

**EFFECTIVE DATE:** 02/01/2024

**POLICY LAST REVIEWED:** 09/18/2024

## OVERVIEW

Automated insulin delivery systems, also known as artificial pancreas device systems, link a glucose monitor to an insulin infusion pump that automatically takes action (eg, suspends or adjusts insulin infusion) based on the glucose monitor reading. These devices are proposed to improve glycemic control in patients with insulin-dependent diabetes, in particular, reduction of nocturnal hypoglycemia.

## MEDICAL CRITERIA

### Medicare Advantage Plans and Commercial Products

Use of a U.S. Food and Drug Administration (FDA) cleared or approved automated insulin delivery system (artificial pancreas device system) with a low-glucose suspend feature may be considered medically necessary in patients with type 1 diabetes who meet all of the following criteria:

- Age 6 years and older
- Glycated hemoglobin level between 5.8% and 10.0%
- Used insulin pump therapy for more than 6 months
- At least 2 documented nocturnal hypoglycemic events in a 2-week period.

Use of an FDA cleared or approved automated insulin delivery system (artificial pancreas device system) designated as a hybrid closed-loop insulin delivery system (with low glucose suspend and suspend before low features) may be considered medically necessary in patients with type 1 diabetes who meet all of the following criteria:

- Over age 6 years AND
  - Glycated hemoglobin level between 5.8% and 10.0%
  - Used insulin pump therapy for more than 6 months
  - At least 2 documented nocturnal hypoglycemic events in a 2-week period.

OR

- Age 2 to 6 years AND
  - Clinical diagnosis of type 1 diabetes for 3 months or more
  - Used insulin pump therapy for more than 3 months
  - Glycated hemoglobin level <10.0%
  - Minimum daily insulin requirement (Total Daily Dose) of greater than or equal to 8 units

Use of an FDA cleared or approved automated insulin delivery system (artificial pancreas device system) designated as a closed-loop insulin delivery system may be considered medically necessary in individuals with type 1 diabetes who meet all of the following criteria:

- Age 6 years and older AND
  - Clinical diagnosis of type 1 diabetes for 12 months or more;
  - Using insulin for at least 12 months;
  - Diabetes managed using the same regimen (either pump or multiple daily injections, with or without continuous glucose monitoring) for 3 months or longer.

## PRIOR AUTHORIZATION

Prior authorization is required for Medicare Advantage and recommended for Commercial Products and is obtained via the online tool for participating providers. See the Related Policies section.

## **POLICY STATEMENT**

### **Medicare Advantage Plans and Commercial Products**

Use of an FDA cleared or approved automated insulin delivery system (artificial pancreas device system) with a low-glucose suspend feature may be considered medically necessary in patients with type 1 diabetes when the medical criteria above are met.

Use of an FDA-approved automated insulin delivery system (artificial pancreas device system) designated as hybrid closed-loop insulin delivery system (with low glucose suspend and suspend before low features) may be considered medically necessary in patients with type 1 diabetes when the medical criteria above are met.

Use of an automated insulin delivery system (artificial pancreas device system) is not covered for Medicare Advantage Plans and not medically necessary for Commercial Products for individuals who do not meet the above criteria.

Use of an automated insulin delivery system (artificial pancreas device system) not approved by the Food and Drug Administration is not covered for Medicare Advantage Plans and not medically necessary for Commercial Products.

## **COVERAGE**

Benefits may vary by groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable medical equipment, medical supplies and prosthetic devices and diabetic equipment/supplies or not medically necessary/not covered benefits/coverage.

## **BACKGROUND**

Tight glucose control in patients with diabetes has been associated with improved health outcomes. The American Diabetes Association has recommended a glycated hemoglobin level below 7% for most patients. However, hypoglycemia may place a limit on the ability to achieve tighter glycemic control. Hypoglycemic events in adults range from mild to severe based on a number of factors including the glucose nadir, the presence of symptoms, and whether the episode can be self-treated or requires help for recovery. Children and adolescents represent a population of individuals with type 1 diabetes who have challenges in controlling hyperglycemia and avoiding hypoglycemia. Hypoglycemia is the most common acute complication of type 1 diabetes.

