

# Implantable and Non-Covered Diabetes Management Technologies

MEDICAL POLICY NUMBER: 27

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**INSTRUCTIONS FOR USE:** Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

**SCOPE:** Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

## PLAN PRODUCT AND BENEFIT APPLICATION

Commercial

Medicaid/OHP\*

Medicare\*\*

### \*Medicaid/OHP Members

*Oregon*: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Continuous Blood Glucose Monitors: Guideline Note 108

Self-Monitoring of Blood Glucose in Diabetes: Guideline Note A2, OAR 410-12-0520

### \*\*Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

## COVERAGE CRITERIA

**Notes:** This policy does not address all advanced diabetes management technologies. It is limited to the items and services listed in the “Criteria” table. Items and services not addressed in this medical policy may be considered medically necessary, unless addressed in a separate medical policy (see Policy Cross References). In addition, external and disposable continuous glucose monitors (CGMs) are **not** addressed by this medical policy, but are addressed by Pharmacy policy.

### Implantable Continuous Glucose Monitoring Systems

- I. Implantable continuous glucose monitoring systems and their associated supplies may be considered **medically necessary** for the treatment of insulin-dependent diabetes when both of the following criteria are met (A.-B.):
  - A. The requested device is FDA-approved and is being used in accordance with the approved indications of use (see [Table 1](#) for list of devices and indications); **and**
  - B. The patient is currently treated with multiple daily injections of insulin (i.e., at least 2 injections per day) that includes a rapid-acting insulin (such as Humalog®) or regular insulin (such as Humulin R®).

**NOTE:** Some supply codes have specific limitations. See the [“Billing Guidelines and Coding”](#) section below for quantity limits of supplies.

- II. Implantable continuous glucose monitoring systems and their associated supplies are considered **not medically necessary** when criterion I. above is not met.

#### **Replacement of Implantable Continuous Glucose Monitoring Systems**

- III. Upgrade or replacement of existing implantable continuous glucose monitoring systems may be considered **medically necessary** when there is documentation that one or more of the device components meet all of the following criteria (A.-C.):
  - A. Are no longer functional; **and**
  - B. Are not under warranty (see [Table 1](#) for list of devices); **and**
  - C. Cannot be repaired.
- IV. Upgrade or replacement of existing implantable continuous glucose monitoring systems is considered **not medically necessary** when criterion III. above is not met.

#### **Removal of Implantable Continuous Glucose Monitoring Systems**

- V. Removal of implantable continuous glucose monitoring systems may be considered **medically necessary** if it has been thoroughly evaluated and found to be no longer functional and was appropriately placed for medical necessity.
- VI. Removal of continuous glucose monitoring systems is considered **not medically necessary** when criterion V. above is not met.

#### **Not Covered**

- VII. Implantable insulin infusion pumps are considered **not medically necessary** for any indication, including the treatment of insulin-dependent diabetes.
- VIII. Enhancements or optional accessories for existing advanced diabetes management technology via smartphones, tablets, wrist-watches and computers are considered convenience items and therefore are **not medically necessary**, including, but not limited to (A.-D.):
  - A. Mobile Apps (e.g., t: connect®, Glooko, Dexcom Share2 App, Dexcom Follow, Dexcom CLARITY® Reports App, MiniMed Connect)
  - B. Diabetes management software (e.g., d-Nav Technology, Dexcom CLARITY®, FreeStyle CoPilot Health Management System, Medtronic CareLink® system)
  - C. Remote glucose monitoring devices (e.g., mySentry)
  - D. Hypoglycemic wristband alarm (e.g., Diabetes Sentry™).

Link to [Evidence Summary](#)

## **POLICY CROSS REFERENCES**

- [Blood Glucose Monitors and Supplies](#), MP239

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

## **POLICY GUIDELINES**

### **BACKGROUND**

#### **Diabetes Mellitus**

Patients with poorly controlled diabetes mellitus (DM; or simply referred to as diabetes) are at risk for numerous acute and chronic complications. Common long-term complications due to elevated blood glucose include cardiovascular disease, kidney damage, eye disease, and nerve damage. Pregnant women with poorly controlled diabetes are at higher risk for maternal and neonatal complications. Extremely elevated blood glucose levels may lead to diabetic ketoacidosis and other potentially life-threatening conditions. Conversely, overly aggressive treatment of diabetes may lead to life-threatening hypoglycemia, especially among patients with comorbidities who are unaware of the signs and symptoms of hypoglycemia.<sup>1</sup>

#### **Continuous Glucose Monitoring: Implantable Systems**

Continuous glucose monitoring (CGM) systems are devices that measure glucose levels in interstitial fluid at frequent predetermined intervals. CGM systems are designed to obtain information regarding daily patterns in glucose levels that, when evaluated in real time or reviewed retrospectively, can guide adjustments to therapy, with the goal of improving overall glycemic control.<sup>1</sup>

Implantable CGMs, such as the Eversense system, are designed for long-term use and involve subcutaneous sensor placement in the upper arm. These systems transmit glucose data to an external transmitter and mobile app, offering real-time glucose trends and alerts. Unlike traditional CGMs, Eversense sensors can last up to 180 days and require a minor in-office procedure for insertion and removal.

