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Medical Policy

Continuous Glucose Monitoring Systems, Artificial Pancreas Device Systems, and Insulin Delivery Devices

Policy Number: OCA 3.966
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Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

This policy applies to the following devices: continuous glucose monitoring systems (CGMS), combined CGMS with external insulin pumps using continuous subcutaneous insulin infusion (CSII), and artificial pancreas device system (sensor-augmented pump therapy/closed-loop glucose management system) provided in the outpatient setting. Plan prior authorization is required.

The Plan's Pharmacy Department manages requests for intermittent or flash CGM device (e.g., FreeStyle Libre Flash Glucose Monitoring System), single-use/disposable and nonprogrammable external insulin pump (e.g., V-Go), and Omnipod DASH from prescribers when covered through the member's pharmacy benefit (rather than the member's medical benefit). A provider may submit a prescription for the requested device.

All requests for durable medical equipment (DME), including non-disposable external insulin pumps, single-use and disposable, programmable external insulin infusion pumps (e.g., other OmniPod

products), home blood glucose monitors, and associated DME supplies and accessories should be submitted to Northwood at www.northwoodinc.com or by phone at 1-866-802-6471 to obtain prior authorization. Requests for services managed as a DME benefit from DME providers, pharmacy providers, home infusion providers, and home care providers related to CGMS, combined CGMS with external insulin infusion pump, and associated supplies and accessories should also be submitted to Northwood.

Prior authorization is NOT required by the Plan or Northwood for the use of implantable insulin pumps (IIP). An additional Plan prior authorization is NOT required for CGMS and/or insulin delivery systems provided in an inpatient setting when the inpatient admission has been authorized by the Plan.

Clinical Criteria

1. Medical Necessity Criteria for Stand-Alone CGMS, Combined CGMS External Insulin Pump using CSII, or Artificial Pancreas Device System in the Outpatient Setting:

   ONE (1) of the criteria must be met in items a through c:

   a. Stand-Alone CGMS:

      ALL criteria are met in items (1) through (6) for members **2 years of age or older** on the date of service with **type 1 or type 2 diabetes** (including but not limited to a pregnant member):

      (1) Member requires the use of an insulin pump or multiple daily insulin injections or the provider submits documentation to the Plan confirming that the member is not receiving insulin due to physical disability, visual impairment, and/or cognitive impairment; AND

      (2) CGM is recommended by the endocrinologist or member's primary care provider; AND

      (3) Member or caregiver is consistently compliant with self-monitoring of blood glucose at least 4 times per day (finger sticks, alternative site testing) or the provider submits documentation to the Plan confirming that the member is not compliant due to physical disability, visual impairment, and/or cognitive impairment; AND

      (4) The endocrinologist or primary care provider managing the member's diabetes confirms the member or caregiver is capable of using the CGM system on a daily basis; AND

      (5) CGMS/CGM device will be used as an adjunct to self-monitoring of blood glucose (finger stick testing or alternative site testing) or an enhanced, FDA-approved CGM device will be used to make treatment decisions, including insulin dosage, without regular confirmatory self-monitoring of blood glucose; AND

(6) The member is still experiencing or remains at risk for ANY of the conditions in items (a) through (e):

(a) A1C greater than or equal to 7.0%; OR

(b) Hypoglycemic unawareness; OR

(c) Postprandial hyperglycemia; OR

(d) Recurrent diabetic ketoacidosis; OR

(e) Recurrent episodes of severe hypoglycemia (i.e., blood glucose less than 50mg/dl) despite appropriate modifications in medication regimen; OR

b. Combined CGMS with External Insulin Pump Using CSII:

ALL criteria must be met in items (1) through (3) for members **2 years of age or older** on the date of service with **type 1 or type 2 diabetes** (including but not limited to a pregnant member):

(1) Member meets criteria for continuous glucose monitoring in items 1a-1f; AND

(2) The requested device is being prescribed according to its FDA-approved clearance and guideline information for a combined CGMS with an external insulin pump with subcutaneous insulin, including intended use for the member's age and medical condition; AND

(3) Member does NOT have existing devices that are fully functional and duplicate the same purpose served by a combined CGMS with wireless communication capability to an external insulin pump; OR

c. Artificial Pancreas Device System/Sensor-Augmented Pump Therapy/Closed-Loop Glucose Management System:

ALL criteria are met in items (1) through (3) for a member with **type 1 diabetes**:

(1) Member with type 1 diabetes meets criteria for continuous glucose monitors in items 1a-1f and the member is NOT pregnant; AND

(2) The requested artificial pancreas device system will be used according to its FDA-approved clearance and guideline information, including member's age and medical condition (with Medical Director review required for members younger than age 2 on the date of service); AND

(3) Member does NOT have existing devices that are fully functional and duplicate the same purpose that is served by an artificial pancreas device system/sensor-augmented pump therapy.

