Insulin Pumps - External

I. Policy

University Health Alliance (UHA) will reimburse for external insulin pump (E0784) when they are determined to be medically necessary and when they meet the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. An external insulin pump (E0784 and S1034) is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:

1. Patient clearly has a history of type 1 diabetes mellitus;

2. Auto-antibody test, i.e., islet cell cytoplasmic auto-antibodies (ICA), glutamic acid decarboxylase auto-antibodies (GADA) or insulinoma-associated antigen 2 auto-antibodies (IA-2A) is positive;

3. Fasting C-peptide level is:
   i. Less than or equal to 110 percent of the lower limit of the reference range and a fasting blood glucose obtained at the same time is less than or equal to 225 mg/dl; or
   ii. For patients with renal insufficiency and a creatinine clearance (actual or calculated) is less than or equal to 50 ml/minute, fasting C-peptide level is less than or equal to 200 percent of the lower limit of the reference range and a fasting blood glucose obtained at the same time is less than or equal to 225 mg/dl.

4. The patient or caregiver has completed a comprehensive diabetes self-management education program, including instruction in carbohydrate counting;

5. The patient or caregiver has demonstrated compliance and competence with an intensive insulin regimen for at least three months prior to the request for the insulin pump, including the following:
   i. Multiple daily injections of insulin i.e., at least three injections per day, with frequent self-adjustments of insulin dose based on glucose measurements and carbohydrate counting.
   ii. Glucose self-testing an average of at least four times per day.

6. The patient has one of the following despite treatment with an intensive insulin regimen:
   i. Glycosylated hemoglobin level (HbA1c) is greater than seven percent
   ii. Repeated and unpredictable hypoglycemia
   iii. Wide fluctuations in preprandial blood glucose
   iv. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
   v. Severe glycemic excursions

7. The external insulin pump is ordered and follow-up care will be provided by a physician who manages multiple patients on continuous subcutaneous insulin infusion (CSII) therapy and who works closely with a team of nurses, diabetic educators and dieticians who are knowledgeable in the use of CSII.
B. It may be considered medically necessary to initiate the use of insulin infusion pumps during pregnancy earlier than the criteria stated above to avoid fetal and maternal complications of diabetes and pregnancy. It may be considered medically necessary for poorly controlled women with diabetes to sometimes get started on the pump pre-pregnancy or in the first trimester.

C. Replacement of an external insulin pump is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the following criteria are met:

1. Documentation from the patient’s medical record supports that the pump is malfunctioning, out of warranty and cannot be repaired; or
2. Documentation supports that a pump with newer technology or special feature is medically necessary; AND
3. The replacement is initiated and ordered by the treating physician;
4. The patient has type 1 diabetes, has continued to use the pump and has a documented frequency of glucose self-testing an average of at least four times per day during the month prior to the request for replacement.;

D. NOTE: This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member’s individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Replacement of an insulin pump for the sole purpose of receiving an upgrade in technology is not covered.

B. Supplies used with an insulin pump are not covered when coverage criteria for the insulin pump are not met.

C. Transdermal insulin delivery system, e.g., V-Go Disposable Insulin Delivery Device, is not covered because it is not known to be effective in improving health outcomes.

IV. Administrative Guidelines

A. Prior authorization is required.

B. The following documentation must be submitted:

1. Beta cell antibody or fasting C-peptide with blood glucose (in the absence of a clear history of type 1 diabetes mellitus).
2. Notes documenting that the patient has completed a comprehensive diabetes self-management education program.
3. Record (logs) supporting administration of multiple daily doses of insulin with frequent self-adjustment of dose based on glucose measurements and carbohydrate counting and supporting glucose self-testing an average of at least four times per day in the three months preceding the request.

4. Results of HbA1c obtained within three months of the request.

C. Prior authorization for replacement pumps is required and must be initiated by the treating physician. The following documentation must be submitted:

1. Supporting documentation that the patient has continued to use the external infusion pump and that the pump is malfunctioning or that new technology is medically necessary.

2. Record (log) supporting frequency of glucose self-testing an average at least four times per day during the month prior to the request for replacement.

3. Results of HbA1c obtained within three months of the request for replacement.

D. To request prior authorization, please go to UHA’s website: https://uhahealth.com/page/prior-authorization-forms to submit via online.

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<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E0784</td>
<td>External ambulatory infusion pump, insulin</td>
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<tr>
<td>S1034</td>
<td>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 the devices</td>
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V. Policy History

Policy Number: M.DME.11.121120
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Previous Revision Dates: 09/01/2016

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