#### **Implantable Insulin Pumps**

Insulin pumps are devices used to deliver insulin in a programmed and controlled manner to diabetic individuals by way of continuous subcutaneous insulin infusion (CSII). These devices work with a separate glucometer through manual or remote functions. The goals of insulin pump therapy are to achieve near-normal control of blood glucose levels. They are proposed as an alternative to administering insulin via multiple daily injections (MDI) and are thought to improve metabolic control in people with diabetes.

Implantable insulin pumps deliver insulin via intraperitoneal or intravenous routes. Currently, there are no implantable insulin infusion pumps that are approved by the FDA. However, some devices have been granted Investigational Device status.

## **REGULATORY STATUS**

## U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

**Table 1. Examples of FDA-Approved Advanced Diabetes Management Technologies**

Note:

The FDA frequently approves diabetic devices. Please consult the FDA [premarket approval \(PMA\)](#) and [510\(k\) premarket notification](#) databases for new devices not listed below.

Device	Manufacturer	Age Restriction	Indications	Contraindications
Eversense CGM System (i.e. <a href="#">Eversense E3</a> or <a href="#">Eversense 365</a> )	Senseonics  Warranty: 1 year	18 years and older	<p>The Eversense CGM System is indicated for continually measuring glucose levels in adults (age 18 and older) with diabetes for up to 90 days (Eversense E3) or 1 year (Eversense 365).</p> <p>The Eversense E3 system is indicated for use as an adjunctive device to complement, not replace, information obtained from standard home blood glucose monitoring devices.</p> <p>The Eversense 365 CGM System is also intended to autonomously communicate with digitally connected devices, including automated insulin dosing (AID) systems. The Eversense 365 CGM System can be used alone or in conjunction with these digitally connected medical devices for the purpose of managing diabetes.</p>	MRI exposure, known allergies to adhesives or dexamethasone, etc.

## CLINICAL EVIDENCE AND LITERATURE REVIEW

## EVIDENCE REVIEW

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of advanced diabetes management technology. Below is a summary of the available evidence identified through February 2026.

### Continuous Glucose Monitors: Implantable

#### *Systematic Reviews*

- In 2023 Hayes conducted a health technology assessment of the accuracy and utility of the Eversense Continuous Glucose Monitor for maintaining glycemic control in adults with diabetes mellitus.<sup>2</sup> Searching the literature, investigators identified 10 studies (reported in 11 publications) that compared Eversense with venous blood glucose (VBG) or self-monitored blood glucose (SMBG) using finger stick blood sampling and a glucometer. The assessment included prospective single-arm cohort studies, randomized controlled trial, and a randomized crossover trial. Outcomes of interest included Eversense's clinical validity, clinical utility and safety.

Overall, evidence suggested that Eversense device is highly correlated with reference standards (VBG or SMBG). While results suggested moderate accuracy, with a high proportion of readings falling outside of 20% of the reference standard (7%-16%), a lack of consensus regarding what is considered accurate in assessments of interstitial glucose compared with blood glucose limits definitive conclusions. Hayes ultimately assigned a "C" rating (potential but unproven benefit), concluding that "low quality" evidence suggested that Eversense was highly correlated with and moderately accurate in the measurement of glucose levels compared with VBG or SMBG as reference standards. Limitations included small sample sizes, lack of long-term data, lack of power analysis, lack of reporting of patient characteristics, lack of reporting details of study procedures, and a lack of reporting of patient recruitment methods.

