MEDICAL POLICY STATEMENT
INDIANA MEDICAID

Policy Name	Policy Number	Date Effective
Continuous Glucose Monitoring (CGM)	MM-1096	01/01/2021-11/30/2021

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Continuous Glucose Monitoring (CGM)

B. Background

Continuous glucose monitors are Food and Drug Administration (FDA)-approved devices used to record ongoing glucose levels in interstitial fluid. Continuous glucose monitoring provides information about glucose fluctuations that might not otherwise be obtained with traditional testing methods and alerts the user of impending dangerously low blood sugar. The purpose of continuous glucose monitoring is to provide additional information to the provider and the member in order to aid improved glycemic control and prevent dangerously low blood sugars.

Continuous glucose monitors are reimbursable for all ages by the IHCP for both short-term and long-term use when considered medically necessary. HCPCS codes A9277 and A9278 for long-term continuous glucose monitoring require MSRP documentation (or a cost invoice, if no MSRP is available for the item) be submitted with the claim.

C. Definitions

D. Policy

I. Prior authorization based on the following criteria must be obtained for use of continuous glucose monitors for long-term or short-term monitoring:
   A. The member must have one of the following conditions:
      1. Type 1 diabetes
      2. Type 2 insulin-dependent diabetes
      3. Pregnant with either type 1, type 2, or gestational diabetes
   B. The member must have shown compliance in his or her own care.
   C. The member must meet at least one of the following:
      1. The member must not have achieved the American Diabetes Association (ADA) recommended target hemoglobin A1C despite consistent self-blood glucose monitoring
      2. The member has evidence of insulin-induced hypoglycemia occurring multiple times per week.
   D. The member must show continued suboptimal diabetes control while utilizing multiple daily injections of insulin or an insulin pump to manage glucose levels.
   E. The device used must be approved by the FDA for use in the age range appropriate for the member.
   F. Monitoring must be performed for a minimum of 24 hours. If the service is performed less than 24 hours, the service is not considered medically necessary.

II. Short-Term Continuous Glucose Monitoring (Up to 72 Hours)
   A. IHCP reimbursement is available for a continuous glucose monitor for up to 72 hours (three days) as an evaluation tool for providers to treat members who have not obtained acceptable glycemic control.
   B. The CGM is deemed medically necessary when all the following criteria are met:
      1. The member is compliant with his or her own care and had been instructed by a health care professional regarding diabetic management.
      2. The member meets one of the following conditions:
         a. Has type 1 diabetes
         b. Has type 2 insulin-dependent diabetes
         c. Is a pregnant woman with either type 1, type 2, or gestational diabetes
      3. The member has suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of three injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day):
         a. Hemoglobin A1C is >7.0% (ADA recommended goal)
         b. Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week
         c. Episodes of diabetic ketoacidosis or hypoglycemia resulting in loss of consciousness, seizure, or need for emergency health services
      4. The 72-hour continuous glucose monitoring device should be used on appropriate periodic basis (as determined by medical necessity) in order to direct changes in diabetic management.

III. Long-Term Continuous Glucose Monitoring
   A. IHCP reimbursement is available for long term continuous glucose monitoring when considered medically necessary and all the following criteria have been met:
      1. The member is compliant
      2. The member meets one of the following conditions:
         a. Has Type 1 diabetes
         b. Has Type II insulin dependent diabetes
         c. Is a pregnant woman with either type 1, type 2, or gestational diabetes
      3. The member has one of the following:
         a. Suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of three injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day)
         b. Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week
         c. History of hypoglycemic unawareness resulting in loss of consciousness, seizure, or need for emergency health services
         d. An insulin pump used for maintenance of blood sugar control.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	09/30/2020	
Date Revised		
Date Effective	01/01/2021	
Date Archived	11/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. Indiana Medicaid Provider Reference Module. Durable and Home Medical Equipment and Supplies. Continuous Glucose Monitors.

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

IN-MED-P-306628 Issue Date 09/30/2020 OMPP Approved 10/20/2020