



## ***Continuous Glucose Monitoring***

<b>Origination:</b> 10/19/06	<b>Revised:</b> 09/01/17	<b>Annual Review:</b> 11/02/17
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### **Purpose:**

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Continuous Glucose Monitoring in order to determine inclusion in the benefit plan.

### **Compliance Status:**

- Food and Drug Administration (FDA)

### **Recommendation:**

A recommendation was made by the MTAC following discussion by committee members based on current literature:

### ***Definitions***

- Continuous glucose monitoring (CGM) systems are minimally invasive or noninvasive devices that measure glucose levels in interstitial fluid at frequent intervals over a period of several days. CGM systems are designed to obtain diurnal patterns in glucose levels that, when reviewed retrospectively by the physician, can guide adjustments to therapy, with the goal of improving overall glycemic control. The glucose measurements provided during continuous monitoring are not intended to replace standard self-monitoring of blood glucose obtained using finger stick blood samples.
- Remote glucose monitors. These monitors (i.e. mySentry by Minimed) monitor glucose and signal an alarm if glucose levels drop below a pre-determined value.

### ***Coverage Guidelines***

- *Continuous Glucose Monitoring* can be approved when ANY of the following criteria are met:
  1. Diabetes with a lack of residual beta-cell activity (documented with a C-peptide level or a positive beta cell autoantibody test) requiring six (6) or more finger sticks per day and a recent HgbA1C > 8.0;
  2. Diabetes with documented "Hypoglycemic unawareness";
- *Remote glucose monitors* can be approved if ALL of the following are met:
  1. Member is 10 years and younger and currently using an Insulin pump;
  2. Nocturnal hypoglycemic episodes have been documented.



## *Continuous Glucose Monitoring*

### **Reference:**

1. National Diabetes Education Program. NIH.

### **Disclaimer Information:**

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but 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 the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.