MetroPlus Health

Policy and Procedure

Title: Continuous Glucose Monitoring	Division: Medical Management Department: Utilization Management
Approval Date: 11/17/17	LOB: Medicare, Ultracare, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, MLTC
Effective Date: 11/17/17	Policy Number: UM-MP221
Review Date: 10/31/2024	Cross Reference Number: UM-MP232
Retired Date:	Page 1 of 6

1. POLICY DESCRIPTION:

Guideline for covering continuous glucose monitors (CGMs) for enrollees with gestational or Type 1 or Type 2 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.

Type 2 Diabetes: an impairment in the way the body regulates and uses sugar (glucose) as a fuel. This long-term (chronic) condition results in too much sugar circulating in the bloodstream. Eventually, high blood sugar levels can lead to disorders of the circulatory, nervous and immune systems.

Gestational Diabetes: Gestational diabetes is diabetes diagnosed for the first time during pregnancy (gestation). It is a condition in which a hormone made by the placenta prevents the body from using insulin effectively. Glucose builds up in the blood instead of being absorbed by the cells. Like other types of diabetes, gestational diabetes affects how cells use sugar (glucose). Gestational diabetes causes high blood sugar that can affect pregnancy and a baby's health.

Non -Adjunctive CGM systems (formerly therapeutic) are devices used to make treatment decisions without the need for a stand-alone blood glucose monitor (BGM) to confirm testing results.

Adjunctive CGM systems (formerly non-therapeutic) are devices used as an adjunct to BGM testing

4. POLICY:

MetroPlus will cover Continuous Glucose Monitors (CGM) for members who are diagnosed with diabetes and meet **all** the following criteria:

CGM devices considered medically necessary when:

a) Member with a diagnosis of gestational diabetes, or
b) Member with a diagnosis of type 1 or type 2 diabetes, who meet all the following criteria:
    - Member is under the care of an endocrinologist, or an enrolled Medicaid provider with experience in diabetes treatment, who orders the device.
    - Member is compliant with regular visits to review CGM data with their provider.
    - Member is on an insulin treatment plan or an insulin pump.
    - Member or member caregiver can hear and view CGM alerts and respond appropriately.

Additional CGM Guidelines:

- Only Providers who have had a recent visit with their patient (within the last six months) should order a CGM.
- Prescribers should be actively monitoring their patients to ensure adherence to treatment plans. Diabetes education is strongly encouraged.
- Providers must document CGM data in patients´ charts. All collected data should be used in clinical decisions.
- Insulin pump replacement will be considered when medically necessary, 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 percent of fee).
- Ancillary devices (such as, but not limited to, phones, tablets, and personal computers) are not covered.
- Providers should verify manufacturer´s age requirements for the CGM device ordered
- 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.
- 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

- Provider should not order new equipment when current equipment is operational. Replacement will be considered when medically necessary and outside of manufacturer's warranty and not for recent technology upgrades.
- Claims submitted for all supplies and receiver (monitor) without a diagnosis of Gestational diabetes or Type 1 or Type 2 diabetes will be denied.

5. LIMITATIONS/ EXCLUSIONS:

All codes in Table 6 requires prior approval.

Effective 4/1/2023, NYS Medicaid members enrolled in mainstream Medicaid Managed Care (MMC) Plans, Health and Recovery (HARP) Plans, and HIV-Special Needs Plans (HIV-SNP) will receive their pharmacy benefits through the NYRx Pharmacy program (previously known as Medicaid FFS) instead of through their MMC Plan. Diabetic diagnostics, continuous glucose monitors (CGM), glucose testing supplies, insulin syringes, disposable insulin pumps (Omnipod), and infusion supplies is covered by the NYRx program.

6. APPLICABLE PROCEDURE CODES:

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

CODE:	DESCRIPTION	MAX. UNITS/ FREQUENCY
A4238	#Supply allowance for adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service	1 unit per month
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service	1 unit per month
A9276	# Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day	30 units/month
A9277	# Transmitter; external, for use with interstitial continuous glucose monitoring system	1 unit per year
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	1 unit every 3 years

E2102	Adjunctive, non-implanted continuous glucose monitor or receiver	1 unit every 3 years
E2103	Non-adjunctive, non-implanted continuous glucose monitor or receiver	1 unit every 3 years

The supply allowance (A4238, A4239) 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, Updated Continuous Glucose Monitoring Criteria
https://www.emedny.org/ProviderManuals/DME/PDFS/Glucose_Monitoring_Criteria_-_10-2-23.pdf

New York State (NYS) Medicaid, 2023 Coding Changes for Continuous Glucose Monitoring
https://www.emedny.org/ProviderManuals/communications/2023_Coding_Changes_for_Continuous_Glucose_Monitoring_-_1-13-23.pdf

New York State Medicaid Update - January 2023 NYRx Pharmacy Benefit Transition Part Two: Special Edition Volume 39 - Number 1
https://www.health.ny.gov/health_care/medicaid/program/update/2023/no01_2023-01_speced.htm

New York State (NYS) Medicaid, January 2022 Volume 38 - Number 1
https://www.health.ny.gov/health_care/medicaid/program/update/2022/no01_2022-01.htm

8. REVISION LOG:

REVISIONS	DATE
Creation date	11/03/17
Revised, frequency updated	5/23/18
Annually Revised	5/10/19
Annually revised	8/28/20
Revised criteria	5/12/21
Revised criteria	3/3/22
Annual Review/Revised criteria	1/31/23
Revised criteria	10/31/23

Approved: Glendon Henry Digitally signed by Glendon Henry Date: 2023.11.02 09:21:46 -04'00' **Date:**	**Approved:** Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2023.11.02 11:31:24 -04'00' **Date:**
Glendon Henry, MD **Sr. Medical Director**	**Sanjiv Shah, MD** **Chief Medical Officer**

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Medical Guideline Disclaimer:

 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.