Clinical Policy: Continuous Glucose Monitoring System (CGMS)

Reference Number: OH.PHAR.PPA.20
Effective Date: 08/19
Last Review Date: 07/21
Line of Business: Medicaid

Revision Log

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

Description

Continuous glucose monitoring (CGM) systems consist of a several components which can vary depending on the brand and model of CGM. Such components may include a monitor, transmitter, handheld reader and a sensor worn on a designated area of the body

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Buckeye Health Plan that a Continuous Glucose Monitoring System (CGMS) is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Type 1 Diabetes Mellitus or Type II Diabetes Mellitus (must meet all)**:**

1. Diagnosis of Type 1 Diabetes Mellitus or Type II Diabetes Mellitus
    a. Within the last 12 months, member has been on a maintenance program involving at least THREE injections of insulin per day, or requires frequent adjustments of insulin dosage, or is using an insulin pump.
2. Member (or someone assisting member) has performed glucose self-testing at least FOUR times per day on average during the preceding month.
3. Member is at high risk for preventable complications of diabetes.
4. Member (or someone assisting member) is capable of managing the device and that the desired improvement in metabolic control can be achieved.
5. Member has one or more of the following symptoms or conditions (note all that apply):
    a. HbA1c greater than 7%
    b. History of recurring hypoglycemia
    c. Wide fluctuations in blood glucose before mealtime
    d. A marked early morning increase in fasting blood sugar (Dawn Phenomenon – glucose level exceeds 200mg/dl)
    e. History of severe glycemic excursions
6. Member has had an appointment with a provider within the last 6 months.
7. Provider will review and monitor CGM testing results on a regular basis.

- **Approval duration: 12 months (1 receiver every 4 years, 1 transmitter every three months, 4 sensors per month).**

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT Type 1 Diabetes Mellitus or Type II Diabetes Mellitus.

II. Continued Therapy

A. Type 1 Diabetes Mellitus and Type II Diabetes Mellitus (must meet all)**:**

1. Currently receiving device via Buckeye benefit or member has previously met initial approval criteria;
2. Member (or someone assisting member) is capable of managing the device and that the desired improvement in metabolic control can be achieved.
3. There is documented evidence of improvement in control of diabetes (specific to baseline status of disease for individual members).

- **Approval duration: 12 months (1 receiver every 4 years, 1 transmitter every three months, 4 sensors per month).**

Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Buckeye benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT Type 1 Diabetes Mellitus or Type II Diabetes Mellitus.

III. Product Availability CGM SystemContinuous Glucose Monitor Models (this is not an exhaustive list):

- Freestyle Libre 10 day **Pharmacy benefit**
- Freestyle Libre 14 day **Pharmacy benefit**
- Freestyle Libre 2 **Pharmacy benefit**
- Dexcom G6 ** Pharmacy benefit**
- Medtronic MiniMed Guardian Connect **DME – medical benefit**
- Senseonics Eversense **DME – medical benefit**

IV. References

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	06/19	07/19
Annual Review – no changes deemed necessary	10/20	10/20
Criteria I.A.2 - Added verbiage indicating member is currently enrolled in a diabetes education program, or has completed one; criteria I.A.3 – added verbiage that member is utilizing an insulin pump; added criteria I.A.8 and I.A.9 indicating member must have had an appointment with provider within the last 6 months, and provider will monitor and review CGM results; removed Dexcom G4, and Dexcom G5 from list of available products; added Senseonics Eversense and Freestyle	07.21	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Libre 2 to list of available products; changed Dexcom G6 status to pharmacy benefit.		
Removed to more closely align with Caresource: Member is currently enrolled in or has completed a diabetes education program within the preceding 12 months.	12.21	

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. This clinical policy is not intended to recommend treatment for members. Members 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 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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.