MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-04

Distribution: Medical Suppliers, Practitioners, Medicaid Health Plans

Issued: March 1, 2019

Subject: Continuous Glucose Monitoring Systems

Effective: April 1, 2019

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS), MIChild, Healthy Michigan Plan

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHPS) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in a MHP, the provider must check with the beneficiary's health plan for prior authorization requirements.

Effective April 1, 2019, the Michigan Department of Health and Human Services (MDHHS) will begin coverage of personal use continuous glucose monitoring systems (CGMSs).

I. Definition

CGMSs are devices that measure glucose levels taken from interstitial fluid continually throughout the day and night, providing real-time data to the beneficiary or physician. The CGMS is comprised of three parts: (1) a disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels), (2) the transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor), and (3) a receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low).

II. Standards of Coverage

MDHHS will cover a personal use CGMS for persons with Type I Diabetes when all the following standards of coverage are met:

- The beneficiary is under the care of one of the following:

  A. An endocrinologist; or

B. A physician or non-physician practitioner (nurse practitioner [NP], physician assistant [PA], or clinical nurse specialist [CNS]) who is managing the beneficiary's diabetes. (This provider must provide documentation that the beneficiary completed a Medicaid-covered certified diabetes self-management education [DSME] training program within one year prior to the written order);

- The beneficiary has Type I Diabetes requiring the administering of insulin three or more times per day or is currently using an insulin pump; and at least one of the following:

  - Is unable to consistently and reliably identify hypoglycemic events (e.g., hypoglycemic unawareness);
  - A recent history of hospitalization or emergency room visits for seizures or other conditions attributed to a hypoglycemic event;
  - Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);
  - The presence of microvascular complication (e.g., vasculopathy, retinopathy); or
  - Ketoacidosis or uncontrolled glucose.

  At least one of the above conditions must be documented (e.g., hypoglycemic unawareness).

- The beneficiary's treatment plan recommends testing blood glucose a minimum of four times per day;
- The beneficiary has poor diabetic control despite attempts to maximally optimize care (e.g., compliance) with hypoglycemic unawareness, seizures, unexplained hypoglycemic episodes, recurrent ketoacidosis, and/or HbA1c not in an acceptable range;
- The beneficiary's current treatment plan requires frequent adjustments to insulin dosage throughout the day;
- The endocrinologist/physician/non-physician practitioner documents beneficiary compliance with their treatment plan; and
- The beneficiary or his/her caregiver is educated on the use of the device and is willing and able to use the CGMS.

III. Documentation

Documentation must be less than 90 days old and include all the following:

- The order is written by the endocrinologist or other physician/non-physician practitioner treating the beneficiary;
- Diagnosis related to the need for the CGMS;
- Length of need;
- Number of finger-stick tests beneficiary performs per day;

- Frequency of insulin administered per day or if the beneficiary is using an insulin pump;
- Records of hypoglycemic events, HbA1c levels, uncontrolled glucose, ketoacidosis, recent hospitalizations or emergency room visits related to conditions attributed to hypoglycemic events, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable;
- Current treatment plan and beneficiary's compliance with the plan; and
- Documentation of beneficiary completion of a Medicaid-covered certified DSME training program (if provider other than an endocrinologist is treating the beneficiary's diabetes). The DSME training program must have been completed within one year prior to the written order for the CGMS and include education on the use of a CGMS. (Refer to the Hospital chapter of the Medicaid Provider Manual for additional information. The Medicaid Provider Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.)

The initial order must be written for six months. If the beneficiary continues to be compliant with use of the CGMS and treatment plan, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and receivers (following frequency rules below) may be written for a 12-month period.

Note: For CSHCS beneficiaries, a prescription from a pediatric endocrinologist is required for a CGMS.

IV. External Insulin Pumps Combined with CGMSs

An external insulin pump combined with a CGMS is covered when the external insulin pump policy and the CGMS policy standards of coverage are met. To be considered for coverage, the device must be approved by the Food and Drug Administration (FDA) as a combined insulin pump/CGMS.

Refer to the Medicaid External Infusion (Insulin) Pump policy, Medicaid Medical Supplier database, and the Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) code assignment of combination pump/CGMS.

V. Prior Authorization

Prior authorization is not required for infants and toddlers (age 5 and under*) if standards of coverage and documentation requirements are met. Prior authorization is required for all other ages and conditions.

*It is assumed that hypoglycemic unawareness is common within this age group.

VI. Payment Rules

The CGMS sensor, transmitter and receiver are purchase only-items, except for K0554 (may be purchased, rented or a used item). MDHHS covers the following HCPCS codes:

A9276 – Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial CGMS, one unit = one day supply

A9277 – Transmitter; external, for use with interstitial CGMS

A9278 – Receiver (monitor); external, for use with interstitial CGMS

K0553 – Supply allowance for therapeutic CGMS, includes all supplies and accessories, one-month supply = one unit of service

K0554 – Receiver (monitor); dedicated, for use with therapeutic CGMS

VII. Frequency

HCPCS Code	Limit	Fee	Modifier
A9276	30 per month	$13.32	NU
A9277	2 per year	$525.51	NU
A9278	1 per 3 years	$422.47	NU
K0553*	1 per month	$205.66	NU
K0554	1 per 3 years	$216.35	NU
K0554	10 months per 3 years	$21.63	RR
K0554	1 per 3 years	$162.26	UE

*The following HCPCS codes are included in the allowance for K0553 and may not be billed separately: A4233, A4234, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100, E2101.

The warranty must be expired prior to replacement of the transmitter and/or receiver.

Providers are reminded to use the most appropriate HCPCS code for each brand/make/model of CGM systems by reviewing the FDA's product approvals and the PDAC website for HCPCS code assignments. Upcoding a product to receive higher reimbursement is incorrect billing and could result in post-payment recovery of funds or provider audit.

Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered by Medicaid.

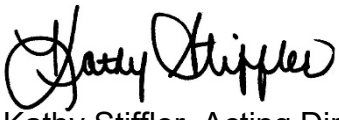
Manual Maintenance

Retain this bulletin until the information is incorporated into the Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Kathy Stiffler, Acting Director
Medical Services Administration