


<b>MEDICAL POLICY</b>	<b>Diabetes: Blood Glucose Monitor and Supplies (Medicare Only)</b>
<b>Effective Date: 9/1/2021</b>   <div style="text-align: right;">9/1/2021</div>	Medical Policy Number: 276
	Medical Policy Committee Approved Date: 8/2020; 08/2021
Medical Officer	Date

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

## SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

## APPLIES TO:

Medicare only

### MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

**Note:** Blood glucose test or reagent strips (A4253) are addressed in the Providence Health Plan Pharmacy policy: Miscellaneous Products, Blood Glucose Test Strips.

Service	Medicare Guidelines
<i>Home blood glucose monitors and related accessories and supplies</i>	<ul style="list-style-type: none"> <li>• Local Coverage Determination (LCD): Glucose Monitors (<a href="#">L33822</a>)<sup>1</sup></li> <li>• Local Coverage Article: Glucose Monitor – Policy Article (<a href="#">A52464</a>)<sup>2</sup></li> </ul>

## BILLING GUIDELINES

See Providence Health Plan Pharmacy Operational Policy: Miscellaneous Products, Blood Glucose Test Strips regarding glucose test or reagent strips.

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### CPT/HCPCS CODES

<b>Medicare Only</b>	
No Prior Authorization Required	
<b>Blood Glucose Monitors:</b>	
E0607	Home blood glucose monitor
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/blood sample
<b>Glucose Supplies</b>	
A4206	Syringe with needle, sterile, 1 cc or less, each
A4215	Needle, sterile, any size, each
A4233	Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4255	Platforms for home blood glucose monitor, 50 per box
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box of 100
S8490	Insulin syringes (100 syringes, any size)
Not Covered	
<b>Glucose Supplies</b>	
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisoex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4257	Replacement lens shield cartridge for use with laser skin piercing device, each
A9270	Non-covered item or service
A9275	Home glucose disposable monitor, includes test strips
E0620	Skin piercing device for collection of capillary blood, laser, each

### INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical

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practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

## **REGULATORY STATUS**

### Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

## **REFERENCES**

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Glucose Monitors (L33822). Revision Effective Date: For services performed on or after 07/18/2021. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33822>. Accessed 07/25/2021.
2. Centers for Medicare & Medicaid Services. Local Coverage Article: Glucose Monitor - Policy Article (A52464). Revision Effective Date: 07/18/2021. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52464>. Accessed 07/25/2021.