Overview

The purpose of this document is to describe the guidelines Neighborhood Health Plan (NHP) utilizes to determine the medical necessity for continuous glucose monitors. The treating specialist must request prior authorization for long-term continuous glucose monitors.

Coverage Guidelines

As of February 20, 2017, medical necessity for Continuous Glucose Monitor is determined through McKesson’s InterQual® criteria. To access the criteria, log in to NHP’s provider website at NHP.Net and click the InterQual® Criteria Lookup link under the Resources Menu. NHP covers continuous glucose monitors for individuals when it is recommended by the member’s providers and when the request meets the medical necessity criteria. In addition, the member’s endocrinologist is responsible for providing all necessary clinical information for the determination of medical necessity including: medical history, diabetes education received, treatment to date, glucose reading logs, pertinent laboratory testing, treatment plan, and medical necessity rational. The treating endocrinologist must sign a prescription for any requested continuous glucose monitor/supply at least yearly.

Continuous Glucose Monitors- Long Term -Exclusions

1. Use of sensors more frequently than every 72 hours.
2. Replacement or repair of home long-term (more than 7 days) continuous glucose monitors when:
   a. It is still under manufacture warranty;
   b. It is lost, stolen, or damaged due to improper care, or misuse, or neglect (NHP may require proof of the stolen or damaged item. Proof consists of a police report, pictures, or corroborating statement);
   c. The member has a functioning model and a newer or upgraded model is not medically necessary;
3. Devices or device features that are to be principally used for convenience and are not medically necessary;
4. Devices or device features that are considered experimental and investigational. (e. g. Medtronic My Sentry Device).

Definitions

Continuous Glucose Monitors: Minimally invasive or noninvasive devices that measure glucose levels in the interstitial fluid surrounding skin cells over a short-term period of several days or for long-term use to provide continuous information about glucose fluctuations that is not otherwise captured by intermittent testing. The continuous glucose monitoring systems measure blood glucose with minimal invasiveness through continuous measurement of interstitial fluid (ISF) with a subcutaneously implanted sensor. These devices typically require calibration with fingerstick glucose levels. The readings from the CGMS are intended to supplement, not replace, information obtained from standard home glucose monitoring devices. Several CGMS have been approved by the FDA. In addition to stand-alone continuous
Continuous glucose monitors, several insulin pump systems have included a built-in continuous glucose monitor. Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimens can be a useful tool to lower hemoglobin A1C levels in highly selected patients.

**Glycated hemoglobin**: Also known as HbA1c, is a form of hemoglobin. (Hemoglobin is the iron-rich protein in red blood cells that gives blood its red color.) In the normal 120-day life span of a red blood cell, glucose molecules react with hemoglobin forming glycated hemoglobin. Individuals with diabetes have higher quantities of glucose in their capillary blood and as a result they also have increased numbers of glycated hemoglobin molecules. The 2010 American Diabetes Association Standards of Medical Care include an HbA1c level $\geq 6.5\%$ as one of the criteria for diagnosing diabetes. Once a hemoglobin molecule is glycated, it remains that way. A build-up of glycated hemoglobin within the red blood cells therefore reflects the average level of glucose to which the cell has been exposed during its life cycle. Measuring glycated hemoglobin assesses the effectiveness of therapy for the treatment of diabetes.

**Hypoglycemia**: The International Hypoglycemia Study Group recommended a blood glucose value of 70 mg/dL or less as sufficiently low for treatment with fast-acting carbohydrates and less than 54 should be considered serious, clinically significant hypoglycemia. Severe hypoglycemia is defined as severe cognitive impairment requiring assistance from another person for recovery.

**Optimum Glycemic Control per ADA 2017**:
- Lowering A1C for non-pregnant adults to < or about 7% to reduce microvascular and neuropathic complications of diabetes and, possibly, macrovascular disease.
- Lowering A1C for a selected individual adult to <6.5% without causing significant hypoglycemia or other adverse effects of treatment.
- Less stringent A1C goals (e.g. <8%) may be appropriate for an adult patient with a history of: severe hypoglycemia, limited life expectancies, advanced microvascular or macrovascular complications, extensive comorbid conditions, or those with longstanding diabetes in whom the general goal is difficult to obtain despite education, monitoring, and appropriate medications.
- Lowering A1C for children to < 7.5% with special consideration for the unique risks of hypoglycemia in very young children.

**Related Policies**
- Insulin Pumps

**Effective**
November 2017: Annual update.
February 2017: McKesson’s InterQual® criteria replaced the criteria as indicated in the policy.
July 2016: Annual update
July 2015: Effective date.

**References**


International Hypoglycemia Study Group. Glucose concentration of less than 3.0 mmol/L (54 mg/dL) should be reported in clinical trials: a joint position statement of the ADA and EASD. *Diabetes Care* 2017; 40:155-157.


Pickup J., Freeman, S., Sutton, A. Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self monitoring of blood glucose: Meta-analysis of randomized controlled trials using individual patient data. *BMJ* 2011; 343: 3805. doi: [http://dx.doi.org/10.1136/bmj.d3805](http://dx.doi.org/10.1136/bmj.d3805)