#### *Nonrandomized Studies*

- In 2015, Dehennis et al. published a small multicenter study which assessed the accuracy of glucose measurement by the Senseonics' Eversense® CGM system compared to measurements obtained by venous blood, including 24 adults (between the ages of 18 and 65) with insulin-dependent type 1 or type 2 diabetes.<sup>3</sup> Twenty two of the twenty four (92%) sensors reported glucose continuously for 90 days, and the mean absolute relative difference (MARD) for all 24 sensors was  $11.4 \pm 2.7\%$  compared to venous reference glucose values. There was no significant difference in glucose values detected by the CGM compared to standard blood glucose monitoring throughout the 90-day study, nor was there a significant difference between the two methods at low (<70mg/dL) or high >180mg/dL glucose levels. No serious adverse events were noted. The authors concluded that the study showed successful in-clinic and home use of the Senseonics CGM system over 90 days in subjects with diabetes mellitus.
- In 2017, Kropff et al. published the results of an uncontrolled multicenter observational trial which assessed the accuracy and longevity of the implantable Eversense CGM in the PRECISE study, including 71 adults (18 years and older) with type 1 and type 2 diabetes. The participants were followed for 180 days to test the accuracy of the implanted CGM.<sup>4</sup> The mean absolute relative

difference (MARD) for venous reference glucose values >4.2 mmol/L over the study duration was 11.1% (95% CI 10.5, 11.7). However, device performance in the hypoglycemic range ( $\leq 75$  mg/dL) significantly less than the overall performance (21.7 vs. 11.6% MARD;  $p < 0.001$ ). A Kaplan-Meier analysis for sensor survival estimated that 100, 82, and 40% of sensors were functional through day 45, day 90, and day 180, respectively. The authors noted that participants with type 2 diabetes and participants of non-Caucasian descent were underrepresented in this study; limiting the applicability of the results to a wider population.

Our meta-analysis of 5 studies in patients aged 18 years or younger showed no mean between-group difference in change from baseline HbA<sub>1c</sub> level favoring rt-CGM (Table 2). We performed a subsidiary analysis for 3 studies (56, 57, 59) that reported data separately for adults. Our meta-analysis of these 3 studies showed a between-group mean difference in HbA<sub>1c</sub> levels; however, heterogeneity was significant (Table 2). Three other studies did not present results separately for adults and children and were excluded from this subsidiary meta-analysis

### **Insulin Infusion Pumps: Implantable**

*No relevant research identified on implantable insulin infusion pumps.*

## **CLINICAL PRACTICE GUIDELINES**

### **Continuous Glucose Monitors**

#### Adult Patients

#### *Advanced Technologies & Treatments for Diabetes (AATD) Congress*

In 2019, the AATD Congress published recommendations addressing clinical targets for continuous monitoring data Interpretation on the basis of expert consensus.<sup>5</sup> The consensus report was endorsed by the h Association, American Association of Clinical Endocrinologists, American Association of Diabetes Educators, European Association for the Study of Diabetes, Foundation of European Nurses in Diabetes, International Society for Pediatric and Adolescent Diabetes, JDRF, and Pediatric Endocrine Society. Please refer to the following [link](#) to view data tables of outlining each recommendation.

#### *American Diabetes Association (ADA)*

The 2025, the ADA “Standards of Medical Care in Diabetes” evidence-based guidelines recommended the following regarding the use of CGMs, insulin pumps and integrated systems for people with diabetes mellitus:<sup>6</sup>

- Recommend real-time CGM (rtCGM) — Recommendation Level A — or intermittently scanned CGM (isCGM) — Recommendation Level C for youth and B for adults — for diabetes management in people on any type of insulin therapy. The choice of CGM device should be based on the individual’s circumstances, preferences, and needs.
- Consider using rtCGM and isCGM in adults with type 2 diabetes treated with glucose-lowering medications other than insulin to achieve and maintain individualized glycemic goals. Recommendation Level B. The choice of device should be based on the individual’s circumstances, preferences, and needs.

- In people with diabetes on insulin therapy, rtCGM devices should be used as close to daily as possible for maximal benefit. Recommendation Level A. isCGM devices should be scanned frequently, at minimum once every 8 hours, to avoid gaps in data. Recommendation Level A. People with diabetes should have uninterrupted access to supplies to minimize gaps in CGM. Recommendation Level A.
- CGM can help achieve glycemic goals (e.g., time in range, time above range) in type 1 diabetes and pregnancy. Recommendation Level A. CGM can help achieve A1C goals. Recommendation Level B. CGM may also be beneficial for other types of diabetes in pregnancy. Recommendation Level E.
- When consistent use of CGM is not feasible, consider periodic use of personal or professional CGM to adjust medication and/or lifestyle. Recommendation Level C. Skin reactions, either due to irritation or allergy, should be assessed and addressed to aid successful device use. Recommendation Level E.
- People who wear CGM devices should be educated on potential interfering substances and other factors that may affect accuracy. Recommendation Level C.