Type 1 diabetes is caused by the destruction of the pancreatic beta cells which produce insulin, and the necessary mainstay of treatment is insulin injections. Multiple studies have shown that intensive insulin treatment, aimed at tightly controlling blood glucose, reduces the risk of long-term complications of diabetes, such as retinopathy and renal disease. Optimal glycemic control, as assessed by glycated hemoglobin, and avoidance of hyper- and hypoglycemic excursions have been shown to prevent diabetes-related complications. Currently, insulin treatment strategies include either multiple daily insulin injections or continuous subcutaneous insulin infusion with an insulin pump.

For individuals who have type 1 diabetes who receive an artificial pancreas device system with a hybrid closed-loop insulin delivery system, the evidence includes multicenter pivotal trials using devices cleared by the U.S. Food and Drug Administration, supplemental data and analysis for expanded indications, and more recent studies focused on children and adolescents. Three crossover RCTs using a similar first-generation device studied and approved outside the United States have been reported. Relevant outcomes are symptoms, change in disease status, morbid events, resource utilization, and treatment-related morbidity. Of these 3 crossover RCTs 2 found significantly better outcomes (ie, time spent in nocturnal hypoglycemia and time spent in preferred glycemic range) with the device than with standard care. The third study had mixed findings (significant difference in time spent in nocturnal hypoglycemia and no significant difference in time spent in preferred glycemic range). Additional evidence from device performance studies and clinical studies all demonstrate reductions in time spent in various levels of hypoglycemia, improved time in range (70-180 mg/ dL), rare diabetic ketoacidosis, and few device-related adverse events. The evidence suggests that the

magnitude of reduction for hypoglycemic events in the type 1 diabetes population is likely to be clinically significant. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have type 1 diabetes who receive an artificial pancreas device system with a closed-loop insulin delivery system, the evidence includes a 13-week multicenter RCT of the iLet Bionic Pancreas System compared to usual care in 326 individuals ages 6 to 79 years with type 1 diabetes. Comparator group participants continued their pre-study subcutaneous insulin delivery (either multiple daily injections, an insulin pump without automation of insulin delivery, an insulin pump with predictive low glucose suspend feature, or an insulin pump as part of an HCL system) plus real-time CGM. The glycated hemoglobin level decreased from 7.9% to 7.3% in the closed-loop insulin delivery system group and did not change (7.7% at both time points) in the standard-care group (mean adjusted difference at 13 weeks,  $-0.5\%$ ; 95%CI  $-0.6$  to  $-0.3$ ;  $p < 0.001$ ). The rate of severe hypoglycemia was 17.7 events per 100 participant-years in the closed-loop insulin delivery system group and 10.8 events per 100 participant-years in the standard-care group ( $p = 0.39$ ). No episodes of diabetic ketoacidosis occurred in either group. The trial's results for the subgroups of adults (ages 18 and older) and youth (ages 6 to 17 years) have additionally been reported and were similar to the main results for the full cohort. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome. For individuals who have type 1 diabetes (T1D) who receive an artificial pancreas device system with a low-glucose suspend feature, the evidence includes three randomized controlled trials (RCTs) conducted in home settings. Relevant outcomes are symptoms, change in disease status, morbid events, resource utilization, and treatment-related morbidity. Primary eligibility criteria of the key RCT, the Automation to Simulate Pancreatic Insulin Response (ASPIRE) trial, were ages 16-to-70 years old, T1D, glycated hemoglobin levels between 5.8% and 10.0%, and at least 2 nocturnal hypoglycemic events ( $\leq 65$  mg/dL) lasting more than 20 minutes during a 2-week run-in phase. Both trials required at least six months of insulin pump use. Both RCTs reported significantly less hypoglycemia in the treatment group than in the control group. In both trials, primary outcomes were favorable for the group using an artificial pancreas system; however, findings from one trial were limited by nonstandard reporting of hypoglycemic episodes, and findings from the other trial were no longer statistically significant when two outliers (children) were excluded from analysis. The RCT limited to adults showed an improvement in the primary outcome (area under the curve for nocturnal hypoglycemic events). The area under the curve is not used for assessment in clinical practice but the current technology does allow user and provider review of similar trend data with continuous glucose monitoring. Results from the ASPIRE study suggested that there were increased risks of hyperglycemia and potential diabetic ketoacidosis in subjects using the threshold suspend feature. This finding may be related to whether or not actions are taken by the user to assess glycemic status, etiology of the low glucose (activity, diet or medication) and to resume insulin infusion. Both retrospective and prospective observational studies have reported reductions in rates and severity of hypoglycemic episodes in automated insulin delivery system users. The evidence is sufficient that the magnitude of reduction for hypoglycemic events in the T1D population is likely to be clinically significant. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have T1D who receive an artificial pancreas device system with a hybrid closed-loop insulin delivery system, the evidence includes multicenter pivotal trials using devices cleared by the U.S. Food and Drug Administration, supplemental data and analysis for expanded indications and more recent studies focused on children and adolescents. Three crossover RCTs using a similar first-generation device approved outside the United States have been reported. Relevant outcomes are symptoms, change in disease status, morbid events, resource utilization, and treatment-related morbidity. Of the three crossover RCTs assessing a related device conducted outside the United States, two found significantly better outcomes (ie, time spent in nocturnal hypoglycemia and time spent in preferred glycemic range) with the device than with standard care and the other had mixed findings (significant difference in time spent in nocturnal hypoglycemia and no significant difference in time spent in preferred glycemic range). Additional evidence from device performance studies and clinical studies all demonstrate reductions in time spent in various levels of hypoglycemia, improved time in range (70-180mg/dl), rare diabetic ketoacidosis and few device-related adverse events. The evidence suggests that the magnitude of reduction for hypoglycemic events in the T1D

