Diabetic Management, Services and Supplies

Policy Number: BIP043.K
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➲ Instructions for Use

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Federal/State Mandated Regulations

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

Oklahoma

Title 36 Oklahoma Statutes Section 6060.2, Coverage for Diabetes Treatment

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87360

A. 1. Every health plan benefit issued or renewed on or after November 1, 1996, shall, subject to the terms of the policy contract or agreement, include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state:
   a. Blood glucose monitors
   b. Blood glucose monitors to the legally blind
   c. Test strips for glucose monitors
   d. Visual reading and urine testing strips
   e. Insulin
   f. Injection aids
   g. Cartridges for the legally blind
   h. Syringes
   i. Insulin pumps and appurtenances thereto
   j. Insulin infusion devices
   k. Oral agents for controlling blood sugar
   l. Podiatric appliances for prevention of complications associated with diabetes

2. The State Board of Health shall develop and annually update, by rule, a list of additional diabetes equipment, related supplies and health care provider services that are medically necessary for the treatment of diabetes, for which coverage shall also be included, subject to the terms of the policy, contract, or agreement, if such equipment and supplies have been approved by the federal Food and Drug Administration (FDA). Additional FDA-approved diabetes equipment and related supplies, and health care provider services shall be determined in consultation with a national diabetes association affiliated with this state, and at least three (3) medical directors of health benefit plans, to be selected by the State Department of Health.

3. All policies specified in this section shall also include coverage for:

a. Podiatric health care provider services as are deemed medically necessary to prevent complications from diabetes, and
b. Diabetes self-management training. As used in this subparagraph, "diabetes self-management training" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training shall comply with standards developed by the State Board of Health in consultation with a national diabetes association affiliated with this state and at least three (3) medical directors of health benefit plans selected by the State Department of Health. Such coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of which are weight reduction, shall be limited to the following:
    1. Visits medically necessary upon the diagnosis of diabetes,
    2. A physician diagnosis which represents a significant change in the symptoms or condition of the patient making medically necessary changes in the self- management of the patient, and
    3. Visits when reeducation or refresher training is medically necessary; provided, however, payment for the coverage required for diabetes self-management training pursuant to the provisions of this section shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training.

4. Diabetes self-management training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of this state. Diabetes self-management training may be provided by the physician or other appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered, certified, or licensed health care professionals may be provided in group settings where practicable.
5. Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when medically necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the patient's supervising physician when medically necessary.
6. Coverage may be subject to the same annual deductibles or coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits within a given policy.
7. Any health benefit plan, as defined pursuant to Section 6060.4 of this title, that provides coverage for insulin pursuant to this section shall cap the total amount that a covered person is required to pay for insulin at an amount not to exceed Thirty Dollars ($30.00) per thirty-day supply or Ninety Dollars ($90.00) per ninety-day supply of insulin for each covered insulin prescription, regardless of the amount or type of insulin needed to fill the prescription or prescriptions of the covered person.
    a. Nothing in this paragraph shall prevent a Health benefit plan from reducing the cost-sharing of a covered person to an amount less than Thirty Dollars ($30.00) per thirty-day supply or Ninety Dollars ($90.00) per ninety-day supply.
    b. The Insurance Commissioner shall ensure all health benefit plans comply with the requirements of this paragraph.
    c. The Commissioner may promulgate rules as necessary to implement and administer the requirements of this paragraph and to align with federal requirements.

B 1. Health benefit plans shall not reduce or eliminate coverage due to the requirements of this section.
2. Enforcement of the provisions of this act shall be performed by the Insurance Department and the State Department of Health.

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title

Section 310:590-3-1, Equipment, Supplies and Appliances to Treat Diabetes

http://okrules.elaws.us/oac/310:590-3-1

When deemed medically necessary and upon prescription or diagnosis by a physician or health care provider with prescribing authority working under the supervision of a physician, all individual or group health insurance defined by statute and or governed by the Oklahoma Insurance Commissioner or other appropriate statutory state agency as defined by statute must reimburse/cover the following equipment, appliances, insulin, prescriptions, drugs, and supplies:

1. Blood glucose monitors, which includes all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes.
2. Blood glucose monitors to the legally blind which includes all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes.
3. Test strips for glucose monitors, which includes test strips whose performance shall achieve the standards of the American College of Pathology, glucose control solutions, lancet devices and lancets for monitoring glycemic control.

4. Visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketone. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
5. Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.
6. Injection aids, which includes devices used to assist with insulin injection.
7. Syringes, which includes insulin syringes, pens-like insulin injection devices, pen needles for pen-like insulin injection devices and other disposable parts required for insulin injection aids.
8. Insulin pumps as prescribed by the physician and appurtenances thereto, which includes insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. Includes durable and disposable devices used to assist in the injection of insulin.
9. Oral agents for controlling the blood sugar level which are prescription drugs.
10. Podiatric appliances for prevention of complications associated with diabetes, which includes therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.
11. Glucagon Emergency Kits or injectable glucagon.

Section 310:590-3-2, Related Provider Services

http://okrules.elaws.us/oac/310:590-3-2

When deemed medically necessary and upon prescription or diagnosis by a physician or health care provider with prescribing authority working under the supervision of a physician, all individual or group health insurance defined by statute and or governed by the Oklahoma Insurance Commissioner or other appropriate statutory state agency as defined by statute shall reimburse/cover the following related provider services:

1. Insulin and prescription drugs including oral-glucose lowering agents, antihypertensive and lipid lowering agents and other medications for delaying or preventing both acute and chronic complications;
2. Medical nutrition therapy recommendations and instructions by a registered, licensed dietitian;
3. Self-glucose monitoring instruction by a licensed, registered health care professional;
4. Foot examination annually;
5. Annual screening dilated eye examinations by an eye physician for persons with diabetes;
6. Glycohemoglobin determination done as frequently as necessary to assess and achieve near normal glycemia;
7. Recommendations for appropriate life-style changes including smoking cessation, exercise, and stress management;
8. Lipid profile upon diagnosis for adults and annually thereafter. If lipid profile is abnormal and the person with diabetes is on a lipid lowering therapy, a lipid profile shall be done as frequently as necessary to assess and achieve the desired lipid level. Children shall have a lipid profile once glucose control has been established; and
9. Screening microalbumin annually.

Section 310:590-3-3, Podiatric Health Care Provider Services

http://okrules.elaws.us/oac/310:590-3-3

When determined as medically necessary for the prevention of lower extremity complications and upon referral by a physician, all individual or group health insurance defined by statute shall reimburse/cover as defined by statute the following, but not limited to, podiatric health care provider services:

1. Fitting of therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications;
2. Callus and nail trimming;
3. Complex evaluation of sensory loss; and
4. Treatment of ulcer with total contact casting.

Section 310:590-3-4, Diabetes Self-Management Training

http://okrules.elaws.us/oac/310:590-3-4

a) When deemed medically necessary and prescribed by a physician or health care provider with prescribing authority working under the supervision of a physician diabetes self-management training shall be covered by individual and group health insurance policies as defined by statute.
b) The diabetes self-management training process shall comply with the standards as defined in this chapter and documentation shall be issued upon successful completion of the training by the licensed health care provider/diabetes educator.
c) Individual and group insurance policies as defined by statute shall provide coverage for medical nutrition therapy relating to diet, caloric intake, and diabetes management, but shall exclude programs whose only purpose is weight reduction.
d) The diabetes self-management training process may be conducted, but not limited to settings such as in-patient, out-patient, office, community, or home and as individual or group sessions.

e) Diabetes self-management training visits shall include, but not limited to:
   1) The diagnosis of diabetes;
   2) A significant change in the patient's diabetes symptoms or condition; or
   3) Re-education or refresher training.

Section 310:590-3-5, Standards for Diabetes Self-Management Training

http://okrules.elaws.us/oac/310:590-3-5

When deemed medically necessary and prescribed by a physician or health care provider with prescribing authority working under the supervision of a physician diabetes self-management training shall be covered by individual and group health insurance policies as defined by statute. The diabetes education process for self-management training shall include the following standards.