*Oregon Health Evidence Review Commission (HERC)*

In 2023, HERC issued a coverage guidance addressing CGM for the treatment of diabetes.<sup>7</sup> Investigators made the following recommendations:

“We recommend coverage for CGM in individuals with T2DM or gestational diabetes who use insulin when all of the following criteria are met:

- A. Have received or will receive diabetes education specific to the use of CGM, AND
- B. Have used the device for at least 50% of the time by their first follow-up visit, AND
- C. Have one of the following at the time of CGM therapy initiation:
  - a. Baseline HbA1c levels greater than or equal to 8.0%, OR
  - b. Frequent or severe hypoglycemia, OR
  - c. Impaired awareness of hypoglycemia (including presence of these conditions prior to initiation of CGM).

Every 6 months following the initial prescription for CGM, the prescriber must conduct an in-person or telehealth visit with the member to document adherence to their CGM regimen and diabetes treatment plan.

Retrospective (physician-owned) CGM is not recommended for coverage.”

*Endocrine Society*

The 2016 Endocrine Society evidence-based clinical practice guideline on “Continuous Subcutaneous Insulin Infusion Therapy and Continuous Glucose Monitoring in Adults”<sup>8</sup> recommended the following regarding the use of CGMs for people with diabetes mellitus:

- Real-time CGM is recommended for adults with well-controlled DM1 and for adults with DM1 who have HbA1c levels above target. Patients should be willing and able to use a CGM device on a nearly daily basis.

- Short-term use of real time CGM is suggested for adult patients with DM2 who have HbA1c levels greater or equal to 7% and are both willing and able to use a CGM device.
- Education, training, and ongoing support to help achieve and maintain individualized glycemic goals are suggested for adults with diabetes using CGM.

*National Institute for Health and Care Excellence (NICE)*

The 2022 NICE guideline “Type 1 Diabetes in Adults: Diagnosis and Management”<sup>9</sup> was based on a systematic review of the evidence and recommended the following regarding the use of CGMs for people with type 1 diabetes:

- Routine use of real time (rt) CGM in adults with type 1 diabetes is not recommended.
- Consider rt- CGM for adults with type 1 diabetes who are willing to commit to using it at least 70% of the time and calibrate it as needed, and who have at least one of the following (despite optimized use of insulin therapy and conventional blood glucose monitoring): more than one episode a year of severe hypoglycemia that has no obviously preventable cause; complete hypoglycemia unawareness; frequent asymptomatic hypoglycemia that interferes with daily activities; extreme fear of hypoglycemia; or hyperglycemia that persists despite frequent testing (but only continue CGM if HbA1c can be sustained at 7% or below, or if there has been a fall in HbA1c of 2.5% or more).
- For adults with type 1 diabetes using CGM, insulin therapy should be applied with either multiple daily injections of insulin or continuous subcutaneous insulin infusion therapy.

The 2022 NICE guideline “Type 2 Diabetes in Adults: Management” did not recommend the use of CGMs for people with type 2 diabetes due to a lack of high quality RCTs and conflicting evidence. The panel stated that there is still uncertainty regarding the effectiveness of continuous glucose monitoring.<sup>10</sup>

*American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE)*

In 2016, the AACE and ACE published a joint consensus statement on “Outpatient Glucose Monitoring”<sup>11</sup> recommended the following regarding the use of CGMs for people with diabetes mellitus:

- CGM is recommended for adults and children with type 1 diabetes, particularly for individuals with a history of severe hypoglycemia and hypoglycemia unawareness, and to assist in correcting hyperglycemia in patients not within target range for blood glucose level.
- Before CGM use, patients should have knowledge of the basics of sensor insertion, calibration, and real-time data interpretation. More in-depth training and more frequent follow-up is recommended for CGM users who are children.
- Current evidence is limited for CGM use for patients with type 2 diabetes who are receiving insulin or sulfonylureas; trials assessing the use of CGM for these patients are ongoing.
- No recommendation was provided regarding the use of CGM for persons with type 2 diabetes who have a low risk of hypoglycemia.
- The benefits of CGM in pregnant individuals with preexisting diabetes are unclear; and additional studies are needed. CGM should primarily be considered a teaching tool when used during pregnancy, and should be used to evaluate peak postprandial blood glucose, fine-tune insulin dosing, and identify foods associated with blood glucose fluctuations.

- Additionally, CGM can be used as a supplement to blood glucose monitoring during pregnancy, in particular for monitoring nocturnal hypoglycemia or hyperglycemia and postprandial hyperglycemia.

