MetroPlus Health

Policy and Procedure

Title: Insulin Pump	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 4/13/18	**LOB: Medicaid, FHP, HIV SNP, CHP, MetroPlus Gold, GoldCare I & II Market Plus, Essential, HARP, MLTC**
Effective Date: 4/13/18	**Policy Number: UM-MP232**
Review Date: 5/27/2025	**Cross Reference Number:**
Retired Date:	**Page 1 of 3**

1. POLICY DESCRIPTION:

Guideline for Ambulatory Insulin Pumps for all persons with diabetes.

For the Medicare and UltraCare lines of business, MetroPlusHealth determines medical necessity based on applicable Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).
https://www.cms.gov/medicare-coverage-database/search.aspx

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Provider Contracting.

3. POLICY:

An external ambulatory infusion pump will be covered for Diabetes Mellitus up to 2 times per lifetime as medically necessary when ordered by an endocrinologist or a medical practitioner who has experience managing patients on continuous subcutaneous insulin infusion therapy if all the following coverage criteria are met:

A. The member has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump and has failed to achieve acceptable control of blood sugars that are not explained by poor motivation or compliance, AND;

a. Has completed a comprehensive diabetes education program, AND

b. Has one or more of the following criteria while receiving multiple daily injections:

i. HB A1c >7%
ii. History of recurring hypoglycemia
iii. Wide fluctuations in blood glucose before mealtime (>140mg/dl)
iv. Dawn phenomenon in a fasting state (>200mg/dl)
v. History of severe glycemic excursions

B. The member has a diagnosis of gestational diabetes.

4. APPLICABLE PROCEDURE CODES

CPT Code	Description
E0784	External ambulatory infusion pump, insulin

5. APPLICABLE ICD10 CODES

ICD10 Code	Description
E08.00 – E08.9	Diabetes Mellitus due to underlying condition
E10.00 – E10.9	Type I Diabetes
E11.00 – E11.9	Type 2 Diabetes

References

1. NYS Medicaid DME guidelines Version 2025 (4/1/2025)

https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf

REVISION LOG:

REVISIONS	DATE
Creation date	4/13/18
Annual Review	3/29/19
Annual Review	6/8/2020
Annual Review	5/24/2021
Annual Review	5/30/2023
Annual Review	5/28/2024
Annual Review	5/27/2025

Approved: David Ackman — Digitally signed by David Ackman Date: 2025.05.28 09:28:45 -04'00' — Date:	Approved: Sanjiv Shah MD — Digitally signed by Sanjiv Shah MD Date: 2025.05.30 11:57:25 -04'00' — Date:
David Ackman, MD **VP 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.