

Policy Number	THE801.035
Policy Effective Date	06/15/2026

Insulin Potentiation Therapy

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Insulin potentiation therapy (IPT) **is considered experimental, investigational and/or unproven.**

Policy Guidelines

None.

Description

The observation that some cancer cells may express a greater number of insulin receptors has been the basis of the hypothesis for insulin potentiation therapy (IPT). The physiologic effects of insulin in IPT are thought to increase the permeability of cell membranes and facilitate increased intracellular absorption of pharmacologic agents. Theoretically, the increased absorption of a pharmacologic agent results in higher intracellular drug concentrations; lower dosage requirements could then reduce toxicity and adverse side effects. IPT was developed in

the 1930s by a physician in Mexico. Insulin potentiation therapy is primarily used in the treatment of cancer, for which increasing the intracellular concentration and cytotoxic effects of chemotherapy agents while decreasing the adverse effects is thought to increase antitumoral activity and patient tolerance to treatment. There have been proponents of using IPT for other conditions as well, such as chronic degenerative disease.

Rationale

This policy is based on a review of the National Comprehensive Cancer Network® (NCCN) Guidelines. No mention of insulin potentiation therapy was noted as a recommended treatment modality for any of the reviewed cancer types. (1-68)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	96549
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <<https://www.cms.hhs.gov>>.

Policy History/Revision

Date	Description of Change
06/15/2026	Document updated. Coverage unchanged. References 5 and 50 added, others updated/removed.
11/15/2025	Document updated. Coverage unchanged. References 1-67 added.
05/15/2024	Document updated with literature review. Coverage unchanged. No new references added; one reference removed.
03/15/2023	Reviewed. No changes.

07/01/2022	Document updated with literature review. Coverage unchanged. No new references added; one removed.
04/01/2021	Reviewed. No changes.
09/01/2020	Document updated with literature review. Coverage unchanged. No new references added; some removed.
11/15/2019	Reviewed. No changes.
04/15/2018	Document updated with literature review. Coverage unchanged. References 11 was added.
04/01/2017	Reviewed. No changes.
06/01/2016	Document updated with literature review. Coverage unchanged.
07/15/2015	Reviewed. No changes.
07/01/2014	Document updated with literature review. Coverage unchanged.
12/15/2011	Document updated with literature review. Coverage unchanged. Document number changed from RX504.014. This document is no longer scheduled for routine literature review and update.
08/01/2009	New medical document that that considers Insulin Potentiation Therapy to be experimental, investigational and unproven.