### Pregnant Women

#### *American Diabetes Association (ADA)*

The 2025, the ADA “Standards of Medical Care in Diabetes”<sup>12</sup> evidence-based guidelines recommended the following regarding the use of CGMs for pregnant people with diabetes mellitus:

- Continuous glucose monitoring (CGM) can help achieve glycemic goals (e.g., time in range, time above range). Recommendation Level A. CGM can also help achieve A1C goals. Recommendation Level B. CGM may be beneficial in other types of diabetes during pregnancy. Recommendation Level E.
- Recommend CGM for pregnant individuals with type 1 diabetes. Recommendation Level A. When used with the goal of achieving traditional pre- and post-prandial glycemic targets, real-time CGM can reduce the risk of large-for-gestational-age infants and neonatal hypoglycemia in pregnancies complicated by type 1 diabetes. Recommendation Level A.
- CGM metrics may be used together with blood glucose monitoring to achieve optimal pre- and post-prandial glycemic goals. Recommendation Level E.

#### *Oregon Health Evidence Review Commission (HERC)*

In 2017, HERC issued a coverage guidance addressing CGM for the treatment of diabetes.<sup>7</sup> Investigators made the following recommendations:

- CGM is not recommended for coverage during pregnancy for type 2 diabetes or gestational diabetes (*weak recommendation*).
- CGM is recommended for coverage for women with type 1 diabetes who are pregnant or who plan to become pregnant within six months without regard to HbA1c levels (*weak recommendation*).

#### *National Institute for Health and Care Excellence (NICE)*

The NICE 2020 guideline, “Diabetes in Pregnancy: Management from Preconception to the Postnatal Period”<sup>13</sup> recommended the following regarding the use of CGMs for pregnant individuals with diabetes:

- CGM should not be offered routinely to pregnant women with diabetes.
- Consider CGM for pregnant women on insulin therapy who either have severe hypoglycemia or unstable blood glucose levels, or to gain information about changes in blood glucose levels.

#### *Endocrine Society*

The 2013 Endocrine Society evidence-based clinical practice guideline on “Diabetes and Pregnancy”<sup>14</sup> suggested that CGM be used during pregnancy for women with overt or gestational diabetes when SMBG is not sufficient to assess glycemic control. The society deemed this a weak recommendation due to low quality evidence. The society stated that “although there is a paucity of literature on continuous glucose monitoring use during pregnancy, there is evidence that in gestational diabetes, it will detect

clinically meaningful hypoglycemia and postprandial hyperglycemia that may go unrecognized by self-monitoring of blood glucose”.

### **Implantable Insulin Infusion Pumps**

No clinical guidelines identified related to implantable insulin infusion pumps.

### **EVIDENCE SUMMARY**

The evidence regarding implantable continuous glucose monitoring systems is limited and is largely restricted to small nonrandomized studies and one health technology assessment evaluating the Senseonics Eversense system. Available data suggest that Eversense demonstrates moderate analytical accuracy and high correlation with venous or capillary blood glucose measurements; however, performance is reduced in the hypoglycemic range, and there is limited evidence demonstrating improvement in clinical outcomes such as HbA1c reduction, hypoglycemia prevention, or quality of life compared with external CGM systems. No clinical studies or clinical practice guidelines were identified addressing the safety, effectiveness, or clinical utility of implantable insulin infusion pumps.

## **HEALTH EQUITY CONSIDERATIONS**

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online [here](#).

## **BILLING GUIDELINES AND CODING**

No more than a 3-month (90-day) quantity of any supply should be dispensed at one time.

<b>CODES*</b>		
<b>CPT</b>	0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including 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
	0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education
	0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days
<b>HCPCS</b>	E0782	Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.)
	E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)
	E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
	E1399	Durable medical equipment, miscellaneous

**\*Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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## POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
6/2023	Interim update. Added criteria regarding device removal. Removal of S1030 & S1031.
7/2023	Interim update and code set update for Q3 codes. Add a cumulative limit of 12 per calendar year for A4238 and A4239
6/2024	Annual update. No changes to criteria.
1/2025	Q1 code set update.
4/2025	Q2 code set update. Termed codes.
6/2025	Annual update. D-Nav Technology added to non-covered criteria. Clarified expected utilization frequency for supplies.
10/2025	Interim update. Added device to table; coding configuration update.
5/2026	Annual update. Added NMN counterpart to V.
6/2026	Interim update; removed external CGMs from scope of this policy, transfer to Pharmacy policy. Also removed external insulin infusion pumps from scope of policy.