

## Medical Policy



### Insulin Infusion Pump and Supplies

#### Description

An insulin infusion pump is a battery-operated device which is used to deliver insulin at a controlled rate through a needle placed under the skin.

#### Policy

An insulin pump is **reasonable and necessary** for administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when members meet the coverage criteria below.

#### Policy Guidelines

##### Medicare Member Coverage Criteria:

Refer to Medicare policy (L33794) and article (A52507) for coverage criteria.

##### Non-Medicare Member Coverage Criteria:

With a diagnosis of diabetes mellitus, the medical record must show documentation of **ALL** of the following:

- a. Completion of a comprehensive diabetes education program.
- b. A regimen of at least three injections daily with frequent self-adjustments of insulin dose for at least six months prior to the initiation of the pump **(not applicable for pediatric members, under age 21 – ALL health plans)**.
- c. Frequency of glucose self-testing on average at least four times per day during the two months prior to initiation of the insulin pump. **\*This requirement does not apply to those members who are currently utilizing Continuous Glucose Monitoring (CGM).**
- d. At least **one** of the following while on the multiple daily injection regimen:
  - i. Glycosylated hemoglobin level (HbA1c)  $> 7.0$  percent
  - ii. History of recurring hypoglycemia
  - iii. Wide fluctuations in blood glucose before mealtime

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- iv. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
- v. History of severe glycemic excursions

#### Continued Coverage

Continued coverage of an external insulin pump and supplies requires that the member be seen and evaluated by the treating practitioner at least every 3 months. In addition, the external insulin infusion pump must be ordered, and follow-up care rendered by a practitioner who manages multiple members on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dietitians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

#### Limitations:

1. Repair of an insulin pump is limited to restoration to a serviceable condition.
2. Replacement of an insulin pump will be covered when the cost of repair exceeds the purchase price, or when necessitated by irreparable damage not due to misuse, intentional or non-intentional. **For NH Medicaid members replacement is limited to one pump per recipient every 4 years.**
3. The following items are considered not reasonable and necessary.
  1. Easy fill filling aid
  2. Remote Controller
  3. Computer software, adapter, and upload kits
  4. Pump covers, cases including shower bags
  5. Infusion set insertion device (Quick-serter, Sil-serter, Sof-serter)
4. Supplies are limited to the **quantities** listed below:

HCPCS Code	Description	Pump Model	Quantity
A4230	Infusion set for external insulin pump;	MiniMed	20 per month

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	non-needle type		(Two boxes of 10 count)
A4231	Infusion set for external insulin pump; needle type	MiniMed	20 per month (Two boxes of 10 count)
A4232	Supplies for external infusion pump, syringe type cartridge, sterile, each	MiniMed	20 per month (Two boxes of 10 count)
A4649	Piston Rod	All models	1 every 12 months
A6257	Transparent dressing <b>(Medicaid only)</b>	All models	12 per month
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	MiniMed	6 per month

### HCPCS Level II Codes and Description

#### COVERED HCPCS CODES:

A4224	Supplies for maintenance of insulin infusion catheter, per week <b>(Medicare)</b>
A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile each (Medicare)
A4230	Infusion set for external insulin pump, non-needle cannula type
A4231	Infusion set for external insulin pump, needle type
A4232	Syringe with needle for external insulin pump, sterile, 3 cc.
A4649	Surgical supply, miscellaneous (use for batteries, piston rod, adapter)
A5120	Skin barrier wipes or swabs, each 50ct. every other month. <b>(Medicaid Only)</b>
A6257	Transparent film, 16 sq. inches or less, each dressing <b>(Medicaid Only)</b>
E0784	External ambulatory infusion pump, insulin
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5v, each
K0602	Replacement battery for external infusion pump owned by patient silver oxide, 3volt, each
K0603	Replacement battery for external infusion pump owned by patient alkaline, 1.5 volt, each
K0604	Replacement battery for external infusion pump owned by patient, alkaline, 3 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each

#### NON-COVERED HCPCS CODES:

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A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or pHisoHex solution, per pint
A4247	Betadine or iodine swabs, per box
A5120	Skin barrier wipes or swabs, each
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories. Not reasonable and necessary due to not being standard and basic (this does <b>not</b> apply to WellSense NH Medicaid).

#### Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines. Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating practitioner in connection with diagnosis and treatment decisions.

Northwood follows all CMS National Coverage Determinations (NCD) and Local coverage Determinations (LCD), as applicable.

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#### References

Cigna: External Insulin Pumps.

[http://www.cigna.com/customer\\_care/healthcare\\_professional/coverage\\_positions/medical/mm\\_0087\\_coveragepositioncriteria\\_external\\_insulin\\_pumps.pdf](http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0087_coveragepositioncriteria_external_insulin_pumps.pdf) Last accessed and reviewed December 9, 2025.

Aetna: Infusion Pumps. [http://www.aetna.com/cpb/medical/data/100\\_199/0161.html](http://www.aetna.com/cpb/medical/data/100_199/0161.html) Last accessed and reviewed 12/9/25.

Centers for Medicare & Medicaid Services (CMS). Decision memo for insulin pump: C-peptide levels as a criterion for use (CAG-00092R). Baltimore, MD: CMS; Accessed 6/9/2011 from: <http://www.cms.gov/mcd/viewdecisionmemo.asp?id=109>.