1. Needs assessment. The licensed health care provider/diabetes educator shall conduct an individualized educational needs assessment with the participation of the patient, family or support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include but is not limited to the following:
   A. Health history;
   B. Medical history;
   C. Previous use of medication;
   D. Diet history;
   E. Current mental health status;
   F. Use of health care delivery system;
   G. Life-style practices such as occupation, education, financial status, social, cultural, religious practices, preventive behaviors;
   H. Physical and psychological factors including age, mobility, visual acuity, hearing acuity, manual dexterity, alertness, attention span, and ability to concentrate;
   I. Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
   J. Family and social support; and
   K. Previous diabetes education, including actual knowledge and skills.
2. Education plan. The licensed health care provider/diabetes educator shall develop a written education plan from information obtained in the needs assessment and that includes the following:
   A. Desired patient outcomes;
   B. Measurable, behaviorally stated learner objectives; and
   C. Instructional methods.
3. Education intervention. The licensed health care provider/diabetes educator shall create an educational setting conducive to learning with adequate resources such as space, teaching and audio-visual aids to facilitate the educational process and use a planned content outline. The content outline shall be provided based on the needs assessment:
   A. Diabetes pathophysiology;
   B. Stress and psychological adjustment;
   C. Family involvement in disease management;
   D. Medical nutrition therapy;
   E. Exercise and physical activity;
   F. Medications;
   G. Blood glucose monitoring and use of results;
   H. Diabetes management which is the relationship between nutrition, exercise, medication, and blood glucose levels;
   I. Prevention, detection and treatment of acute complications;
   J. Prevention, detection and treatment of chronic complications;
   K. Foot, skin, and dental care;
   L. Behavior change strategies, goal setting, risk factor reduction, and problem solving;
   M. Benefits, risks, and management options for improving glucose control;
   N. Uses of health care systems and community resources; and
   O. Preconception care, pregnancy and gestational diabetes.
4. Evaluation of learner outcomes. The licensed health care provider/diabetes educator shall review and evaluate the degree to which the person with diabetes is able to demonstrate diabetes self-management skills as identified by behavioral objectives.
5. Plan for follow-up for continuing learning needs. The licensed health care provider/diabetes educator shall review the educational plan and recommend any additional educational interventions to meet continuing learning needs.
6. Documentation. The licensed health care provider/diabetes educator shall completely and accurately document the educational experiences provided.

Oregon

ORS Section 743.A.185, Telemedical Health Services for Treatment of Diabetes

https://www.oregonlegislature.gov/bills_laws/ors/ors743A.html

(1) As used in this section:
   (a) "Health benefit plan" has the meaning given that term in ORS 743B.005 (Definitions).
   (b) "Originating site" means a location where health services are provided or where the patient is receiving a telemedical health service.
   (c) "Telemedical" means delivered through a two-way electronic communication, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry, that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf, who is at an originating site.

(2) A health benefit plan must provide coverage of a telemedical health service provided in connection with the treatment of diabetes if:
   (a) The plan provides coverage of the health service when provided in person by the health professional;
   (b) The health service is medically necessary;
   (c) The telemedical health service relates to a specific patient; and
   (d) One of the participants in the telemedical health service is a representative of an academic health center.

(3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) A health benefit plan may subject coverage of a telemedical health service under subsection (2) of this section to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service when provided in person.

(5) This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan. [2011 c.312 §2]

Notes:

- See 743A.001 (Automatic repeal of certain statutes on individual and group health insurance).
- 743A.185 (Telemedical health services for treatment of diabetes) was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

ORS Section 743A.082, Diabetes Management for Pregnant Women

https://www.oregonlegislature.gov/bills_laws/ors/ors743A.html
https://oregon.public.law/statutes/ors_743a.082

(1) Except as provided in subsections (2) and (3) of this section, a health benefit plan, as defined in ORS 743B.005 (Definitions), may not require a copayment or impose a coinsurance requirement or a deductible on the covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.

(2) Subsection (1) of this section does not apply to a high deductible health plan described in 26 U.S.C. 223.

