Original Effective Date: 05/01/2014
Current Effective Date: 06/23/2023
Last P&T Approval/Version: 04/24/2024
Next Review Due By: 04/2025
Policy Number: C5108-A

Diabetic Testing Supplies

PRODUCTS AFFECTED

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
N/A

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. FOR ALL INDICATIONS, FOR NON-FORMULARY METER AND TEST STRIPS, NEEDLES, OR SYRINGES:
   1. Documentation of ONE of the following:
      (a) Medically necessary justification (e.g., mental, or physical limitation) why the patient needs to remain on their current glucometer/test strip/needle/syringes
      OR

(b) Member has a physical or mental limitation that requires the use of a specific non-formulary glucometer/test strip/needle/syringes
OR
(c) Member is currently on an insulin pump or an insulin delivery device (e.g., OmniPod) that requires a specific glucometer/test strip

CONTINUATION OF THERAPY:
N/A

DURATION OF APPROVAL:
Initial authorization: 12 months, Continuation of therapy: N/A

PRESCRIBER REQUIREMENTS:
None

AGE RESTRICTIONS:
None

QUANTITY:
Child, Insulin dependent or pregnant member: 200 strips/30 days
Adult, non-insulin dependent member: 100 strips/30 days OR Documentation describing need for more frequent testing

PLACE OF ADMINISTRATION:
The recommendation is that supplies in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
N/A

DRUG CLASS:
Diagnostic Tests

FDA-APPROVED USES:
Routine blood glucose monitoring

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
The American Diabetes Association (ADA) recommends routine blood glucose monitoring in patients using insulin therapy. The ADA also notes that blood glucose monitoring may be helpful to guide treatment decisions for patients using noninsulin therapies. The ADA does not differentiate between brands of diabetic meters or test strips in their recommendation. This program allows members utilizing

an insulin pump to continue on their current diabetic meter/test strip if it the diabetic meter/strip is part of the system and interfaces directly with the insulin pump.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
None

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:

REFERENCES

1. Diabetes Technology: Standards of Medical Care in Diabetes 2022 American Diabetes Association Diabetes Care Jan 2022, ~~44~~-45(Supplement 1) S97-S;112 DOI: 10.2337/dc 22-S007
2. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes – 2023. Diabetes Care 2023; 46 (Suppl. 1): S140-S157. https://doi.org/10.2337/dc23-S009
3. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes – 2024. Diabetes Care 2024; 47 (Suppl. 1): S158-S178. https://doi.org/10.2337/dc24-S009

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: References	Q2 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy References	Q2 2023
REVISION- Notable revisions: References	Q2 2022
Q2 2022 Established tracking in new format	Historical changes on file