South Carolina

Medicare Advantage

Policy and Procedure

Subject:	Continuous Glucose Monitor
Policy Number:	105
Department:	5B Medicare Advantage
Provision Effective Date:	
Revision Date:	

PURPOSE
The purpose of this document is to describe the guidelines used to determine medical necessity for continuous glucose monitors. The treating specialist must request prior authorization for long-term continuous glucose monitors.

POLICY
Member must meet guidelines for medical necessity as listed below in the Procedure section.

SCOPE
Members with diabetes mellitus, providers prescribing continuous glucose monitors

REFERENCE DOCUMENTS
1. Medicare National Coverage Determination (NCD) 40.2 for Home Blood Glucose Monitors (accessed Nov. 10, 2021).
2. Medicare National Coverage Article (LCA) A52464 for Glucose Monitor – Policy Article (accessed Nov. 10, 2021).
3. Medicare Local Coverage Determination (LCD) L33822 for Glucose Monitors (accessed Nov. 10, 2021).

DEFINITIONS
Continuous Glucose Monitoring Devices are devices that use a variety of inserted components (usually a sensor designed to monitor capillary glucose levels through a needle or small catheter that is sterilely deployed and changed every week or two weeks) and an external reading device that is able to receive information from the inserted sensor. These systems include but are not limited to the Freestyle Libre and the Dexcom systems.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and, following instructions that may vary with the device used, inserts it into the device to get a reading. Lancets, reagent strips and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

RESPONSIBILITIES
Medical director, utilization management

PROCEDURE
Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels. Accordingly, coverage of home blood glucose monitors is limited to patients meeting all of the following conditions:

1. The patient has been diagnosed as having diabetes.
2. The patient's physician states the patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician.
3. The device is designed for home rather than clinical use.

CGM devices covered by Medicare under the DME benefit are defined in CMS Ruling 1682R as therapeutic CGMs. Refer to the Non-Medical Necessity Coverage and Payment Rules in the LCD-related policy article for additional information (LCA A52464). Therapeutic CGMs and related supplies are covered by Medicare when all of the following coverage criteria (1 – 5) are met:

1. The beneficiary has diabetes mellitus (refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses).
2. The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump.
3. The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results.

4. Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate his or her diabetes control and determined that criteria 1– 3 above are met.
5. Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

When a therapeutic CGM (code K0554) is covered, the related supply allowance (code K0553) is also covered. If any of coverage criteria 1 – 5 are not met, the CGM and related supply allowance will be denied as not reasonable and necessary. The supply allowance (code K0553) is billed as one (1) \unit of service (UOS) per 30 days. Only one (1) UOS of code K0553 may be billed to the DME MACs at a time. Billing more than one (1) UOS per 30 days of code K0553 will be denied as not reasonable and necessary.

APPROVAL SIGNATURES

Title	Printed Name	Signature	Date

REVISION HISTORY

Implementation Date	Description	Business Owner (Signature Required)	Approval Committee