(3) The coverage required by subsection (1) of this section may be limited by network and formulary restrictions that apply to other benefits under the plan. Subsection (1) of this section does not apply to services, medications, test strips and syringes that are not covered due to the network or formulary restrictions.

(4) An insurer may require an enrollee or the enrollee's health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum. [2013 c.682 §2; 2014 c.74 §1]

Texas

28 TAC Section 21.2601-2606, Diabetes

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2601

§21.2601-Definitions

The following words and terms, when used in the subchapter, have the following meanings, unless the context clearly indicated otherwise.

(1) Basic benefit: Health care service or coverage, which is included in the evidence of coverage, policy, or certificate, without additional premium.

(2) Caretaker: A family member or significant other responsible for ensuring that an insured not able to manage his or her illness (due to age or infirmity) is properly managed, including overseeing diet, administration of medications, and use of equipment and supplies.
(3) Diabetes: Diabetes mellitus. A chronic disorder of glucose metabolism that can be characterized by an elevated blood glucose level. The terms "diabetes" and "diabetes mellitus" are synonymous.
(4) Diabetes equipment: The term "diabetes equipment" includes items defined in Insurance Code §1358.051 and §1358.056, and §21.2605 of this title (relating to Diabetes Equipment and Supplies).
(5) Diabetes supplies: The term "diabetes supplies" includes items defined in Insurance Code §1358.051 and §1358.056, and §21.2605 of this title.
(6) Diabetes self-management training: Instruction enabling an insured and/or his or her caretaker to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

(8) Insured: A person enrolled in a health benefit plan who has been diagnosed with:
(A) Insulin dependent or noninsulin dependent diabetes; or
(B) Elevated blood glucose levels induced by pregnancy or another medical condition associated with elevated glucose levels.

Section 21.2602, Required Benefits for Persons with Diabetes

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2602

(a) Notwithstanding §172.014, Local Government Code, or any other law, health plans provided by a risk pool created under Chapter 172, Local Government Code, delivered, issued for delivery, or renewed on or after January 1, 1998, that provide benefits for the treatment of diabetes and associated conditions must provide coverage to an insured for diabetes equipment, diabetes supplies, and diabetes self-management training programs, in accordance with §21.2603 of this title (relating to Out of Pocket Expenses), §21.2605 of this title (relating to Diabetes Equipment and Supplies) and §21.2606 of this title (relating to Diabetes Self-Management Training).
(b) Health benefit plans (other than reciprocal exchanges operating under Chapter 942 of the Texas Insurance Code) delivered, issued for delivery, or renewed on or after January 1, 1999, must provide coverage to each insured in accordance with §21.2603 of this title and §21.2604 of this title (relating to Minimum Standards for Benefits for Persons with Diabetes).
(c) Health benefits plans delivered, issued for delivery, or renewed on or after January 1, 1998, by an entity other than an HMO, which provide coverage limited to hospitalization expenses, shall provide coverage to each insured for diabetes equipment, diabetes supplies, and diabetes self-management training programs, in accordance with §§21.2603, 21.2605 and 21.2606 of this title, during hospitalization of the insured.
(d) A determination of medical necessity may be applied to benefits required under this subchapter provided it complies with all applicable laws and regulations.

Section 21.2603, Out of Pocket Expenses

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2603

(a) The basic benefits required under this subchapter shall not be subject to a deductible, coinsurance, or copayment requirement that exceeds the applicable deductible, coinsurance, or copayment applicable to other analogous chronic medical conditions or other similar benefits provided under the plan.
(b) No more than one copayment shall be charged for a thirty-day supply of any item of diabetes supplies listed in §21.2605 of this title (relating to Diabetes Equipment and Supplies). The amount of supplies that constitutes a thirty-day supply for an insured is the amount prescribed as a thirty-day supply by the physician or practitioner of the insured.

