External Insulin Pumps
Corporate Medical Policy

File name: External Insulin Pumps
File code: UM.DME.02
Origination: 04/2006
Last Review: 04/2017
Next Review: 04/2018
Effective Date: 07/01/2017

Description/Summary

An external insulin infusion pump is a programmable, battery-powered mechanical syringe/reservoir device controlled by a micro-computer to deliver a continuous subcutaneous insulin infusion (CSII) into the body. Typical devices have a two to three day supply of insulin connected to an infusion set attached to a small needle or cannula programmed to deliver a steady basal amount of insulin and release a bolus dose at meals and at programmed intervals. The purpose of an insulin pump is to provide an accurate, continuous, controlled delivery of insulin, which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. An insulin pump is considered Durable Medical Equipment (DME).

Policy

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I- HCPCS code table & instructions

See the BCBSVT prior approval list for medical equipment to determine prior approval requirements for external insulin pumps.

When a service may be considered medically necessary

External insulin pumps may be considered medically necessary in the treatment of diabetic patients based on the following criteria.

All members must meet ALL of the general criteria:

- Completion of a diabetes self-management education program
- Treatment program including at least three insulin injections per day with frequent self-adjustments of insulin dose
• Documented frequent blood glucose self-testing 3-4 times per day prior to initiation of the insulin pump

Members with diagnosis of type 1 or type 2 diabetes mellitus must also meet one of the following:

• History of diabetic ketoacidosis
• Positive antibodies consistent with autoimmune diabetes, such as GAD-65, islet-cell cytoplasmic, Zinc Transporter 8, insulinoma-associated-2, insulin antibodies

Members on a multiple daily injection regimen must also meet one of the following:

• Glycated hemoglobin level (HbA1c) > 7.0%
• History of recurring hypoglycemia
• Wide fluctuations in blood glucose before mealtime
• Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
• History of severe glycemic excursions

Previously diagnosed diabetic members with gestational diabetes, or who are planning a pregnancy that is anticipated to occur within three months must also meet one of the following:

• Erratic blood sugars in spite of maximal patient compliance and split dosing
• Other evidence that adequate control is not being achieved.

Enhanced Features

An external insulin pump with enhanced features may be considered medically necessary when the criteria for a standard external insulin pump are met and there is a documented special need, such as a vision* or hearing impairment*, that requires an additional or enhanced feature for successful use of an insulin pump.

*legally blind or deaf

Replacement of External Insulin Pump or System Component

The replacement of an existing external insulin pump, or an insulin pump system component required for the delivery of insulin, may be considered medically necessary for an individual with successfully managed type 1 or type 2 diabetes mellitus when BOTH of the following criteria are met:

1. the pump/component is malfunctioning; OR no longer under warranty; OR cannot be repaired

2. health care provider managing the diabetes has seen the individual in the last six month and supports the need for a replacement device
When requesting a new pump due to a malfunction, documentation containing a complete description of the specific malfunction is required.

**When a service is considered non-covered (benefit exclusion)**

Supplies required for the proper use of a medically necessary external insulin pump, including custom-designed batteries and power supplies, are considered medically necessary. However, off-the-shelf batteries that can also be used to power non-medical equipment are considered convenience items and therefore a benefit exclusion.

Replacement of a functioning insulin pump, or additional software/hardware for the sole purpose of upgrading to the latest technology is considered a convenience and is therefore a benefit exclusion.

Deluxe features/items, add-ons, or upgrades that do not significantly enhance the functionality of the insulin pump, or are for the ease of member/caregiver use is considered a convenience, and is therefore a benefit exclusion.

Any treatment, Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience.

When an external insulin pump does not provide a therapeutic benefit to a patient in need because of certain medical conditions or illnesses.

**Reference Resources**


Related Policies

Medical Equipment and Supplies (DME)
Continuous or Intermittent Glucose Monitoring (CGMS) in Interstitial Fluid

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer’s benefit plan if an ASO group, determines benefits that are in effect at the time of
service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member’s contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member’s benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

<p>| 04/2006 | New Policy |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>07/2007</td>
<td>Re-reviewed based on new controlled clinical trial information. Real time continuous glucose monitoring is considered investigational and not medically necessary.</td>
</tr>
<tr>
<td>02/2014</td>
<td>ICD-10 remediation. Updated standard language (document precedence, audit information added. Removed PA requirement for insulin pump supplies. RLJ.</td>
</tr>
<tr>
<td>08/2015</td>
<td>Section headers added, updated and/or clarified. Other minor format changes. Approved in MPC on 8/31/15 RLG.</td>
</tr>
<tr>
<td>04/2017</td>
<td>External input received with updates to medical criteria, removed fasting C-Peptide testing requirements. Reformatted medical criteria section to clarify language. Added “enhanced features section” ICD 10 table removed.</td>
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</tbody>
</table>

**Eligible providers**

Qualified healthcare professionals practicing within the scope of their license(s), to include:

**Durable Medical Equipment (DME) Providers**

Approved by BCBSVT Medical Directors Date Approved

Gabrielle Bercy-Roberson, MD, MPH
Senior Medical Director
Chair, Health Policy Committee

Joshua Plavin, MD, MPH
Chief Medical Officer

Attachment I
HCPCS Code Table & Instructions
<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
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<tbody>
<tr>
<td>HCPCS</td>
<td>E0784</td>
<td>External ambulatory infusion pump, insulin</td>
<td>See DME prior approval list for requirements.</td>
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<tr>
<td>HCPCS</td>
<td>S9145</td>
<td>Insulin pump initiation, instruction in initial use of the pump (pump not included)</td>
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