External Insulin Infusion Pumps

DESCRIPTION

An external insulin infusion pump is used to deliver insulin into patients with diabetes, and several insulin pump systems include a built-in CGM component.

MEDICARE ADVANTAGE POLICY CRITERIA

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>CMS Coverage Manuals*</td>
<td>None</td>
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<tr>
<td>National Coverage Determinations (NCDs)*</td>
<td>None</td>
</tr>
<tr>
<td>Noridian Healthcare Solutions (Noridian) Local</td>
<td>External Infusion Pumps (L33794) (See criterion IV A-D within the LCD, and the requirements for continued coverage of an external insulin pump.)</td>
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</tbody>
</table>
Coverage Determinations (LCDs) and Articles (LCAs)*

See also the LCA for External Infusion Pumps - Policy Article (A52507) for coding guidance. According to A52507, “Use code J1817 for insulin administered through an external insulin pump (E0784).” According to L33794, if criteria are not met “the pump and related accessories, supplies, and insulin will be denied as not reasonable and necessary.” Therefore, J1817 would only be allowed if the coverage criteria for the insulin pump is met. If the coverage criteria are not met, the insulin for the pump would not be allowed as a “related” item or service.

**Scroll to the “Public Version(s)” section at the bottom of the LCD for links to prior versions if necessary.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below must be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Either C-peptide test levels or Beta cell autoantibody test results; and,
- One of the following:
  o Documentation of a completed a diabetes education program, multiple daily injections of insulin with frequent self-adjustments for at least 6 months prior to insulin pump use, and has documented glucose self-testing an average of at least 4 times/day during the 2 months prior to pump use, and meets one or more of the following while on multiple injection regimen:
    ▪ 1. HbA1C > 7%
    ▪ 2. History of recurring hypoglycemia
    ▪ 3. Wide fluctuations in blood glucose before mealtime
    ▪ 4. Dawn phenomenon with fasting blood sugars frequently > 200 mg/dL
    ▪ 5. History of severe glycemic excursions; or
  o If the beneficiary was on an external insulin infusion pump prior to enrollment in Medicare, documentation must support frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

CROSS REFERENCES

None

REFERENCES
1. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §110.1 - Definition of Durable Medical Equipment, C. Replacement
2. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.1 - Definition of Durable Medical Equipment, B and B.2

**CODING**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CPT</td>
<td>None</td>
<td>Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training</td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0784</td>
<td>External Ambulatory Infusion Pump, Insulin</td>
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<tr>
<td></td>
<td>E0787</td>
<td>External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing</td>
</tr>
</tbody>
</table>

*IMPORTANT NOTE: Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan’s web control as these sites are not maintained by the health plan.*