Section 21.2604, Minimum Standards for Benefits for Persons with Diabetes, Requirement for Periodic Assessment of Physician and Organization Compliance

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2604

(a) Health benefit plans provided by HMOs shall provide coverage for the services in paragraphs (1) through (7) of this subsection and shall contract with providers that agree to comply with the minimum practice standards outlined in subsection (b) of this section. Services to be covered include:
1. Office visits and consultations with physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;
2. Immunizations required by Insurance Code, Chapter 1367 Coverage for Childhood Immunizations;
3. Immunizations for influenza and pneumococcus;

4. Inpatient services, and physician and practitioner services when the insured is confined to:
   (A) A hospital;
   (B) A rehabilitation facility; or
   (C) A skilled nursing facility;
5. Inpatient and outpatient laboratory and diagnostic imaging services;
6. Diabetes equipment and supplies in accordance with §21.2605 of this title (relating to Diabetes Equipment and Supplies); and
7. Diabetes self-management training, in accordance with subsection (b)(1)(A)(iii) of this section and §21.2606 of this title (relating to diabetes self-management training);

(b) HMOs shall contract with providers who, at a minimum, provide care that complies with subsection (a) of this section that includes:
1. For all insureds:
   (A) At initial visit by the insured:
      i. A complete history and physical including an assessment of immunization status;
      ii. Development of a management plan addressing all of the following that are applicable to the insured:
         I. Nutrition and weight evaluation;
         II. Medications;
         III. An exercise regimen;
         IV. Glucose and lipid control;
         V. High risk behaviors;
         VI. Frequency of hypoglycemia and hyperglycemia;
         VII. Compliance with applicable aspects of self-care;
         VIII. Assessment of complications;
         IX. Follow up on any referrals;
         X. Psychological and psychosocial adjustment;
         XI. General knowledge of diabetes; and
         XII. Self-management skills;
      iii. Diabetes self-management training given or referred by the physician or practitioner as required by §21.2606 of this title and §21.2607 of this title;
      iv. Referral for a dilated funduscopic eye exam to be performed by an ophthalmologist or therapeutic optometrist for an insured with Type 2 Diabetes.
   (B) At every visit the following:
      i. Weight and blood pressure taken,
      ii. Foot exam performed without shoes or socks, and
      iii. Dental inspection.
   (C) Every six months the following:
      i. Review of the management plan, and
      ii. Glycosylated hemoglobin test.
   (D) Annually the following:
      i. Lipid profile,
      ii. Microalbuminuria;
      iii. Influenza immunization;
      iv. Referral for a dilated funduscopic eye exam performed by an ophthalmologist or therapeutic optometrist; and
      v. For insureds under eighteen years of age, a referral for a retinal camera examination to be performed by an ophthalmologist or therapeutic optometrist.
2. For treatment of an insured sixty-five years of age and over or an insured with complications affecting two or more body systems:
   A. Minimum practice standards as set forth in paragraph (1) of this subsection; and
   B. Specific inquiries into and consideration of treatment goals for comorbidity and polypharmacy.
3. For pregnant insureds with pre-existing or gestational diabetes:
   A. Minimum practice standards as set forth in paragraph (1) of this subsection; and
   B. Enhanced fetal monitoring based on the standards promulgated by the American College of Gynecologists and Obstetricians.
4. For insureds with Type 1 Diabetes:
   A. Minimum practice standards as set forth in paragraph (1) of this subsection;
   B. An initial diagnosis, consideration of hospitalization due to the insured's:
      i. Age;
      ii. Physical condition;
      iii. Psychosocial circumstances; or

iv. Lack of access to outpatient diabetes self-management training as required in §21.2606 of this title or §21.2607 of this title; and

C. On-going management which includes quarterly office visits at which evaluation includes:
i. Weight;
ii. Blood pressure;
iii. Ophthalmologic exam;
iv. Thyroid palpation;
v. Cardiac exam;
vi. Examination of pulses;
vii. Foot exam;
viii. Skin exam;
ix. Neurological exam;
x. Dental inspection;
xi. Results of home glucose self-monitoring;
xii. Frequency and severity of hypoglycemia or hyperglycemia;
xiii. Medical nutrition plan;
xiv. Exercise regimen;
xv. Adherence problems;
xvi. Psychosocial adjustment;
xvii. Reevaluation of short and long term self-management goals;
xviii. Anticipatory guidance related to issues of Type 1 Diabetes;
xix. Glycosylated hemoglobin;
xx. Counseling for high risk behaviors; and
xxi. For insureds under eighteen years of age, growth assessment.

