Clinical Policy: Continuous Glucose Monitoring

Reference Number: MI.CP.MP.501 Coding Implications
Last Review Date: 12/21 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This criteria refers to outpatient chronic interstitial real-time Continuous Glucose Monitoring (CGM). It does not include acute CGM in a hospital setting. Only long-term use is approved for coverage. Meridian will cover any FDA approved Continuous Glucose Monitor.

Defintion:

Continuous Glucose Monitors (CGMs)	Devices that measure glucose levels taken from interstitial fluid continually throughout the day and night providing real-time data to the member or physician. The system is made up of three parts: (1) a disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose level). (2) The transmitter (attaches to the sensor and stores the data to a wireless receiver/monitor), and (3) a receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or low). The CGM is not intended to replace finger-stick blood glucose tests.

Policy/Criteria
It is the policy of MeridianHealth that continuous glucose monotoring(CGM) is **medically necessary** when the below criteria are met.

I. Prior authorization
   A. **Age 5 and under** – PA not required for infants and toddlers if standards of coverage and documentation requirements are met. It is assumed that hypoglycemic unawareness is common within this age group.
   B. **All other ages** – PA is required for all other ages and conditions.

II. **All** of the following criteria must be met:
   A. The member is under the care of:
      i. An endocrinologist; **OR**
      ii. A physician or non-physician practitioner (nurse practitioner) [NP], physician assistant [PA], or clinical nurse specialist [CNS] who is managing the beneficiary's diabetes.
         1. This provider must provide documentation that the member completed a Medicaid-covered certified diabetes self-management education [DSME] training program within one year prior to the written order.
   B. For **CSHCS** members, a prescription from a pediatric endocrinologist is required from CGMs.
   C. Member has a diagnosis of **Type 1 diabetes** mellitus requiring the use of insulin 3 or more times a day or is currently using an insulin pump and at least one of the following is documented:
      i. Is unable to consistently and reliably identify hypoglycemic events (e.g. hypoglycemic unawareness);

ii. A recent history of hospitalization or emergency room visits for seizures or other conditions that attributed to a hypoglycemic event;
iii. Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);
iv. The presence of:
1. Microvascular complication (e.g., vasculopathy, retinopathy) ***Or***
2. Ketoacidosis or uncontrolled glucose

D. Ability to comply with at least 4x daily blood glucose monitoring is documented
E. The member has poor diabetic control despite attempts to maximally optimize care (e.g. compliance) with hypoglycemic unawareness, seizures, unexplained hypoglycemic episodes, recurrent ketoacidosis, and/or hbA1c not in an acceptable range;
F. The member's current treatment plan requires frequent adjustments to insulin dosage throughout the day;
G. The member or his/her caregiver is educated on the use of the device and is willing and able to use the CGM;
H. The requested device must be FDA-approved for the purpose and patient requested.

III. **External Insulin Pumps Combined with CGMs**
A. When Meridian receives a request for an insulin pump in combination with CGM, the insulin pump will be reviewed using InterQual®

IV. **Non-covered**
A. Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered

V. **Replacements**
A. CGMs are replacable as long as they are within the state's benefit limit, ***OR***
B. Device Malfunction
i. Device is malfunctioning and out of warranty, ***OR***
C. Upgrade
i. CGM upgrade for compatibility with the member's insulin pump is appropriate

VI. **Absolute Contraindications:**
A. CGM is not covered for members with Type 2 diabetes mellitis
B. CGM is not covered for convenience of member, provider or caretaker
C. The use of CGM for nesidioblastosis (primary islet cell hypertrophy) and for monitoring blood glucose in nondiabetic persons following gastric bypass surgery is considered experimental and investigational and will not be covered.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

CLINICAL POLICY
Continuous Glucose Monitoring

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
N/A	

HCPCS ®* Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		3/27/15
Annual Review • No content changes • Assigned new policy number MI.CP.MP.501 per CNC numbering system • Removed IL Criteria and References • Transferred on to Centene template • Outline format, references/Links updated	03/26/21	03/26/21
Ad Hoc Review • **Added examples of microvascular complication** • **Added non-covered smart devices** • **Added replacement CGM section and criteria** • **Added absolute contraindications; Type 2 DM** • **Removed Minimed CGM from contrainidcation**	12/06/21	12/17/21

References

1. Michigan Department of Health and Human Services (MDHHS), Medicaid Provider Manual, Medical Supplier, Section 2.10.B Continuous Glucose Monitoring Equipment and Supplies, Pages 41-44, October 1, 2021
2. American Diabetes Association. 2016 ADA Standards of Care.

3. Continuous Glucose Monitoring: An Endocrine Society Clinical Practice Guideline. Endocrine Society. J Clin Endocrinol Metab, October 2011, 96(10):2968-2979.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions

expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.