Diabetic Test Strips

Policy # 00322
Original Effective Date: 05/22/2013
Current Effective Date: 11/11/2024

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider brands other than CONTOUR®‡ or TRUE®‡ blood glucose test strips to be **eligible for coverage**** when one of the below patient selection criteria is met:

Patient Selection Criteria

Coverage eligibility will be considered for brands other than CONTOUR or TRUE blood glucose test strips when one of the following criteria is met:

- The patient has visual impairment that would require a specific brand (other than CONTOUR or TRUE) of blood glucose test strips; OR
- The patient has an insulin pump that would require a specific brand (other than CONTOUR or TRUE) of blood glucose test strips; OR
- There is clinical evidence or patient history that suggests the use of CONTOUR or TRUE brand blood glucose test strips will be/was ineffective or will/did cause an adverse reaction to the patient.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of brands other than CONTOUR or TRUE blood glucose test strips when patient selection criteria are not met or for usage not included in the above patient selection criteria to be **not medically necessary**.******

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Background/Overview

Blood glucose test strips are used in conjunction with a blood glucose meter to measure a patient's blood glucose.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The patient selection criteria presented in this policy takes into consideration clinical evidence or patient history that suggests the use of CONTOUR or TRUE brand blood glucose test strips will be/was ineffective or will/did cause an adverse reaction to the patient. It also takes into account whether or not the patient has visual impairment or uses an insulin pump that would require a different brand of blood glucose test strips (other than CONTOUR or TRUE). Based on a review of the data, in the absence of the above mentioned caveats, there is no advantage of using a brand other than CONTOUR or TRUE brand blood glucose test strips.

References

1. Freckmann G, Baumstark A, Jendrike N, Zschornack E, Kocher S, Tshiananga J, Heister F, and Haug C. System Accuracy Evaluation of 27 Blood Glucose Monitoring Systems According to DIN EN ISO 15197. Diabetes Technology & Therapeutics. March 2010, 12(3): 221-231. doi:10.1089/dia.2009.0128.
2. Harrison B, Leazenby C, Halldorsdottir S. Accuracy of the Countour Blood Glucose Monitoring System. J Diabetes Sci Technol. 2011. July; 5(4):1009-1013.
3. Frank J, Block T, Carter J, Mullen L, Tideman A, Parkes J. Performance and Ease of Use of the Breeze 2 Blood Glucose Monitoring System. Bayer Health Care Diabetes Care. 2007.
4. Nipro Diagnostics.

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Policy History

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05/02/2013	Medical Policy Committee review
05/22/2013	Medical Policy Implementation Committee approval. New policy.
05/01/2014	Medical Policy Committee review
05/21/2014	Medical Policy Implementation Committee approval. No change to coverage.
10/02/2014	Medical Policy Committee review
10/15/2014	Medical Policy Implementation Committee approval. Removed Roche as a preferred test strip (AccuCheck). Added Nipro as a preferred strip (TRUE).
10/08/2015	Medical Policy Committee review
10/21/2015	Medical Policy Implementation Committee approval. No change to coverage.
10/06/2016	Medical Policy Committee review
10/19/2016	Medical Policy Implementation Committee approval. No change to coverage.
10/05/2017	Medical Policy Committee review
10/18/2017	Medical Policy Implementation Committee approval. No change to coverage.
10/04/2018	Medical Policy Committee review
10/17/2018	Medical Policy Implementation Committee approval. No change to coverage.
10/03/2019	Medical Policy Committee review
10/09/2019	Medical Policy Implementation Committee approval. No change to coverage.
10/01/2020	Medical Policy Committee review
10/07/2020	Medical Policy Implementation Committee approval. No change to coverage.
10/07/2021	Medical Policy Committee review
10/13/2021	Medical Policy Implementation Committee approval. No change to coverage.
10/06/2022	Medical Policy Committee review
10/11/2022	Medical Policy Implementation Committee approval. No change to coverage.
10/05/2023	Medical Policy Committee review
10/11/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/03/2024	Medical Policy Committee review
10/08/2024	Medical Policy Implementation Committee approval. Removed Breeze 2 from the policy due to its discontinuation.

Next Scheduled Review Date: 10/2025

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**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.