




KERN HEALTH SYSTEMS

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POLICY AND PROCEDURES					
SUBJECT: Diabetes Treatment and Management			POLICY #: 3.54-P		
DEPARTMENT: Director of Quality Improvement, Health Education and Disease Management					
Effective Date: 10/2005	Review/Revised Date: <i>07/11/2013</i>	DMHC		PAC COMMITTEE	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	



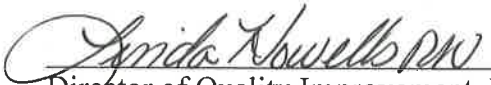
 Douglas A. Hayward
 Chief Executive Officer

Date *7/4/13*

 Chief Medical Officer


 Director of Health Services

Date _____
 Date *7/10/13*



 Director of Quality Improvement, Health Education
 and Disease Management

Date *7-2-13*

POLICY:

Kern Health Systems (KHS) shall provide its members who have the diagnosis of non-insulin dependent diabetes, insulin dependent diabetes, and gestational diabetes with equipment, supplies, and pharmaceuticals necessary for the management and treatment of their disease. KHS shall also make available outpatient self-management training, education, and medical nutrition therapy. KHS will coordinate the care of members under the age of 21 with the diagnosis of diabetes with the California Children’s Services (CCS) for possible CCS condition.

KHS will provide diabetes treatment and management as required by California Health and Safety Code §1367.51.

PROCEDURES:

1.0 ACCESS

Medical nutrition therapy should be accessed as outlined in *KHS Policy and Procedure #3.37 – Specialty Nutrition Consultation*. Diabetes outpatient self-management training and education should be accessed as outlined in *KHS Policy and Procedure #2.35-P: Disease Management*.

All other diabetes treatment and management services require prior authorization. Authorization should be requested as outlined in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process*.

Prescription medicine that is not covered on the KHS Formulary requires prior authorization. Authorization should be requested as outlined in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests*.

2.0 COVERED SERVICESⁱ

Covered services include outpatient self-management training, diabetes education classes, prescription drugs, medical nutrition therapy, and specific diabetic supplies that are medically necessary for the treatment and management of diabetes.

Covered diabetic supplies are included in the KHS Formulary and the plan's Pharmacy Benefit Manager to provide easy access for diabetic members. Healthy Families members are subject to co-payments and deductibles according to their benefit plan. KHS covers the following diabetic supplies in medically appropriate quantities:

- A. Blood glucose monitors and testing strips
- B. Blood glucose monitors designed to assist the visually impaired (prior authorization required)
- C. Ketone urine testing strips (Note: glucometers are supplied by the manufactures)
- D. Lancets
- E. Pen delivery systems for the administration of insulin (prior authorization required)
- F. Insulin syringes and needles
- G. Insulin
- H. Glucagon
- I. Insulin pumps and all related necessary supplies (prior authorization required)
- J. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- K. Podiatric devices to prevent or treat diabetes complications need to be reviewed on an individual basis to determine medical necessity for services requested

Additional information on the provision of diabetes outpatient self-management training, education and medical nutrition therapy is outlined in *KHS Policy and Procedure #2.35-P: Disease Management*.

3.0 COMPREHENSIVE DIABETS CAREⁱⁱ

3.1 Blood Glucose Monitoring

HbA1C testing measures the percentage of glycosalated hemoglobin in the blood and estimates the clinical level of blood glucose over the two to three month period of time immediately prior to the test. An HbA1C of 6% is normal. Diabetes patients under good control should have HbA1C levels less than 7%. If the HbA1C is 7% or higher, it indicates that the control is not at an optimum level.

This test should be done at least two times per year in patients who are meeting treatment goals and who have stable glycemic control.

Perform the HbA1C test quarterly in members whose therapy has changed or who are not meeting glycemic goals.

The use of point-of-care testing for A1C allows for timely decisions on therapy changes, when needed.

The goal of therapy is to reduce the A1C to a level of less than 7% as it has been clearly shown to reduce microvascular and neuropathic complications of diabetes and, possibly, macrovascular disease. The A1C goal for nonpregnant adults is <7%.

3.2 Dyslipidemia/Lipid Management

LDL-C testing measures *fasting* lipid profile at least annually.