population is likely to be clinically significant. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Clinical input supported that the outcome of hypoglycemia prevention provides a clinically meaningful improvement in net health outcome, and this use is consistent with generally accepted medical practice. Clinical input also supported that the use of hybrid closed loop artificial pancreas device systems provides a clinically meaningful improvement in net health outcome and is consistent with generally accepted medical practice. Reduction in the experience of hypoglycemia and inappropriate awareness of hypoglycemia and glycemic excursions were identified as important acute clinical outcomes in children, adolescents, and adults and are related to the future risk for end-organ complications.

## **CODING**

### **Medicare Advantage Plans and Commercial Products**

The following codes are covered when medical criteria are met.

- E0787** External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing
- S1034** Artificial pancreas device system (eg, low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices
- S1036** Transmitter; external, for use with artificial pancreas device system
- S1037** Receiver (monitor); external, for use with artificial pancreas device system

The following code is covered when the device is approved:

- S1035** Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system

*Please note Blue Cross Blue Shield of Rhode Island considers it inappropriate to bill the artificial pancreas device system using the following codes specific to a continuous glucose monitoring system and insulin pump when the technology functions as an artificial pancreas and no manual intervention is needed. These codes include but are not limited to the following list:*

- E0784 External ambulatory infusion pump, insulin*
- E2103 Non-adjunctive, non-implanted continuous glucose monitor or receiver (New Code Effective 1/1/2023)*
- A4226 Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week*
- A4239 Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service (New Code Effective 1/1/2023)*
- A9276 Sensor; invasive (e.g., subcutaneous), disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply (Text Revision Effective 1/1/2023)*
- A9277 Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system (Text Revision Effective 1/1/2023)*
- A9278 Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system (Text Revision Effective 1/1/2023)*
- K0553 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service (Code Deleted Effective 12/31/2022)*
- K0554 Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system (Code Deleted Effective 12/31/2022)*
- S1030 Continuous non-invasive glucose monitoring device, purchase (for physician interpretation of data, use CPT code)*
- S1031 Continuous non-invasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use CPT code)*

## **RELATED POLICIES**

Glucose Monitoring - Continuous

Preauthorization via Web-Based Tool for Durable Medical Equipment (DME)

## PUBLISHED

Provider Update, November 2024

Provider Update, December 2023

Provider Update, November/December 2022

Provider Update, October 2021

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