Diabetic Management, Services and Supplies

Policy Number: BIP042.L
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➲ Instructions for Use

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Related Medical Management Guidelines

- Clinical Practice Guidelines
- Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes
- Preventive Care Services

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California Health and Safety Code 1367.51

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.51.&lawCode=HSC

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:
  (1) Blood glucose monitors and blood glucose testing strips
  (2) Blood glucose monitors designed to assist the visually impaired
  (3) Insulin pumps and all related necessary supplies
  (4) Ketone urine testing strips
  (5) Lancets and lancet puncture devices
  (6) Pen delivery systems for the administration of insulin
  (7) Podiatric devices to prevent or treat diabetes-related complications
  (8) Insulin syringes
  (9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

(b) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:
  (1) Insulin
  (2) Prescriptive medications for the treatment of diabetes
  (3) Glucagon

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(c) The copayments and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given plan.
(d) Every plan shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an enrollee to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b), and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the member's participating physician. If a plan delegates outpatient self-management training to contracting providers, the plan shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.
(e) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (d) shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.
(f) The copayments for the benefits specified in subdivision (d) shall not exceed those established for physician office visits by the plan.
(g) Every health care service plan governed by this section shall disclose the benefits covered pursuant to this section in the plan's evidence of coverage and disclosure forms.
(h) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.
(i) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

California Health and Safety Code 1367.19

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.19.&lawCode=HSC
On and after January 1, 1991, every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under such terms and conditions as may be agreed upon between the group contract holder and the plan.

As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

State Market Plan Enhancements

Note: Glucose monitors are covered under the member’s DME benefit; strips and lancets are covered under the pharmacy benefit. For members without the pharmacy benefit, members would still obtain lancets and test strips through the contracted pharmacy but no copayment is assessed.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Notes:
- Refer to the Medical Management Guideline titled Clinical Practice Guidelines
- Supplemental Outpatient Prescription benefit required for coverage of insulin, glucagon and other diabetic medications. Refer to the Benefit Interpretation Policy titled Medications and Off-Label Drugs.

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- Diabetic management and treatment, which include, but are not limited to:
  - Outpatient diabetic self-management training (ODSMT) services/training, education and medical nutritional therapy services.
    These services must be ordered/prescribed and provided by appropriately licensed or registered health care professionals under the direction of a network provider:
    - Initial diabetic self-management training
    - Additional visits when a physician identifies or diagnoses a significant change in the member's symptoms or condition that necessitates changes in a member's self-management

Diabetic Self-Management Training (DSMT)

Diabetic self-management training (DSMT) services are intended to educate members in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose, education about diet and exercise, an insulin treatment plan developed specifically for the members, and motivation for members to use the skills for self-management. Diabetic self-management training (DSMT) services may be covered when criteria are met. For coverage criteria, refer to the Medicare Benefit Policy Manual, Chapter 15, §300 – Diabetic Self-Management Training Services.

- FDA approved medically necessary diabetic supplies and equipment for diabetics including gestational diabetics, when prescribed or ordered by a physician (based upon the medical needs of the member)
  Note: The physician must determine that the member or home support person(s) can be trained in equipment use and monitor the blood glucose.
  - Intermittent blood glucose monitors, blood-testing strips, and lancets and lancet puncture devices
  - Modified blood glucose monitors and supplies for the visually impaired (covered under the member's DME benefit). The physician must certify that visual impairment is so severe that the member requires specific supplies, which include, but are not limited to:
    - Voice synthesizers
    - Automatic timers
    - Specially designed supplies to promote self-management
- Continuous subcutaneous insulin infusion pump (CSII) and all related necessary supplies are covered when medical criteria are met. Refer to the Medical Management Guideline titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes.
  Note: Payment may be made for drugs necessary for the effective use of an external infusion pump as long as the drug being used is in itself reasonable and necessary for the member's treatment.
- Materials necessary for the function of the CSII pump that are not available over the counter (e.g., tubing, syringe reservoir, special needles).
- Visual aids for member's who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. (Refer to the Benefit Interpretation Policy titled Vision Care and Services).
- Pen delivery systems (for the administration of insulin).
- **United HealthCare Benefits Plan of California**: Batteries and battery chargers for insulin infusion pumps and home blood glucose monitors are covered
- Supplies for DME items only when necessary for the effective use of the item/device.
- Urine test strips, ketone urine test strips, and tablets
- Insulin syringes

Not Covered

- Insulin, except when:
  - Member has supplemental prescription drug benefit
  - Used in conjunction with a continuous subcutaneous insulin infusion pump (CSII)
- Alcohol, alcohol wipes, betadine, betadine wipes or iodine, iodine wipes
- Cotton swabs, peroxide or phisohex
- Implantable infusion pumps for the infusion of insulin
- Eyeglasses or contact lenses

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References

Medicare Benefit Policy Manual, Chapter 15, §300 – Diabetic Self-Management Training Services. Accessed January 31, 2024.

NCD for Diabetes Outpatient Self-Management Training (40.1) and CFR Title 42, Chapter IV, §410. 132-§410.146 – Outpatient Self-Management Training and Diabetes Outcome Measurements. Accessed January 31, 2024.

Policy History/Revision Information

Date	Summary of Changes
04/01/2024	**Covered Benefits** • Removed instruction to refer to the Medical Management Guideline titled *Clinical Practice Guidelines* for information regarding diabetic management and treatment ***Diabetic Self-Management Training (DSMT)*** • Replaced references to "patients" with "members" **Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP042.K

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

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