(c) Health plans provided by HMOs shall periodically assess physician and organizational compliance with the minimum practice standards contained in subsection (b) of this section.

(d) Health benefit plans provided by entities other than HMOs shall provide coverage at a minimum for:
1. Office visits and consultations with physicians and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;
2. Immunizations required by Insurance Code Chapter 1367, Coverage for Childhood Immunizations;
3. Immunizations for influenza and pneumococcus;
4. Inpatient services, physician, and practitioner services when an insured is confined to:
A. A hospital;
B. A rehabilitation facility; or
C. A skilled nursing facility;
5. Inpatient and outpatient laboratory and diagnostic imaging services;
6. Diabetes equipment and supplies in accordance with §21.2605 of this title; and
7. Diabetes self-management training in accordance with §21.2606 of this title.

Section 21.2605, Diabetes Equipment and Supplies

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2605

(a) A health benefit plan shall provide coverage for equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including:
(1) Blood glucose monitors, including those designed to be used by or adapted for the legally blind;
(2) Test strips specified for use with a corresponding glucose monitor;
(3) Lancets and lancet devices;
(4) Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
(5) Insulin and insulin analog preparations;
(6) Injection aids, including devices used to assist with insulin injection and needleless systems;
(7) Insulin syringes;
(8) Biohazard disposal containers;
(9) Insulin pumps, both external and implantable, and associated appurtenances, which include:
(A) Insulin infusion devices;
(B) Batteries;
(C) Skin preparation items;
(D) Adhesive supplies;
(E) Infusion sets;
(F) Insulin cartridges;
(G) Durable and disposable devices to assist in the injection of insulin; and

(H) Other required disposable supplies;
(10) Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
(11) Prescription medications which bear the legend "Caution: Federal Law Prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
(12) Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
(13) Glucagon emergency kits.

(b) As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order.

(c) All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Section 21.2606, Diabetes Self-Management Training

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=21&rl=2606

(a) A health benefit plan shall provide diabetes self-management training or coverage for diabetes self-management training for which a physician or practitioner has written an order, including a written order of a practitioner practicing under protocols jointly developed with a physician, to each insured or the caretaker of the insured in accordance with the standards contained in Insurance Code §1358.054.

(b) A person may not provide a component of diabetes self-management training under subsection (a) of this section unless the subject matter of the component is within the scope of the person's practice and the person meets the education requirements as determined by the person's licensing agency in consultation with the commissioner of health.

(c) Self-management training shall include the development of an individualized management plan that is created for and in collaboration with the insured and that meets the requirements of the minimum standards for benefits in accordance with §21.2604 of this title (relating to Minimum Standards for Benefits for Persons with Diabetes).

(d) Nutrition counseling and instructions on the proper use of diabetes equipment and supplies shall be provided or covered as part of the training.

(e) Diabetes self-management training shall be provided, or coverage for diabetes self-management training shall be provided to an insured or a caretaker, upon the following occurrences relating to an insured, provided that any training involving the administration of medications must comply with the applicable delegation rules from the appropriate licensing agency:
(1) The initial diagnosis of diabetes;
(2) The written order of a physician or practitioner indicating that a significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime;
(3) The written order of a physician or practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

(f) An HMO shall provide oversight of its diabetes self-management training program on an ongoing basis to ensure compliance with this section.

(g) Health benefit plans provided by entities other than HMOs shall disclose in the plan how to access providers or benefits described in subsection (a) of this section.

TIC Chapter 1358, Subchapter A Guidelines for Diabetes Care, Minimum Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1358.htm

Section 1358.005, Coverage Required

a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan.

Subchapter B, Supplies and Services Associated With Diabetes Treatment

Section 1358.054, Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1358.htm

a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:
   1) Diabetes equipment;
   2) Diabetes supplies; and
   3) Diabetes self-management training in accordance with the requirements of Section 1358.055.

