# Clinical Policy: Diabetic Supplies

Reference Number: TX.CP.MP.526
Last Review Date: 05/25

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

Diabetic testing supplies include blood sugar monitors, blood sugar test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of testing equipment and test strips. Results are used to guide treatment decisions and/or member self-management.

Glucose self-testing supplies do not require prior authorization for quantities up to the allowable for insulin dependent or non-insulin dependent members. This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

## Policy/Criteria

**I.** Prior authorization is required for quantities requested **over the allowable limit**. The request must include the following information:
   A. Type of diabetes the member has: insulin dependent, non-insulin dependent, gestational
   B. Prescribed frequency of testing, and
   C. Clinical justification for the frequency of testing.

*Limitations*

| Diagnosis | Procedure Code | Limitation |
|---|---|---|
| **Insulin Dependent Diabetic** | A4253 | 2 boxes per month |
| | A4259 | 1 box per month |
| | A9275 | 2 per month |
| | A4250 | 1 box every 6 months; (quantities within the allowable do not require prior- authorization) |
| *Note: A member may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two of one procedure code or one of each procedure code.* | | |

*Limitations (Cont.)*

| Diagnosis | Procedure Code | Limitation |
|---|---|---|
| **Non-Insulin Dependent Diabetic** | A4253 | 1 box per month |

| | | |
|---|---|---|
| | A4259 | 1 box every 2 months |
| | A9275 | 1 per month |
| | A4250 | 1 box every 6 months; (quantities within the allowable do not require prior- authorization) |
| *Note: A member may receive only one per calendar month of either procedure code A4253 or A9275.* | | |

**II.** Blood ketone strips/tests (A4252) requested beyond 10 units a month up to 30 units per month may be considered medically necessary for members who are on a ketogenic diet and monitored/tested daily.

**Coding Implications**

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| CPT® Codes | Description |
|---|---|
| N/A | |

| HCPCS Codes | Description |
|---|---|
| A4250 | Urine test or reagent strips or tablets (100 tablets or strips) |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips |
| A4259 | Lancets, per box of 100 |
| A9275 | Home glucose disposable monitor, includes test strips |
| A4252 | Blood Ketone Test or Strip |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| ICD 10 CM Code | Description |
|---|---|
| N/A | |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Added A4259 under the no authorization required within benefit limitation table. Updated TMHP reference from 2013 to 2014. Added the verbal order protocol and formatted work process. Updated signatories. | 09/14 | 09/14 |
| Removed work process and imbedded in attachment section. Added policy to reference list. | 02/15 | 02/15 |
| Updated requirement of A4259 to 1 per month – check benefit limitation. Added E2100 (waiver only) and E2101 allowed 1 every 3 years. No auth required. Removed work process from attachment section. Updated reference list. | 08/15 | 08/15 |
| Removed CPT Codes A4230, A4231, A4232, A4601, A4602, A6257, A6258, A6259, K0601, K0602, K0603, K0604, and K0605 as these codes pertain to ambulatory insulin pumps and continuous glucose monitoring devices.<br>Inserted E0620 is not a covered benefit. Removal of "waiver only" from 2100. Removed work process. Updated to ICD 10. Grammatical edits. Updated references. | 08/16 | 08/16 |
| Updated references and review date. | 07/17 | 07/17 |
| Annual review. Grammatical edits. | 08/17 | 08/17 |
| Annual review. Updated references, products, signatories, and deleted revision history prior to 2014. All CPT Codes tables removed and updated medical documentation and review requirements. | 07/18 | 07/18 |
| Updated to new template from TX.UM.10.26 (TX.CP.MP.526 nomenclature implementation 09/14/19). Removed 'type 1' and 'type 2' references and definitions. Reformatted 'Limitations' table. Updated references. | 07/19 | 07/19 |
| Annual Review. Updated References. | 07/20 | 07/20 |
| Annual Review. Updated References. Removed HCPC from CPT Code table and updated to HCPC table. | 07/21 | 07/21 |
| Removed criteria for E2100 as prior authorization removed. Annual Review. References Updated. | 5/22 | 5/22 |
| Annual Review. Updated References. | 05/23 | 05/23 |
| Section II added for blood ketone test/strips (A4252) criteria and added to HCPCS table. | 05/24 | 05/24 |
| Annual Review. Updated References. | 05/25 | 05/25 |

**References**

1. American Diabetes Association. 2013. Standards of Medical Care in Diabetes – 2013. *Diabetes Care*. 36(1). Retrieved from http://care.diabetesjournals.org/content/36/Supplement_1/S11.full.pdf+html
2. Centers for Disease Control and Prevention. 2012. Diabetes Public Health Resource: Basics About Diabetes. Retrieved from http://www.cdc.gov/diabetes/consumer/learn.htm

3. Texas Medicaid Provider Procedures Manual – Durable Medical Equipment, Medical Supplies, and Nutritional Supplies, Volume 2, 2.12.3 Glucose Testing Equipment and Other Supplies, April 2025

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.