  - Hemoglobin A1c tests
  - Fasting blood glucose tests
  - Lipid panels

- Equipment and Related Supplies: Necessary equipment and supplies for the treatment of diabetes, including but not limited to:
  - Blood glucose monitors
  - Test strips
  - Insulin pumps
  - Continuous glucose monitoring systems

- Prescription Drugs for Diabetes Treatment: All medications prescribed for the management of diabetes, including insulin and oral hypoglycemic agents.

3. Members covered under the plans mentioned above will not incur any of the following costs for the covered services listed above:
   - Co-Pays
   - Deductible
   - Co-Insurance
   - Out-Of-Pocket Maximums

4. To qualify for the waived cost-sharing provisions, providers must ensure that the member has been actively treated for Type 1, Type 2, or Gestational Diabetes. This requirement is essential to confirm that the member is receiving appropriate care related to their diabetes management.

5. Providers should use the appropriate diagnosis codes related to diabetes and ensure that all claims submitted for the services listed above reflect the waiver of cost-sharing.

6. Failure by providers to list Type 1, Type 2, or Gestational Diabetes as the primary diagnosis on claims will result in the application of cost-sharing to the member. It is the responsibility of the provider to ensure claims are coded accurately.

7. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

Note: *Members will be responsible for co-insurance, deductible, and co-insurance for emergency room visits, hospitalization and related costs, as well as most specialist visits not covered under this policy.*

Adjudication and Appeal Process

1. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

2. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

3. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	Documentation and Coding: Diabetes Mellitus
PO-RE-023	Reimbursement Policy Diabetes Mellitus Testing

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

2025 Invitation for Participation in NY State of Health
Implementation of Cost Sharing Subsidies
New Cost-Sharing Reductions (CSRS)

VI. Revision History

Revision Date	Summary of Changes
12/3/2025	Added adjudication and appeals section

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.