CGS Administrators, LLC. Jurisdiction B DME MAC, External Infusion Pumps. Local Coverage Determination No. L33794; Last accessed and reviewed 12/9/25.

National Heritage Insurance Company (NHIC), External Infusion Pumps. Local Coverage Determination No. L5044. Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A. Chico, CA: NHIC; revised February 4, 2011.

#### Special Coverage Information Per Plan:

<b>WellSense NH Medicaid Plans only.</b>	The Omnipod (A9274) may be approved and is considered medically necessary <i>if</i> the Insulin Infusion Pump policy criteria is met.
<b>All Health Plans: For pediatric members (under age 21 years).</b>	A regimen of at least three injections daily with frequent self-adjustments of insulin dose for at least six months prior to the initiation of the pump is <b>NOT</b> required for <b>ALL</b> pediatric members.
<b>Security Health Plan (SHP): For pediatric members (under age 17 years).</b>	C-peptide level is not required for SHP members 17 years of age or younger.

#### Change/Authorization History

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Revision Number	Date	Description of Change	Prepared by	Approved by	Review Date	Effective Date
A	11-20-06	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01	12-08	Annual Review – no changes	Susan Glomb	Ken Fasse	n/a	
02	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec.2009	
03	12-02-10	Annual Review – No Changes	Susan Glomb	Ken Fasse	Dec. 2010	
04	04-22-11	Added inclusion of Skin barrier wipes for Medicaid members. 50ct. every other month.	Susan Glomb	Dr. Almasri		
05	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri		
06	11-30-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011	
07	03-28-12	Policy updated to distinguish between criteria for Type 1 diabetics vs. Type 2 diabetics. Cigna reference added to policy.	Susan Glomb	Dr. B. Almasri	March 2012	
08	8-29-12	Removed Type 2 coverage criteria	Susan Glomb	Dr. B. Almasri	August 2012	
09	11-29-12	Annual review – no changes.	Susan Glomb	Dr. B. Almasri	Nov. 2012	
10	12-30-13	Annual review. Added A9274 External ambulatory insulin delivery system, disposable, each includes al supplies and accessories to the list of “not reasonable and necessary” items.	Susan Glomb	Dr. B. Almasri	Dec. 2013	

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11	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
12	12-14-15	Annual Review. Updated Medicare and non-Medicare criteria. Updated references.	Susan Glomb	Dr. B. Almasri	12-14-15	
13	12-28-16	Annual Review. Removed K0552. Added Codes A4224 and A4225.	Susan Glomb	Dr. B. Almasri	12-28-16	
14	04-17-17	Policy updated to indicate that A9274 External ambulatory insulin delivery system, disposable, is not reasonable and necessary due to not being standard and basic.	Susan Glomb	Dr. C. Lerchin		
15	07-10-17	Updated policy to state that a C-peptide level is not required for SHP members 17 years of age or younger.	Susan Glomb	Dr. C. Lerchin		
16	12-20-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2017	
17	12-10-18	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2018	
18	10-4-19	Added “does not apply to CGM users” (Non-Medicare portion of policy) to the testing requirement of 4x/day.	Carol Dimech	Dr. C. Lerchin	October 2019	10-4-19
19	11-4-19	Revised A6257 to allow 12/month.	Carol Dimech	Dr. C. Lerchin	November 2019	11-4-19

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20	12-12-19	Annual review. Updated Medicare reference.	Carol Dimech	Dr. C. Lerchin	December 2019	December 2019
21	12-03-20	Annual review. Updated policy to reflect Omnipod coverage for Mass Health and Well Sense Plans. Per CMS, revised “physician” to “practitioner”.	Carol Dimech	Dr. C. Lerchin	December 3, 2020	December 3, 2020
22	12-15-21	Annual review. Added NCD/LCD verbiage to Important Note.	Carol Dimech	Dr. C. Lerchin	December 15, 2021	December 15, 2021
23	3-21-22	Updated policy to reflect Plan rebranding – changed to WellSense.	Carol Dimech	Dr. C. Lerchin	3-21-22	3-21-22
24	12-15-22	Annual Review No changes	Carol Dimech/Susan Glomb	Dr. C. Lerchin	12-15-22	
25	7/24/23	Removed reference to Animas.	Carol Dimech	Dr. C. Lerchin	7/24/23	7/24/23
26	8/10/2023	Updated quantity box to 20/month as supplies come in 10/box.	Carol Dimech	Dr. C. Lerchin	8/10/2023	8/10/2023
27	11/2/23	Added HNE box coverage criteria for members under age 21.	Carol Dimech	Dr. C. Lerchin	11/2/23	11/2/23
28	12-15-23	Annual review. Revised criteria coverage: “A regimen of at least three injections daily with frequent self-adjustments of insulin dose for at least six months prior to the initiation of the pump” as not applicable to	Carol Dimech	Dr. C. Lerchin	12-15-23	12-15-23



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		pediatric members under 21 years – all Plans.				
29	12-9-24	Annual review. Updated references. Removed Medicare narrative – refer to LCD/Policy Article for Medicare members.	Carol Dimech	Dr. C. Lerchin	12-9-24	12-9-24
30	12-9-25	Annual review. No changes	Susan Glomb	Dr. C. Lerchin	12-9-25	12-9-25