MetroPlus Health

Policy and Procedure

Title: Insulin Pump	Division: Medical Management Department: Utilization Management
Approval Date: 4/13/18	LOB: Medicaid, Medicare, FHP, HIV SNP, CHP, MetroPlus Gold, Goldcare I & II Market Plus, Essential, HARP, MLTC, UltraCare
Effective Date: 4/13/18	Policy Number: UM-MP232
Review Date: 5/31/2022	Cross Reference Number:
Retired Date:	Page 1 of 3

1. POLICY DESCRIPTION:

Guideline for Ambulatory Insulin Pumps for all diabetics

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 of 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 notexplained by poor motivation or compliance **.**

B. Has completed a comprehensive diabetes education program.

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

a. HB A1c >7%
b. History of recurring hypoglycemia (<60mg/dl)
c. Wide fluctuations in blood glucose before mealtime (>140mg/dl)
d. Dawn phenomenon in a fasting state (>200mg/dl)
e. History of severe glycemic excursions
f. Diagnosis of gestational diabetes

For Medicare only, refer to the Medicare Local Coverage Determination Guidelines (LCD).

Exclusions/Limitations:

A. If the request is for Omnipod the following criteria apply:

a. Members daily dose is at least 28 Units/day **AND**

b. The prescriber submits documentation with the member's total expected daily dose of insulin.

4. APPLICABLE PROCEDURE CODES

CPT Code	Description
E0784	External ambulatory infusion pump, insulin
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories

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 2021 (7/1/2021)
https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf

2. Omnipod FAQ Available at: https://www.myomnipod.com/podder-support/faq

3. Medicare LCD Guidelines, External Infusion Pumps, Revisions Effectivc Date 2/28/2022

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33794

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	5/31/2022

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Approved:	**Date:**	**Approved:**	**Date:**
Glendon Henry Digitally signed by Glendon Henry Date: 2022.06.08 09:20:46 -04'00'		Sanjiv Shah MD Digitally signed by Sanjiv Shah MD Date: 2022.06.08 10:21:07 -04'00'	
Glendon Henry, MD **Senior Medical Director**		**Sanjiv Shah, MD** **Chief Medical Officer**	

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.