group health Cooperative of eau claire	DEPARTMENT:	Utilization Management
	SUBJECT:	Insulin Pumps and Supplies
	PRODUCT LINE:	ALL
	POLICY NUMBER:	075
	ORIGINAL POLICY EFFECTIVE DATE:	02/01/2015
KMTSJ, Inc.	LAST REVISED DATE:	06/21/2024
	LAST REVIEWED DATE:	06/21/2024

SCOPE: To ensure that all reviews for medical necessity for diabetes supplies, insulin pumps, and pump supplies are handled in a consistent manner for all Group Health Cooperative of Eau Claire members per their benefit plan.

POLICY: It is the policy of Group Health Cooperative of Eau Claire to review all requests for insulin pumps and pump supplies in the Health Management Department.

PROCEDURE: INSULIN PUMPS and SUPPLIES:

Prior authorization required? YES, for insulin pumps and supplies quantities more than 2 boxes per month.

Associated Codes:

E0784 Insulin Pump
A4230 Infusion set for external insulin pump, non needle cannula type
A4231 Infusion set for external insulin pump, needle type
A4232 Syringe with needle for external insulin pump, sterile, 3cc

Insulin Pump Coverage Criteria:

Insulin pumps are considered medically necessary and are covered when the following criteria are met:

1. Diagnosis of type 1 diabetes mellitus; **AND**
2. Type 1 diabetes confirmed by C-peptide test * (see C-peptide test requirement below); **OR**
3. Beta cell autoantibody test is positive (ICA, GADA, or GAD65); **AND**
4. Member has completed a comprehensive diabetic education and has been in regular contact with a diabetic educator; **AND**
5. Member has advanced carbohydrate counting skills and actively uses this information for insulin dosing
6. Member has been compliant seeing a provider for their diabetes every 3 months; **AND**
7. Member has been on a program of at least 3 daily injections of insulin per day with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump; **AND**
8. Member has documented frequency of glucose self-testing an average of at least 4 times per day or using a continuous glucose monitor during the 2 months prior to initiation of the insulin pump; **AND**
9. The member meets at least one of the following criteria while on multiple daily injections (more than 3 injections per day) of insulin:
   a. Elevated glycosylated hemoglobin level (HbA1c greater than 7.0%);
   OR
   b. History of recent recurring hypoglycemia (less than 60 mg/dL) despite making appropriate insulin dose adjustments to affect control; **OR**
   c. Wide fluctuations in blood glucose before mealtime despite making appropriate insulin dose adjustments to affect control. **OR**
10. The patient has been on an external insulin infusion pump prior to enrollment in the HMO and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to enrollment.

***C-peptide test requirement:**

1. C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. (ex: ref range 0.8-4.3, c-peptide would need to be 0.9 or less, rounded to the nearest .01.)
2. A fasting blood sugar obtained at the same time as the C-peptide level must be less than or equal to 225 mg/dl. If this is greater than 225, the C-peptide test will need to be repeated.

Continued coverage of an external insulin pump and supplies requires that the patient be seen and evaluated by the treating physician at least every 3 months. In addition, the patient must work closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

Replacement Pump Criteria:

The replacement of external insulin pumps that are malfunctioning, are out of warranty, and cannot be refurbished is considered medically necessary.

Commercial/ETF: Covered if criteria above are met. One pump per 5 years or length of warranty.

Medicaid: Covered if criteria above are met. One pump per 5 years.

Pediatrics

The replacement of external insulin pumps for pediatric individuals requiring a larger insulin reservoir will Be considered on an individual basis. The following information is required when submitting requests:

- Current insulin pump reservoir volume
- Current insulin need
- Frequency of current insulin change out required to meet needs of member

Pump Supplies Criteria:

Insulin pump supplies do not require prior authorization when the insulin pump has been previously approved by GHC or another insurer. When previously approved, dispense 2 boxes every month. If more than 2 boxes are needed every month, then prior authorization is required. If the insulin pump has been previously denied as not meeting criteria, then pump supplies would be denied.

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DISPOSABLE EXTERNAL INSULIN PUMP WITH WIRELESS TRANSMITTER AND SUPPLIES (ie: Omnipod):

Prior authorization required? YES

Associated Codes: **E0784** Insulin pump

A9274 External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories

Omnipod pumps are considered experimental and investigational based on Hayes rating of D2.

BLOOD GLUCOSE MONITORS:

Blood glucose monitors are covered through the pharmacy benefit for members who have a diagnosis of diabetes and as noted below.

- **Medicaid:** Covered through Forward Health pharmacy benefit.
- **ETF:** Covered through Navitus.
- **Commercial:** Covered through Express Scripts (ESI).

References:

Local Coverage Determination (LCD) External Infusion Pumps L33794

APPROVED: Michele Bauer MD. DATE: 06/21/2024

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
06/17/2015	Betsy Kelly, RN	Clarified SOW/4201 sensor amounts.
04/22/2016	Betsy Kelly, RN	Removed short term CGMS as no PA required and pump criteria
09/18/2017	Michele Bauer, MD	Removed CGM criteria and added criteria for insulin pumps
09/05/2018	Michele Bauer, MD	Updated replacement pump language
03/30/2020	Michele Bauer, MD	Updated coverage criteria.
03/10/2021	Michele Bauer, MD, CMO	Reviewed. No changes.

03/03/2022	Michele Bauer, MD, CMO	Updated coverage criteria for pump supplies.
06/03/2022	Michele Bauer, MD, CMO	Added Hayes Rating to omnipod coverage criteria
06/12/2023	Michele Bauer, MD, CMO	Reviewed. No Changes.
06/21/2024	Michele Bauer, MD, CMO	Added References. Added Medicare Advantage coverage criteria.