2. Plan Medical Director Review Required:

ANY of the following types of prior authorization requests require Plan Medical Director review and approval:

a. Indications Considered Experimental and Investigational or NOT Medically Necessary:

When applicable medical necessity criteria are NOT met for the requested device, the Plan considers the service either experimental and investigational or NOT reasonable and necessary and Plan Medical Director review is required. Individual consideration will be conducted by the Plan Medical Director based on the clinical documentation submitted by the treating provider and will take into account the following factors: member's age and diagnosis; comorbidities and relevant past medical/surgical/behavioral health/pharmacotherapy history (e.g., history of severe hypoglycemia, limited life expectancy, microvascular or macrovascular complications, long-standing diabetes in whom the A1C goal is difficult to achieve despite diabetes self-management and medical treatment); duration of diabetes; diagnostic (including laboratory test) results; glycemic control targets; complications; progression of the member's clinical condition, illness, or injury; progress of treatment; psychosocial circumstances; home environment and other environmental factors (if applicable); available treatment options; member motivation and adherence; and verification the requested device/system is being prescribed and will be utilized according to its FDA-approved clearance and guideline information, including intended use for the member's age and medical condition.

b. Noncompliance or Ineffective Use of CGMS:

Plan Medical Director review is required for the ongoing use of a CGMS (or combined CGMS with external insulin pump using CSII) when the member (or family member or caregiver on behalf of the member) consistently is unable to manage the device properly, the member (or family member or caregiver on behalf of the member) does not routinely use the device according to product guidelines, and/or the device consistently fails to resolve hypoglycemia, improve or maintain A1C, and/or prevent hospitalization related to glucose management for the member. In these cases, applicable clinical information will be evaluated by the Plan Medical Director to determine the medical necessity for the ongoing use of a CGMS or discontinuation of the device with the implementation of an alternate treatment plan. Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, documentation of diabetes education received by the member (or family member or caregiver on behalf of the member), treatment to date, glucose reading logs, pertinent laboratory testing, individualized treatment plan, and documentation

supporting that the member's plan of care is compliant with the latest standards of medical care in diabetes established by the American Diabetes Association.

c. Replacement System Expected to Provide Clinically Significant Improvements:

When the replacement system is expected to provide clinically significant improvements for the member's glucose management, medical record documentation must be submitted to the Plan's Medical Director for individual consideration in support of the prior authorization request with the following documentation: description of the member's medical condition, how the product-specific features of the device will be clinically useful to the member's medical management beyond those features included in the member's current CGMS, and documentations supporting that the member's plan of care is compliant with the latest standards of medical care in diabetes established by the American Diabetes Association.

d. Upgrade for New Technology:

Plan Medical Director review is required for individual consideration of an upgraded system requested by the member's treating physician when it is expected to significantly improve the member's A1C target level and this improvement cannot be achieved with the member's current CGMS.

Limitations and Exclusions

1. Maximum Authorization Period for Receiver, Transmitter, Sensor, and Supplies in Outpatient Setting:

   If a CGMS or combined CGMS with external insulin pump using continuous subcutaneous insulin infusion (CSII) is approved by the Plan in the outpatient setting, the authorization period is **six (6) months** for the purchase of the receiver and transmitter. A **lifetime authorization** will be granted for sensors and supplies for the CGM device currently used by the member if the CGM device is approved by the Plan. When the device, sensor, and/or related supplies are authorized by Northwood rather than the Plan, the authorization period and guidelines for purchase are established by Northwood; Northwood will notify the requesting provider of these requirements.

2. Fully Implanted Glucose Sensor:

   The Plan considers the use of a fully implantable glucose sensor to be experimental and investigational or NOT reasonable and necessary due to limited evidence documenting the clinical utility and clinical validity of the device.

3. Remote Wireless Monitoring:

   Remote wireless glucose monitoring may either be a feature of a CGMS or an attachment device such as a mobile application with real-time display of interstitial glucose readings. **The Plan provides no additional reimbursement for a wireless transmission feature/device**, even when it is a component of an artificial pancreas device system, integrated into a CGMS, or combined with CGMS with external insulin pump and the system is authorized by the Plan.

