Insulin Pumps
DME–026

Iowa Medicaid Program	Prior Authorization	**Effective Date**	01/17/2025
Revision Number	1	**Last Reviewed**	01/17/2025
Reviewed By	Medicaid Medical Director	**Next Review**	01/16/2026
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	01/17/2025

Descriptive Narrative

Diabetes is one of the most common chronic diseases in the United States, with approximately 38.4 million individuals affected or 11.6% of the population. Of that total number, 8.7 million people remain diagnosed, or 22.8% of the total.

Some diabetics are able to achieve control of their disease with lifestyle modification or oral medication. Others require delivery of exogenous insulin to attain optimal control of their disease. Insulin may be delivered by syringe, pen or pump.

The technology of pump delivery systems allows for a more physiologic replacement of insulin, with the opportunity to provide a continuous basal dose along with intermittent bolus doses, to match requirements in accordance with diet and activity levels and mimicking the natural function of the beta cells in the pancreas. Frequent finger sticks to monitor glucose levels must be performed, or the use of a Continuous Glucose Monitor, (CGM) are necessary to complement the use of an insulin pump.

In a traditional pump, insulin is infused from a reservoir/cartridge within the pump through tubing to a cannula or needle that is inserted subcutaneously. The infusion set and site of infusion are changed by the diabetic individual (or their caregiver) every two to three days. The tubing, which connects the infusion set to the insulin cartridge/reservoir in the pump, can be connected to and disconnected from the infusion site without removing the cannula.

For the patch pump, the insulin reservoir, batteries, and cannula are in a wearable disposable device ("pod"), which delivers insulin subcutaneously. The pod is changed every two to three days. Insulin delivery from the pod is controlled wirelessly by a handheld "controller," compatible smartphone, or personal diabetes manager.

Approval for use of an insulin pump requires **Prior Authorization**.

Criteria

Prior authorization is required.

An insulin pump may be medically necessary when **ALL** the following are met:

1. The member has a diagnosis of diabetes mellitus (any type); **AND**
2. The member or their caregiver have completed **ONE** of the following:
   a. A comprehensive diabetes education program*; **OR**
   b. Has access to a provider team that is experienced and has expertise in management and support of patients with an insulin infusion pump; **AND**
3. **BOTH** of the following criteria are met:
   a. Multiple daily doses of insulin are required; **AND**
   b. Multiple blood glucose tests are performed daily or a CGM is being used.

Continued use of an external insulin pump is medically necessary when **ONE** of the following is met:

1. The member was utilizing an insulin pump prior to enrollment with Iowa Medicaid; **OR**
2. Use of the device has resulted in clinical benefit, such as improvement in A1c levels, or a reduction in episodes of hypoglycemia or hyperglycemia.

*Provided by a certified diabetic educator, hospital-based program, or a PharmD with a diabetic concentration.

Replacement

Replacement of insulin pumps is medically necessary when **BOTH** of the following are met:

1. The device is no longer under warranty; **AND**
2. The device is not working properly and cannot be repaired.

Replacement of an insulin pump is **NOT** medically necessary when it is requested primarily for the convenience of the member or the member's physician.

Replacement of an operable insulin device (with or without an expired warranty) with newer technology is not medically necessary without clear documentation of the reason the upgrade is medically necessary to improve the member's clinical outcome.

Coding

The following list(s) of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
E0784	External ambulatory infusion pump, insulin

ICD-10	Description
E08.00-E13.9	Diabetes mellitus
O24.011-O24.93	Diabetes mellitus in pregnancy, childbirth and the puerperium
P70.2	Neonatal diabetes mellitus

Compliance

1. Should conflict exist between the policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

EncoderPro.

Insulin Infusion Pump. ACG: A-0339 (AC) Milliman Care Guidelines 27th Ed. Copyright 2023.

External Infusion Pumps. CMS. Local Coverage Determination ID L33794. For services performed on or after 07/01/2024.

National Diabetes Statistics Report. Center for Disease Control and Prevention. May 15, 2024.

Weinstock RS. Continuous subcutaneous insulin infusion. UpToDate. Topic last updated: June 07, 2024.

Diabetes Technology: Standards of Care in Diabetes – 2024. American Diabetes Association. Diabetes Care. Section on Insulin Pumps. Volume 47, Issue Supplement_1. January 2024.

IAC 441-73.1(249A)

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
01/17/2025	CAC	Criteria implementation. Tabled at the October 2024 meeting. Updated Replacement section. Added IAC Reference.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee