Medical Necessity Guidelines: Continuous Glucose Monitoring System (CGMS)

Effective: October 1, 2017


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☐ Tufts Health Direct – Health Connector; Fax: 888.415.9055
☒ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Continuous glucose monitoring systems (CGMS) are minimally invasive or noninvasive devices that measure glucose levels in interstitial fluid at frequent intervals over a period of several days. CGMS are designed to obtain information regarding diurnal patterns in glucose levels that, when evaluated in real time or reviewed retrospectively by a physician, can guide adjustments to therapy, with the goal of improving overall glycemic control. The glucose measurements provided during continuous monitoring are not intended to replace standard self-monitoring of blood glucose (SMBG) obtained using finger stick blood samples, but can alert the patient to the need to perform SMBG (Hayes, Inc., 2007).

COVERAGE GUIDELINES

Tufts Health Plan covers continuous glucose monitoring when used for up to 72 hours as a diagnostic test without prior authorization.

Tufts Health Plan may authorize the coverage of a continuous glucose monitoring system (CGMS) to be used by a member with Type I Diabetes Mellitus when there is documentation by an endocrinologist that the Member requires injections at least three times per day or the use of an insulin pump, regularly monitors their blood sugars via fingerstick, is compliant with their insulin regimen and dietary restrictions and one of the following:

- The Member has hypoglycemic unawareness characterized by one of the following:
  - A history of recurrent, severe bouts of hypoglycemia (severe is defined as a disabling episode requiring assistance of another individual to manage).
  - The first manifestation of hypoglycemia for the member is neuroglycopenic (e.g., warm, weak, confusion, tired or drowsy) as opposed to neurogenic (e.g., shaky, tremulous, heart pounding, sweaty, hungry or tingling)
- The Member has recurrent episode of severe hypoglycemia defined as a glucose level of less than 50 mg/dl
- The Member has been unable to achieve an A1c level of 7% or less for two consecutive readings within the last 12 months despite documented compliance with diabetes treatment regimen.

Note: Accessories (sensors and transmitters) associated with the CGMS will be authorized in one-year intervals. For reauthorization of accessories, a letter from the treating endocrinologist is required, stating that the Member continues to use the device and require it as a vital component of their diabetes management regimen.
LIMITATIONS
Tufts Health Plan will not cover CGMS in any of the following circumstances:

- The Member has Type II diabetes mellitus.
- The Member is pregnant and has gestational diabetes or Type II diabetes.
- Replacement or repair of units or associated equipment when lost or damaged secondary to improper care or neglect.
- Tufts Health Plan does not cover the following related items:
  - Glucowatch®

CODES
The following CPT code is covered when medically necessary, without prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>95250</td>
<td>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording</td>
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</tbody>
</table>

The following HCPCS codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>A9276</td>
<td>Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply</td>
</tr>
<tr>
<td>A9277</td>
<td>Transmitter; external, for use with interstitial CGMS</td>
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<tr>
<td>A9278</td>
<td>Receiver (monitor); external, for use with interstitial continuous glucose monitoring system</td>
</tr>
<tr>
<td>K0553</td>
<td>Supply allowance for therapeutic continuous glucose monitor, includes all supplies and accessories, 1 month supply = 1 unit of service</td>
</tr>
<tr>
<td>K0554</td>
<td>Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system</td>
</tr>
</tbody>
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The following HCPCS codes are not covered:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S1030</td>
<td>Continuous noninvasive glucose monitoring device, purchase (e.g. Glucowatch)</td>
</tr>
<tr>
<td>S1031</td>
<td>Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (e.g. Glucowatch)</td>
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REFERENCES

APPROVAL HISTORY
September 5, 2008: Reviewed by the Medical Affairs Medical Policy Committee for a January 1, 2009 effective date

Subsequent endorsement date(s) and changes made:
- July 6, 2009: Tufts Health Plan 'Continuous Glucose Monitoring System Prior Authorization Request Form' approved and attached to MNG
- October 1, 2009: Prior authorization requests must be submitted on the Tufts Health Plan Continuous Glucose Monitoring System Prior Authorization Request Form completed by an endocrinologist
- November 19, 2009: Administrative process updated
- December 2009: Clarification of device and sensor authorization periods
- December 2010: Reviewed by Medical Affairs, Medical Policy. CPT code 95251 removed from MNG, this code is on non-reimbursable list. Effective January 2011
- October 12, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC); no changes
BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLinkSM Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.