4. Noninvasive Continuous Glucose Monitoring System:

   The Plan considers the use of a continuous noninvasive glucose monitoring device (including the purchase or rental of this device) to NOT be reasonable and necessary.

5. Upgrade for New Technology:

   Technology-based methods may be used for diabetes management, but the Plan considers the replacement of a member's currently functional CGMS or functional combined CGMS with external insulin pump for the sole purpose of receiving an upgraded system or the most recent technology to NOT be medically necessary; this includes upgrades for enhanced information/wireless communication technology as a feature of the replacement device or an added component for CGMS, including the use of the internet and/or smart phone application for including uploading, monitoring, and/or sharing blood glucose levels as a convenience feature. .

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, LCD L38623 includes guidelines for the use of implantable continuous glucose monitors. CMS NCD 40.3 is applicable for closed-loop blood glucose control devices used in an inpatient setting. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

In response to the COVID-19 pandemic, CMS will NOT be enforcing clinical indications for coverage for a LIMITED number of NCDs and LCDs (and corresponding services, treatments, and devices included in those documents) for care provided to the Plan's SCO and WellSense Medicare Advantage HMO members. The suspension of clinical indications for coverage for limited number of services, treatments, and devices will be in effect on an interim basis for maximum flexibility and will allow SCO and WellSense Medicare Advantage members to receive care in an unexpected setting such as the home. The list of NCDs and LCDs with waived clinical review criteria may be revised periodically by CMS and does NOT apply to other aspects of CMS guidelines such as benefit category determinations. It is expected that CMS will return to the enforcement of all clinical review criteria included in NCDs

and LCDs used to make medical necessity determinations at the conclusion of this public health emergency. **As of March 31, 2020, CMS will NOT enforce clinical indications for coverage included in NCD 280.14 for infusion pumps and LCD L33794 for external infusion pumps until the conclusion of the COVID-19 pandemic. Prior authorization is required for these services even when clinical indications for coverage are not enforced for SCO and WellSense Medicare Advantage HMO members.** The Plan recommends that providers verify coverage and CMS guidelines for the requested service, treatment, and device on the date of service using the CMS website.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Policy Summary, Clinical Criteria, and Limitations and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Codes Covered When Medically Necessary
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording

HCPCS Codes	Description: Codes Covered When Medically Necessary
	Plan note applicable for the HCPCS codes listed below: DME providers, medical supply providers, pharmacy providers, home infusion providers, home care providers, and specialty pharmacy providers must contact Northwood (rather than then Plan) to determine coverage and reimbursement guidelines for these components and to obtain authorization. Other provider types must contact the Plan to obtain authorization for services.
A9276	Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1-day supply Plan note: Code is NOT payable for the WellSense Medicare Advantage HMO product.
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system Plan note: Code is NOT payable for the WellSense Medicare Advantage HMO product.
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system Plan note: Code is NOT payable for the WellSense Medicare Advantage HMO product.
K0554	Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system

CPT Codes	Description: Codes Considered Experimental and Investigational or NOT Medically Necessary for CGMS with Implantable Interstitial Glucose Sensor
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation

HCPCS Codes	Description: Codes Covered When Medically Necessary for Artificial Pancreas Device System in the Outpatient Setting
	Plan note applicable for the HCPCS codes listed below: DME providers, medical supply providers, pharmacy providers, home infusion providers, home care providers, and specialty pharmacy providers must contact Northwood (rather than then Plan) to determine coverage and reimbursement guidelines for components of the system and to obtain authorization. Other provider types must contact the Plan to obtain authorization for services.
S1034	Artificial pancreas device system (e.g., low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices Plan note: Code is NOT payable for the Senior Care Options and WellSense Medicare Advantage HMO products.
S1035	Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system Plan note: Code is NOT payable for the Senior Care Options and WellSense Medicare Advantage HMO products.
S1036	Transmitter; external, for use with artificial pancreas device system Plan note: Code is NOT payable for the Senior Care Options and WellSense Medicare Advantage HMO products.
S1037	Receiver (monitor); external, for use with artificial pancreas device system Plan note: Code is NOT payable for the Senior Care Options and WellSense Medicare Advantage HMO products.

