

<b>Title: Continuous Glucose Monitoring</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 11/17/17</b>	<b>LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&amp;II, Market Plus, Essential, HARP</b>
<b>Effective Date: 11/17/17</b>	<b>Policy Number: UM-MP221</b>
<b>Review Date: 11/17/17</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 1 of 4</b>

## 1. POLICY DESCRIPTION:

Guideline for Individuals with Type 1 Diabetes

## 2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

## 3. DEFINITIONS:

**Type 1 Diabetes:** once known as juvenile diabetes or insulin-dependent diabetes, is a chronic condition in which the pancreas produces little or no insulin. Insulin is a hormone needed to allow sugar (glucose) to enter cells to produce energy.

## 4. POLICY:

Effective November 3, 2017 MetroPlus will begin covering Continuous Glucose Monitors (CGM) for members who have a diagnosis of Type 1 diabetes and meet the coverage criteria outlined in this policy.

CGM device is considered medically necessary when member:

- Has a diagnosis of Type 1 diabetes; *AND*
- Under the care of the endocrinologist who orders the device; *AND*
- Currently performing at least four finger stick glucose tests daily; *AND*
- On an insulin treatment plan that requires frequent adjustment of insulin dosing; *AND*
- Able, or has a caregiver who is able, to hear and view CGM alerts and respond appropriately.

Additional CGM Guidelines:

- In addition to the above coverage criteria, ordering providers should verify that their patients meet manufacturer's recommendations for appropriate age range, testing and calibration requirements, etc., prior to prescribing the CGM device.
- Members must comply with the manufacturer's specified finger stick testing recommendations for the CGM device prescribed.

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- Only one type of monitor will be covered: either therapeutic (such as but not limited to DexCom5) or non-therapeutic (such as but not limited to Metronics Minimed).
- Ancillary devices (such as but not limited: smart phones, tablets, personal computers) are not covered
- Replacement will be considered when medically necessary and outside of manufacturer's warranty and not for recent technology upgrades.
- Repairs will be funded if outside of manufacturer's warranty and cost effective (< 50% of cost).
- Claims submitted for all supplies and receiver (monitor) without a diagnosis of Type 1 diabetes will be denied.

## 5. LIMITATIONS/ EXCLUSIONS:

Codes K0554 and A9278 require Prior Approval. (underlined)

## 6. APPLICABLE PROCEDURE CODES:

Reimbursement for receiver (monitor) and supplies will be as follows:

<b>Therapeutic Devices</b>		
<b>CODE:</b>	<b>DESCRIPTION</b>	<b>MAX. UNITS/ FREQUENCY</b>
<b><u>K0554</u></b>	Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system	1 unit/ every 3 years
<b>K0553</b>	# Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service	1 unit/ once a month
<b>Non- Therapeutic Devices</b>		
<b>A9276</b>	# Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day	Up to 5/ once a month
<b>A9277</b>	# Transmitter; external, for use with interstitial continuous glucose monitoring system	1 unit/ every 3 months

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<b><u>A9278</u></b>	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	1 unit/ every 3 years
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The supply allowance (K0553) includes all supplies necessary for monitoring glucose levels using CGM, which **includes but is not limited to:** therapeutic sensors, therapeutic transmitters, test strips, home glucose monitor, lancets, alcohol wipes, batteries.

## 7. REFERENCES:

New York State (NYS) Medicaid

## 8. REVISION LOG:

<b>REVISIONS</b>	<b>DATE</b>
Creation date	11/03/17

<b>Approved:</b>	<b>Date:</b>	<b>Approved:</b>	<b>Date:</b>
Sosler Bruce, MD Clinical Medical Director		Talya Schwartz, MD Chief Medical Officer	

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### Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.