(a-1) A health benefit plan described by Subsection (a) must provide to each qualified enrollee coverage for emergency refills of diabetes equipment or diabetes supplies dispensed to the enrollee in accordance with Section 562.0541, Occupations Code, in the same manner as for a nonemergency refill of diabetes equipment or diabetes supplies.

b) A health benefit plan may require a deductible, copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions.

Section 1358.055, Diabetes Self-Management Training

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1358.htm

(a) Diabetes self-management training must be provided by a health care practitioner or provider who is:
   (1) Licensed, registered, or certified in this state to provide appropriate health care services; and
   (2) Acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:
   (1) Training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;
   (2) Additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and
   (3) Periodic or episodic continuing education training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:
   (1) A diabetes self-management training program recognized by the American Diabetes Association;
   (2) Diabetes self-management training provided by a multidisciplinary team:
      (A) The nonphysician members of which are coordinated by:
         (i) A diabetes educator who is certified by the National Certification Board for Diabetes Educators; or
         (ii) An individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
      (B) That consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and
      (C) Each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;
   (3) Diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or
   (4) Diabetes self-management training that provides one or more of the following components:
      (A) A nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;
      (B) A pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;
      (C) A component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
      (D) A component provided by a physician.

(d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:
   (1) The subject matter of the component is within the scope of the individual's practice; and
   (2) The individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

Section 1358.056, Coverage for New or Improved Equipment and Supplies

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1358.htm

A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.

28 TAC Rule Section 11.508, Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

b) Each evidence of coverage must also include coverage for services as follows:
   3) Diabetes self-management training, equipment, and supplies as required by Insurance Code Chapter 1358, Subchapter B, (concerning Diabetes).

Washington

RCW Section 48.44.315, Diabetes Coverage

https://app.leg.wa.gov/RCW/default.aspx?cite=48.44.315

The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

1. The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.
   a. "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and
   b. "Health care provider" means a health care provider as defined in RCW 48.43.005.
2. All health benefit plans offered by health care service contractors, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:
   a. For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and
   b. For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health care services contractor from restricting patients to seeing only health care providers who have signed participating provider agreements with the health care services contractor or an insuring entity under contract with the health care services contractor.
3. Except as provided in RCW 48.43.780 Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.
4. Health care coverage may not be reduced or eliminated due to this section.
5. Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.
6. The health care service contractor need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible members a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.
7. This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan.

RCW Section 48.46.272, Diabetes Coverage: Definitions

https://app.leg.wa.gov/RCW/default.aspx?cite=48.46.272

The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

a. "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and
b. "Health care provider" means a health care provider as defined in RCW 48.43.005.

2) All health benefit plans offered by health maintenance organizations, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:
   a) For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and
   b) For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health maintenance organization from restricting patients to seeing only health care providers who have signed participating provider agreements with the health maintenance organization or an insuring entity under contract with the health maintenance organization.
3) Except as provided in RCW 48.43.780 Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.
4) Health care coverage may not be reduced or eliminated due to this section.
5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.
6) The health maintenance organization need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.
7) This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan.

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:

- 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.
- Diabetic management and treatment, which include but are not limited to:
  - Outpatient diabetic self-management training (ODSMT) services training, education and medical nutritional therapy
    These services must be ordered/prescribed by a participating provider/physician and provided by an appropriately licensed or registered health care professional:
    - 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
  - 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 related drugs and supplies are covered when medical criteria are met (Refer to the Medical Policy titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes)
- 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 members 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)
- Urine test strips, ketone urine test strips and tablets
- Insulin syringes
- Supplies for DME items only when necessary for the effective use of the item/device

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 and contact lenses

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	State(s) Affected	Summary of Changes
01/01/2025	All	**Template Update** • Modified font style; no change to policy content • Updated reference links to related Medical Policies (previously classified as Medical Management Guidelines) **Related Policies** • Removed reference link to the Medical Management Guideline titled *Clinical Practice Guidelines* (retired May 1, 2024)
04/01/2024	All	**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"

Date	State(s) Affected	Summary of Changes
		Supporting Information • Removed *Definitions* section • Archived previous policy version BIP043.J

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.