HCPCS Code	Description: Code Considered NOT Medically Necessary for Single-Use, Disposable and Nonprogrammable/Mechanical Insulin Infusion Devices
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories Plan notes: 1. Code is NOT payable for the WellSense Medicare Advantage HMO product. 2. Code may be used for single-use, disposable and nonprogrammable/ mechanical insulin infusion device (e.g., V-Go). V-Go is covered through the member's pharmacy benefit rather than managed by the Plan's medical or DME benefit coverage. 3. DME providers, medical supply providers, pharmacy providers, home

	infusion providers, home care providers, and specialty pharmacy providers must contact Northwood at 1-866-802-6471 (rather than then Plan) to determine coverage and reimbursement guidelines for all other types of disposable external ambulatory insulin delivery systems (including supplies and accessories) except for single-use, disposable and nonprogrammable/mechanical (non-electric) insulin infusion devices (e.g., V-Go®).

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/08/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/22/08: Utilization Management Committee (UMC) 08/13/08: Quality Improvement Committee (QIC)	11/10/08 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for WellSense Medicare Advantage HMO Product: 01/01/22

Note: Policy title was *Continuous Glucose Monitoring Systems* until 10/31/16. Policy title effective 11/01/16 to 11/30/19 was *Continuous Glucose Monitoring Systems and Insulin Delivery Devices*. As of 12/01/19, the policy title has been changed to the following: *Continuous Glucose Monitoring Systems, Artificial Pancreas Delivery Systems, and Insulin Delivery Devices*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
07/28/09	No changes.	Version 2	07/28/09: MPCTAC 07/28/09: UMC 08/26/09: QIC
07/01/10	Updated clinical criteria with additional criteria for the short and long term use of CGMS. Updated references.	Version 3	08/18/10: MPCTAC 09/22/10: QIC
08/01/11	Updated references. No changes to criteria or code list.	Version 4	08/17/11: MPCTAC 09/28/11: QIC
07/01/12	Updated references. Added following statement to Description of Item or Service section: "Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimens can be a useful tool to lower A1C." Revised Summary section. Added the following criteria in Medical Policy	Version 5	07/18/12: MPCTAC 08/22/12: QIC

Policy Revisions History			
	Statement for medically necessary use of 72 hour and long-term continuous glucose monitoring (CGM): (1) Consultation with an endocrinologist, (2) suspected postprandial hyperglycemia, (3) recurrent diabetic ketoacidosis, and/or (4) type 1 diabetic who is pregnant and has poorly controlled diabetes. Added the following criterion for CGM up to 72 hours: There is discordance between A1C and blood glucose levels. Added definition of type 1 diabetes. Added language regarding prior authorization guidelines for the receiver, transmitter, sensors, and supplies related to a continuous glucose monitoring device. Revised language in Applicable Coding section and updated applicable code definitions.		
07/29/12	Off cycle review for WellSense Health Plan, revised Summary statement, reformatted Medical Policy Statement, added Definitions section, revised Limitations statement.	Version 6	08/03/12: MPCTAC 09/05/12: QIC
07/01/13	Review for effective date 11/01/13. Updated Summary section to include reference to Northwood, Inc. Deleted duplicate text and reformatted Medical Policy Statement section. Added criterion stating that CGMS is used as an adjunct to finger stick testing to the Medical Policy Statement section (as specified in the Summary section). Added definition for diabetes mellitus and added text to Clinical Background Information section. Updated references.	11/01/13 Version 7	07/17/13: MPCTAC 08/15/13: QIC
12/01/13	Review for effective date 05/01/14. Revised Summary, Description of Item or Service, Clinical Background Information, and References sections. Revised criteria in Medical Policy Statement and categorized criteria into short-term and long-term use of CGM. Limitations added.	05/01/14 Version 8	12/18/13: MPCTAC 01/21/14: QIC
12/01/14	Review for effective date 04/01/15. Updated Clinical Background Information section. Revised criteria in Medical Policy	04/01/15 Version 9	12/17/14: MPCTAC 01/14/15: QIC

