Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Diabetes Management Devices

Effective: January 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care Plan – A dual-eligible product; 857-304-6304

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Clinical Guideline Coverage Criteria

Harvard Pilgrim Health Care uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. For **Harvard Pilgrim Health Care Medicare Advantage** plan members, the following criteria is used: LCD - Glucose Monitors (L33822) (cms.gov) and Article - Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM) (A58213) (cms.gov)

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
95249	Patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including

Code	Description
	system activation and patient training
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
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
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4255	Platforms for home blood glucose monitor, 50 per box
A4526	Normal, low, and high calibrator solution/chips
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories
A9276	Sensor; invasive (e.g., subcutaneous) disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring syste
E0784	External ambulatory infusion pump, insulin

Approval And Revision History

March 2020: Reviewed by the Medical Policy Clinical Committee (MPCC); exclusion of OmniPod device removed

Subsequent endorsement date(s) and changes made:

- October 2020: criteria updated for recent CMS releases, AID and interoperable device management updated with current language
- December 2021: Reviewed by the Medical Policy Approval Committee (MPAC), criteria updated per CMS
- October 19, 2022: Reviewed by MPAC, criteria updated to reflect CMS NCDs and LCDs
- November 16, 2023: Reviewed by MPAC, template updated, coding updated, removed K0553 and K0554, effective January 1, 2024

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.