Lifestyle modification focusing on the reduction of saturated fat, *trans* fat, and cholesterol intake; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes.

Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients with overt cardiovascular disease (CVD) or without covert CVD who are over the age of 40 and have one or more other CVD risk factors.

For patients at lower risk than those mentioned above (e.g., without CVD and under the age of 40), statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains >100 mg/dl or in those with multiple CVD risk factors.

In individuals without overt CVD, the primary goal is an LDL-C <100 mg/dl.

In individuals with overt CVD, a lower LDL cholesterol of <70 mg/dl, using a high dose of statin, is an option.

Statin therapy is contraindicated in pregnancy.

3.3 Nephropathy Screening and Treatment

To reduce the risk or slow the progression of nephropathy and to optimize glucose control and blood pressure control.

Perform an annual urinalysis (UA) for microalbumin secretion in all Type 1 diabetics who have had the disease for 5 years and in all type 2 diabetics starting at diagnosis and continuing annually.

Measure serum creatinine at least annually in all adults regardless of the degree of urine albumin secretion. In treatment of the nonpregnant member with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. Use of ACE inhibitors or ARBs is contraindicated in pregnancy.

In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used.

Use of ACE inhibitors or ARBs is contraindicated in pregnancy.

3.4 Retinopathy Screening and Treatment

To reduce the risk or slow the progression of retinopathy, optimize glucose control and to reduce the risk or slow the progression of retinopathy, optimize blood pressure control.

Adults and adolescents with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist within 5 years after the onset of diabetes. Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist shortly after the diagnosis of diabetes.

Subsequent examinations can be performed annually by either a contracted ophthalmologist or optometrist.

Note: Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. Eye examination should occur in the first trimester with close follow up throughout pregnancy and for 1 year postpartum.

Treatment: Promptly refer all patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy.

The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage.

3.5 Foot Care

For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination can be accomplished in a primary care setting and should include the use of a monofilament, tuning fork, palpation, and a visual examination. KHS has a program in place to assist diabetic patients with foot care problems that provides indicated DME that may be not available through fee for service Medi-Cal.

3.6 Medical Nutrition Therapy

Individuals who have pre-diabetes or diabetes should receive individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT. This service is available through the KHS Health Education Department.

In overweight and obese insulin-resistant individuals, modest weight loss has been shown to reduce insulin resistance. Thus weight loss is recommended for all overweight or obese individuals who have or are at risk for diabetes.

For weight loss, either low-carbohydrate or low fat calorie-restricted diets may be effective in the short term (up to one year). Dietary counseling for weight loss is available through KHS Health Education Department.

For patients on low carbohydrate diets, monitor lipid profiles, renal function and protein intake (in those with nephropathy), and adjust hypoglycemic medication as needed.

Physical activity and behavior modification are important components of weight loss programs and are most helpful in maintenance of weight loss.

3.7 Bariatric Surgery

May be considered for adults with type 2 diabetes who have a body mass index of 35 or greater and have associated co morbidities related to their diabetes. This is especially true if the diabetes is difficult to control with lifestyle and pharmacologic therapy. Patients who have undergone bariatric surgery need life-long lifestyle support and medical monitoring. In that regard, and to be sure that patients are legitimate candidates to benefit from this procedure, KHS requires a thorough workup by the member's PCP to qualify them for entry into a pre-bariatric surgery evaluation program developed specifically for this purpose. With completion of this program, qualified patients are referred to a contracted bariatric surgeon for this surgery.

Bariatric surgery is currently not a covered benefit for individuals under the age of 21. There is currently insufficient evidence to support a recommendation for bariatric surgery in patients with a BMI of less than 35.

REFERENCE:

ⁱ **Revision 2013-07:** Minor changes provided by Director of Utilization Management. **Revision 2010-11:** Routine revision completed by UM Department. **Revision 2009-11:** Director of Quality Improvement, Health Education & Disease Management added the ADA Guidelines so that providers will have a procedure to follow for diabetic members. **Revision 2005-11:** Routine revision. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).

ⁱ HSC §1367.51(a) and (b)

ⁱⁱ American Diabetes Association: Clinical Practice Recommendations 2009