Policy Revisions History			
	Statement section and Limitations section.		
10/01/15	Review for effective date 12/01/15. Updated template with list of applicable products and corresponding notes.	12/01/15 Version 10	10/21/15: MPCTAC 11/11/15: QIC
10/21/15	Review for effective date 02/01/16. Revised the Limitations section and updated references. Clarified criteria in the Medical Policy Statement section.	02/01/16 Version 11	10/21/15: MPCTAC 11/11/15: QIC
11/25/15	Review for effective date 02/01/16. Revised language in the Applicable Coding section. Updated Summary and References sections.	02/01/16 Version 12	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
08/01/16	Review for effective date 11/01/16. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Revised policy title and criteria in the Medical Policy Statement and Limitations sections. Added Plan notes and additional administrative changes made to the Applicable Coding section. Added applicable code A9274 as a device NOT considered medically necessary by the Plan when billed for the use of single-use, disposable and nonprogrammable/ mechanical insulin infusion device.	11/01/16 Version 13	08/08/16: MPCTAC (electronic vote) 08/10/16: QIC
10/01/16	Review for effective date 12/01/16. Updated Clinical Background Information and References sections. Administrative changes made to the Limitations section. Plan notes made to applicable codes. No change to criteria and/or the applicable code list.	12/01/16 Version 14	10/19/16: MPCTAC 11/09/16: QIC
12/05/16	Industry-wide code change with the addition of 2017 applicable CPT codes 0446T and 0448T effective 01/01/17.	01/01/17 Version 15	Not applicable because industry-wide code revision.
04/01/17	Review for effective date 07/08/17. Clarified Limitations section without changing criteria. Add experimental and investigational codes to applicable code list for services already listed as experimental and investigational in the Limitations section. Updated Definitions and References sections.	07/08/17 Version 16	04/15/17: MPCTAC

Policy Revisions History			
06/01/17	Review for effective date 07/08/17. Industry-standard code update in the Applicable Coding section.	07/08/17 Version 17	06/21/17: MPCTAC
10/01/17	Review for effective date 01/01/18. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Revised criteria in the Limitations section.	01/01/18 Version 18	10/18/17: MPCTAC
03/01/18	Review for effective date 06/01/18. Administrative changes made to Policy Summary, Definitions, References, and Other Applicable Policies sections. Updated criteria in the Medical Policy Statement and Limitations sections.	06/01/18 Version 19	03/21/18: MPCTAC
10/01/18	Review for effective date 01/01/19. Administrative changes made to the Policy Summary, Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.	01/01/19 Version 20	10/17/18: MPCTAC
09/01/19	Review for effective date 12/01/19. Revised the policy title. Administrative changes made to Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections. Updated coding and Plan notes in the Applicable Coding section.	12/01/19 Version 21	09/18/19: MPCTAC
11/01/19	Review for effective date 12/01/19. Administrative changes made the Limitations and Applicable Coding sections to clarify that the FreeStyle Libre is covered as a pharmacy benefit (and would not be authorized as medically necessary under the member's medical benefit or DME benefit). Updated the References section.	12/01/19 Version 22	11/20/19: MPCTAC
09/25/20	Review for effective date 10/01/20. Administrative changes made to the Medical Policy Statement, Limitations,	10/01/20 Version 23	09/25/20: MPCTAC (electronic vote)

Policy Revisions History			
	Applicable Coding, Clinical Background Information, and Reference to Applicable Laws and Regulations sections to reference CMS guidelines for clinical indications for coverage for SCO members with Medicare coverage during the COVID-19 pandemic.		
09/01/20 and 09/25/20	Review for effective date 12/01/20. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Plan notes updated in the Applicable Coding section. Criteria revised in the Medical Policy Statement and Limitations sections. Renumbered to version 24 with electronic vote on 09/25/20 to incorporate additional revisions made to the policy version effective 10/01/20 (version 23) referencing CMS guidelines for clinical indications for coverage for SCO members during the COVID-19 pandemic.	12/01/20 Version 24	09/16/20: MPCTAC and 09/25/20: MPCTAC (electronic vote)
10/01/21	Review for effective date 01/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria, the Limitations section renamed Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Applicable Coding, and References sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections.	01/01/22 Version 25	10/20/21: MPCTAC
12/01/21	Review for effective date 03/01/22. Removed prior authorization requirement for the interpretation and report of authorized ambulatory continuous glucose monitoring (CPT code 95251).	03/01/22 Version 26 Not implemented – replaced with Version 27	12/15/21: MPCTAC
01/01/22	Review for effective date 03/01/22. Administrative changes made to the Policy Summary and References sections. Non-material revisions made to the Clinical	03/01/22 Version 27	01/19/22: MPCTAC

Policy Revisions History			
	Criteria and Limitations and Exclusions sections. Revisions approved in version 26 implemented.		

Next Review Date

02/01/23

Authorizing Entity

MPCTAC

Disclaimer Information: [+]

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.